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COMMITTEE ON HEALTH, SOCIAL SERVICES & ECONOMIC SECURITY

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August 19, 1991

To: Members, Committee on Health, Social Services and Economic Security

From: Paul Saucier

Re: Enclosures

In addition to the materials received by the entire Commission, you will find enclosed another executive summary (President's and Speaker's Blue Ribbon Commission on Children and Families) and a packet from Joyce regarding the schedule for Friday. See you then.

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FINAL DRAFT FOR EDITING

NOT FOR RELEASE - NOT FOR PUBLIC COMMENT

AUG 09 1991

A NEW VISION: EMPOWERING PEOPLE FOR CHANGE

MAINE'S MODEL FOR UNIFYING STATE SERVICES FOR CHILDREN & FAMILIES

FINAL REPORT OF THE PRESIDENT'S & SPEAKER'S BLUE RIBBON COMMISSION ON CHILDREN & FAMILIES

AUGUST 1991

DRAFT

CHAPTER 1

EXECUTIVE SUMMARY

Editor's Note: The Blue Ribbon Commission recognizes that due to the extensive debate about the state budget and the anticipated recommendations of the Restructuring Commission, the proposed recommendations and timetables may need to be adjusted when implemented.

MISSION OF THE BLUE RIBBON COMMISSION

The Blue Ribbon Commission on Children and Families was initiated in early May, 1990 by the Honorable Charles P. Pray, President of the Maine Senate and the Honorable John L. Martin, Speaker of the Maine House of Representatives. Its mission was to:

- Develop a plan to establish a distinct cabinet-level Department for Families and Children;
- Prepare legislation implementing a department with unified responsibilities for offering integrated services to Maine's children and families;
- Define the principles and components essential for State services to be well coordinated to fully attain a functionally integrated pattern of unified and consolidated administration and service delivery; and
- Identify methods of service delivery which are holistically oriented, child-focused, and family-focused.

BACKGROUND

During the 1980's the issue of "children and families at-risk" evolved into substantial and unresolved public policy debate. Our fellow citizens, educators, law enforcement personnel, business people, clergy, state leaders, and others became concerned. Simple questions were asked with increasing frequency.

"What's wrong with kids today?"
"Can't that family control their kids?"
"How do we sustain our society when children and families are at-risk?"

"Are kids learning to fulfill their potential?"
"Who's raising our children?"

The Blue Ribbon Commission conducted 16 meetings from May 1990 through April 1991. We attempted to answer some of the above concerns. All meetings were open to the public and included parents and community members. The basis for the Commission's formation and deliberations was L.D. 1666, which the Legislature considered in 1989 and 1990. The legislation proposed the establishment of a Department for Families and Children.

National authorities who addressed the Commission provided information on programs and planning efforts in other states about services for children at-risk and their families. Their presentations included information about strategies developed at the national level, the laws of all states, the plans and policies of other states, and their own hands-on experience. The twenty members of the Commission deliberated major policy issues at length, using work sheets, consulting with key administrators of children's programs, and conducting research of their own. Members reached consensus on the findings and recommendations which are included in this report.

Our report, **A New Vision: Empowering People For Change — Maine's Model For Unifying State Services For Children And Families** documents the fact that children and families at-risk are matters of national and state concern. Maine and the nation are engaged in a public policy debate regarding the best methods to address problems and potential problems associated with child development and family life. There is emerging consensus on principles to encourage positive child development, positive family life, and for guiding and restructuring service delivery. There is a growing field of information about how government and communities can become more supportive of at-risk families and children. Actions taken by other states provide a sound foundation for building a positive future. The need for innovative public and private action in Maine is becoming increasingly clear.

Our report consolidates the latest knowledge and best experience. We build on the work of national authorities and other states.

SUMMARY OF FINDINGS

The Blue Ribbon Commission on Children and Families finds:

1. THERE IS A NEED TO ASSURE THE AVAILABILITY OF SERVICES FOR MAINE'S CHILDREN AND FAMILIES. Many Maine children do not have adequate opportunities for personal development. Families in Maine are often isolated and lack natural support networks and other ties to the community. This isolation contributes to a

diminished capacity to fully and productively participate in the public and private life and business of the community. Isolation compounds the proliferation of problematic conditions such as poverty, substance abuse, illiteracy, and other human problems which significantly limit the potential for health family life and individual development. In addition, the Commission finds that current services are overloaded and not able to meet the needs of Maine's at-risk families and children.

2. STATE GOVERNMENT HAS RESPONSIBILITIES FOR AND ROLES TO PERFORM IN PROVIDING SERVICES FOR MAINE'S CHILDREN AND FAMILIES. When children and families are severely affected by poverty, substance abuse, illiteracy, and other human problems that diminish their ability to fully participate in the public and private life of the community, the State has roles to fulfill. These roles involve encouraging healthy child and family development, coordinating a range of supportive services for children and families at-risk, providing financial assistance, intervening to protect children who are abused and/or neglected, and making other services available to families and children who need them.

3. CURRENT PRACTICES FOR PROVIDING SERVICES FOR CHILDREN AND FAMILIES IN MAINE LACK COORDINATION AND PURPOSE. There are a number of state agencies currently providing services for children and families. These agencies are not coordinated, share no unified mission, and offer no single point of entry, responsibility, or accountability. The Legislative and Executive branches of government have responsibilities for developing policy and providing services for children and families. Neither branch of government has coordinated, unified, or efficient mechanisms for carrying out its responsibilities.

4. CURRENT STATE POLICIES RELATIVE TO FUNDING SERVICES FOR CHILDREN AND FAMILIES ARE INCOMPLETE AND INEFFECTIVE. The State currently fails to maximize the use of federal dollars and previously has not claimed all available federal matching for both administrative and supportive service costs. We recognize recent policy and budgetary actions to claim federal funds more appropriately. It is estimated that over $40 million in federal dollars could be obtained if the state chooses to seek them.

5. THE STATE CURRENTLY WASTES RESOURCES THROUGH PIECEMEAL POLICIES, FRAGMENTED, INEFFICIENT, AND COSTLY DUPLICATION OF SERVICES, ORGANIZATIONAL UNITS, AND ADMINISTRATIVE PRACTICES. Over 1,000 state employees provide services for Maine's children and families at a cost of over $100 million dollars a year. Many of these employees carry out duplicative efforts, doing the same work that counterparts in separate agencies

perform. Significant savings would result from the consolidation of duplicative services, organizational units, administrative practices, service contracts, and administrative oversight and audits.

6. **A LACK OF VISION LEAVES SERVICES WITHOUT AUTHORITY OR CAPACITY.** Maine's policy of maintaining multiple state agencies, side-by-side similar state functions, and overlapping responsibilities provides at-risk children and families services which are fragmented, inefficient, costly, and lacking in well-defined authority. Because the present piecemeal state approach lacks unified vision to guide child development and comprehensive family services, the state's ability to encourage appropriate and adequate community supports and community resources for children at-risk is compromised.

SUMMARY OF RECOMMENDATIONS

The Blue Ribbon Commission on Children and Families makes the following recommendations:

1. Adopt a Unified Mission Statement

The Blue Ribbon Commission recommends that the State adopt the following mission statement to govern its roles in the provision of service to children and families:

> *The State of Maine declares that each family has primary responsibility to provide for the developmental and human needs of its members and that state government has a responsibility to help families fulfill that obligation when they are unable to do so. Children have the right to a consistent nurturing environment and to the opportunity to attain their potential for development.*
>
> *The mission of government is to complement the roles of families, support networks and society in order to enhance their strengths. State government has the responsibility to intervene on behalf of children at-risk and to encourage the return to, or creation of, a nurturing family environment. The state's response should include supportive services and interventions that offer a functionally integrated continuum of appropriate and reasonable support, either directly or in concert with private organizations. Services should address the cognitive, educational, emotional, health, physical, and social needs of children and their families. The state's intervention is subject to the rights of*

families and children, their preferences, statutory authorization, and the availability of funds.

NOTE: The Commission recognizes the efforts of the Governor's Task Force to Improve Services for Maine's Children, Youth and Families in the development of the mission statement.

2. Define the Roles of Government

The Blue Ribbon Commission recommends that the roles of State government in providing services for children and families be more concisely defined and that the State base the services it provides in well articulated principles. These guiding principles are outlined later in this report, as are the responsibilities that the Commission believes reside with State government.

3. Creation of Joint Select Committee for Children & Families

The Commission recommends the establishment of a Joint Select Committee for Children and Families to be a focal point for public policy discussion of children's and families' issues and to offer oversight of state administered services. The Commission recommends that the Joint Select Committee for Children and Families be created by Joint Order during the 1991 session of the Legislature as an eventual companion to legislation enacting a Department for Families and Children.

Members of the Commission have divided opinions about the effective date for establishing the Joint Select Committee. Some recommend the effective date for the formal transition period to a unified department be the same as that for the establishment of the Joint Select Committee (i.e., October 1, 1991). Others recommend that the two occur separately, creating the Committee effective immediately upon passage of the joint order (i.e., June, 1991.)

4. Establish a Unified Department for Families & Children

The Commission recommends that a distinct department for children and families be established to unify responsibilities for providing delivery of functionally consolidated supportive services for families and children who need them. The department should be formed by consolidating, transferring, and revitalizing existing programs, administrative practices and personnel.

The programs and agencies recommended for consolidation are currently housed in the Department of Corrections, the Department of Education, the Executive Department, the Department of Human Services, the Department of Mental Health and Mental Retardation, and the Interdepartmental Council. As part of this consolidation, the Commission also recommends initiating a unified case management

system which is holistically-based, comprehensive, designed to stress education, human development, and preparation for the job market, and organized around the needs of high-risk children and their families. Members of the Commission strongly recommend that the transition to and full operation of the new unified department take place by January 1, 1993.

5. *Consolidation of Existing Committees*

The Commission recommends the consolidation of ten existing committees into a single independent advocacy organization for children and families. (Those committees and commissions are listed fully in the body of this report.) The Maine Commission for Children and Families should be an independent group designed to advocate for children and families and to provide an additional check and balance between the public and the State.

6. *Creation of a Family Foundation*

The Commission recommends the establishment of the Maine Family Foundation. This foundation is envisioned as a public-private partnership established to develop and promote positive family life, positive child development, primary prevention, early intervention, improvements in state policy and services, effective program administration, and research relative to children.

7. *State & Local Education Coordination*

In order to assure improved educational outcomes for all school age children, particularly those served by the Department for Children and Families, the Blue Ribbon Commission recommends that significant and substantial actions be taken to define, develop, and increase the coordination and cooperation between special education services personnel at the local level and the personnel and services of the Department for Children and Families.

8. *Medicaid for Children*

The Commission recommends full exploration of the transfer of the administrative responsibilities for the Medicaid program to the Executive Department.

9. *Transition Services for Children At-Risk*

The Commission believes that all children who are receiving supportive services through the Department for Children and Families and preparing to live independently should be eligible for transition services, modeled on the Transition Committee's program. The Commission recommends that the department's transition policy and

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program be designed to prepare all service recipients for independence from the Department's supportive services. This process and policy should be implemented after January 1, 1993.

10. Unified School District within the Department

The Commission recommends that during the transition process, the Department for Children and Families undertake an exploration of the establishment of a unified school district or intermediate educational unit within the Department.

11. Pineland Center

The Commission recommends that the goals, principles, and purposes that guide services for the Department for Children and Families be applied to services provided to the small number of children residing at Pineland Center.

12. Primary Prevention & Other Services

The Commission recommends that state supportive services focus on primary prevention and early intervention. Prevention and early intervention should be components of a comprehensive continuum of services and should be offered in concert with other private and public resources in the community.

Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

DRAFT

TO: Subcommittee members

From: Joyce

RE: Attached - Preparations for state agency presentations at August 23 meeting

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Enclosed are:

1. Memo to invitees

2. Agenda - schedule for presentations

3. Form for data collection

4. List of invitees (Carol is making contact with state agencies to finalize arrangements with speakers)

August 12, 1991

TO:

FROM: Rosalyne S. Bernstein and Roland Caron, Co-chairs
Special Commission on Governmental Restructuring,
Subcommittee on Health, Social Services and Economic
Security

RE: Request for information/presentation

The next meeting of the Special Commission on Governmental Restructuring, Subcommittee on Health, Social Services, & Economic Security will be on August 23 at 9:00 a.m. The focus of the meeting will be the services currently provided by state government. A very brief presentation is requested.

The subcommittee has identified five broad strategic issues. They include:

1. Interdepartmental Coordination
2. Public-private partnerships (privatization, opportunities for group purchasing, insurance, etc. to cut costs to service deliverers)
3. Impact of economic cycles on services
4. Governmental structures may be incompatible with client needs and services
5. Technological capacity

In the context of these five strategic issue areas, please be prepared to answer the following three questions about the services your office provides:

1. Identify duplication and/or overlap of services for this group of consumers. What problems do they present to the client?

2. What do you see as the emerging issues/needs of your clients by the year 2000? And what structural changes are needed to meet those needs?

3. What is the Number 1 thing you would change?

Because of time constraints, the subcommittee has scheduled several individuals from different departments to present information during each time block. Each group will have approximately 20 minutes with an additional five minutes reserved

for questions. You are therefore encouraged to plan your presentation in coordination with the others (names listed at the top of this memo) prior to the meeting in order to make most efficient use of the small amount of time available.

In order to avoid spending time on basics, a simple form is enclosed on which to list specific services provided, client group served, case size, budget, etc. Please bring the completed form on the 23rd.

Thank you for your valued assistance.

COMMITTEE ON GOVERNMENTAL RELATIONS AND PROCESS;
SPECIAL COMMISSION ON GOVERNMENTAL RESTRUCTURING

August 23, 1991 Agenda

9:15 - 10:00 Brief presentations by Legislators:

Representative Charlene Rydell

Representative Gary Reed

Senate President Charles Pray

Senator Pamela Cahill

10:00 - 11:00 Questions and answers with Committee and Legislators

11:00 - 12:00 Staff discussion of materials to be distributed.

12:00 - 12:45 Lunch

12:45 - 2:30 Presentation by, discussion with Finance Commissioner Sawin Millett and Acting Administration Commissioner Dale Doughty.

Department:______________________

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m

(use as many pages as needed to list all services provided to each client group)

Invitees: (tentative)

Children, Youth & Families:

DHS	Peter Walsh
MH	Bob Durgin
DCS	Nikki (or Head Start - Cheryl Leeman)
Educ	David Stockford
Corrections	A.L. Carlysle

Subastance Abuse:

OSA	Ron Speckman
DHS	Sylvia --- (contract manager)
MH	Marlene Pelser
Corr	Jerry Sampson
Educ	Carl Mowatt

Unemployed/Underemployed:

DHS	Sabra Burdick (income maint, GA. Aspire, etc)
VR	
Labor	Jim Naiman (PICs JTPA)

Homeless, Underhoused:

DECD	Margaret Marshall
MSHA	?? ask Dwight
DHS	Peter W or Jamie M. (shelter funding)

Elders:

DHS	Chris G.
MH	Joyce Harmon
MR	?
DHS	Fran Finnegan (Nursing, boarding, etc) Medicaid, funding, licensing issues

Abused & Neglected Adults:

DHS	Chris G (adult protective)
MR	(guardianship program - Duncan McNelly
MH	?? ?? ??
DHS	(battered women svcs ??

Chronically Ill - long term care:

DCS	Elaine Fuller or Fran Finnegan - Nursing & Boarding
DCS	Lani Graham - Aids, CP, CF, other long term dieseases
MH	Ron Welch, Glover - chronically mentally ill
?	MAP account - hospital funding

Mentally Ill:

MH	BOb Glover/Ron Welch
DHS	Chris G. (adults
	Peter W. (children
Corr	AL Carlysle
MH	institutional svcs
Rehab	Pam Tetley
Educ	(PET counseling)

Mentally disabled:

DMR	Welch, Glover
DHS	Pam Tetley

Physically Disabled:

DHS	Pam Tetley
MH	Ron Welch
Labor	BLS - workplace safety/health issues

Others needing health care:

Me Health Program Fran Finnegan
Medicaid "
Prevention - Bur of Hlth Lani Graham\
CON John Dickens
Labor - HOP
Fame - Gloria Neadeau - student loan program

DEPARTMENT OF HUMAN SERVICES
PUBLIC ASSISTANCE BENEFITS
UNEMPLOYED/UNDEREMPLOYED

1. DUPLICATION/OVERLAP

- DHS administrative costs for operating these programs is among the lowest in the nation.

- Therefore, privatization is probably not called for but these and other services provided to these same individuals could benefit from technological enhancements and better coordination.

- The current structure can lead to client confusion and frustration.

2. EMERGING ISSUES

- The Federal Family Support Act of 1988 is intended to change the philosophical direction of public welfare programs; to change "welfare" from an income source in and of itself to a program designed to help families become self sufficient through increased child support from the absent parent and full time employment for the custodial parent. The Act sunsets in 1999. Our major goal should be to achieve the goals of the Act.

- Thus, our major issue is to create opportunities for unemployed/underemployed low income women with children to receive the necessary training and support to achieve economic self sufficiency.

- Maine's child support enforcement program consistently ranks in the top 10% of states in regard to efficiency and effectiveness.

- Through ASPIRE Maine has developed an effective structure for delivering education and training services.

- Efforts should be made to better coordinate the variety of support services developed to supplement the family's basic needs.

3. NUMBER 1 CHANGE

- Create a more coordinated service delivery system through technological enhancements, some restructuring and co-location.

Topic	Sub-Category	Criteria	Service	monthly Clients Served	State	Costs Federal	Total
employed/ Underemployed	AFDC	• 64% poverty • $1,000 assets • deprivation	• monthly cash benefit • medicaid • info/referral • job training	62,000	33.8	66 m	$99.8 m
	Food Stamps	• 130% FPL • $2,000 assets $3,000	monthly allot. I+R minimal job training	125,000	-0-	84 m	$84 m
	ASPIRE	• AFDC elig.	• case mgt. • purchase of job training	6,000	3.3 m	4.8 m	$8.1 m
	Family Services	• teenager on AFDC	• case mgt • purchase of job readiness services	1,000	1.3	1.9	3.2 m
	Emergency Assist.	• 100% FPL • in crisis	• vendor payments for shelter, utilities, home repair as a result of disasters	8,000	1 m.	1 m	$2 m
	General Assist.	• 100% FPL • require help in meeting basic necess.	• vouches for food, utilities, shelter	14,000	15.2 state 3.8 local	-0-	$19 m
	Child Support Enforcement	• absent parent not paying support	• establish paternity • locate absent parent • estab. + collect child support	150,000	—	—	Total revenue $38.1 m
	SSI supplement	aged/blind/ disabled	• State $ supplement • Medicaid	23,500	7.2 m	—	7.2 m

Topic	Sub-Category	Criteria	Service	Clients Served	Costs State	Federal	Total
employed/ Underemployed (cont.)	Medicaid	preg. ♀ + kids under 1 = 185% poverty no asset test kids 1-6 133% FPL no asset test kids 6-9 100% FPL no asset test elderly/disabled 100% FPL $2,000 asset 9-21 = 64% poverty/ +21 + not disabled must meet AFDC guidelines	• payment of medical bills	135,000	see	Bureau Medical Services.	
	Nursing Homes	income under $3,200 2,000 asset	• payment for medical bills starts at 3,200 • payment of nursing home starts at 2,000				
	Boarding Homes	income under 1,500 2,000 asset	boarding home payment				
	Medically Needy	• 50% poverty • 2,000 asset					
	Me. Health Program	up to 18 125% FPL no asset test 18+ 95% poverty 2,000 asset					

Dist 8/23 HHS

TO: Jane Fowler

FROM: Sue Crawford

DATE: August 22, 1991

SUBJ: Prevention of Homelessness - Action Steps for Consideration

I. "One Stop" - Office of Prevention of Homeless

This office would serve as a clearinghouse of information for those who are homeless or at-risk of being homeless. The scenario of clients being "bounced" from one agency to another would cease.

The office would also be responsible for providing training and education for front line workers, including but not limited to DHS, CAPs, Churches, Salvation Army, local GA directors, Housing Providers, etc. Training and educational sessions will also make available a Resource Directory which will help in making sure referrals are appropriate. A part of this program would also include PSAs for the better education of the housing consumer.

Provides research to ascertain all available resources, state and federal dollars, are being fully utilized.

II. Security Deposit Program, rental and mortgage assistance

Revolving loan fund (federal dollars?)

Use THAP for grant recipients only (those who cannot afford to repay a loan)

Make Family Crisis (Emergency Assistance for Needy Families in Maine) a less restrictive grant

III. Prepare for the next round of McKinney funding.

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The state of Maine has approximately fifty homeless shelters. Recent data shows emergency shelters served over 4,700 different persons between 12/1/89 and 6/30/90. While emergency shelters play an integral role in serving Maine's homeless population, our experience has been that those who are either homeless or at-risk of homelessness often times do not access emergency shelters. Typically those who refuse to utilize shelters are single women with children.

Their refusal to use emergency shelters is based upon a variety of reasons. Maine is a rural state and it makes good sense to offer shelters in metropolitan areas. However accessing a shelter from rural areas is difficult if not impossible. In many instances shelters are specialized, that is specifically designed for special needs populations like family violence victims, substance abusers or mentally ill. Because there are no shelters for the general use of women with children, women are hesitant to expose their children to either mentally the ill or substance abusers.

Added to the difficulty of accessing shelters along with the fears of exposing children to potentially dangerous individuals, is the fact that financial resources continue to diminish.

The economy and budget constraints have forced tighter eligibility requirements for welfare programs. Funding levels have also been reduced. Emergency programs which, in the past, provided adequate resources for families to survive have been cutback. These cutbacks result in fewer people being eligible

for emergency services. Those who are eligible find the programs much more restrictive and grant amounts have also been lowered.

At the same time emergency programs are being cut, rental fees are rising. Landlords have little choice as property taxes and insurance costs increase.

Consequently we have seen a major trend change. Those people on the edge, surviving only on Aid For Dependent Children and local General Assistance have found it impossible to maintain their own homes. Because of the rural nature of the state, accessing resources has also been a factor in this trend change. At this time emergency sheltering has primarily become the responsibility of friends and family. Of the housing consumers calling Maine State Housing Authority's information line who are homeless or at-risk of homelessness, nearly 50% are either living with friends or relatives.

Unlike our homeless shelters which offer safe and decent shelter, doubling-up with friends and family creates conditions which are overcrowded, unhealthy and simply not decent nor sanitary. There are numerous scenarios, but the most common is two to three families living in substandard housing. During the crisis, this alternative appears to be temporary as is the case with a shelter. However reality dictates this type of housing has become quite permanent.

Renters are not the only housing consumers experiencing difficulty in maintaining their own home. Budget crunches have also impacted business. More people are unemployed or under-

employed. Unemployed homeowners now seek financial assistance to make mortgage payments.

The overall effects are devastating. Children are removed from their community, friends and school. Structural conditions of their homes is most often deplorable. The emotional effects of all involved may never be overcome.

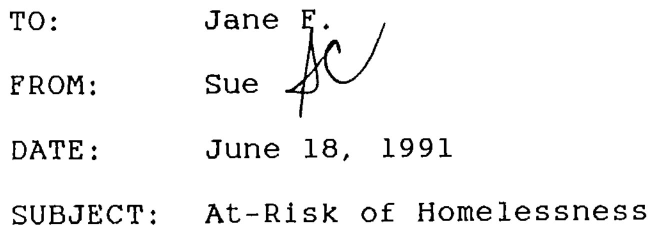
On the other hand, as people continue to share housing, landlords are experiencing vacancies. Landlords are screaming for Section 8 tenants. They are running ads offering free rent for the first month or a free tank of oil. Unfortunately the vacancies still exist and more vacancies are occurring.

For those "middle-class families who are unfamiliar with available resources there are different problems. The network and information sharing of service providers in many cases is inadequate. Those consumers who seldom if ever use the "system" often times become frustrated with the inability of service providers to share all available resources. It is not uncommon for clients to make literally dozens of contacts before locating appropriate resources.

We have been able to identify the "hidden homeless." While the majority of the hidden homeless are not actually living on the streets, the potential is certainly there and at any moment circumstances could push people out of their present living arrangement. Ownership default, family disputes or even local codes enforcers could easily force this at-risk population into homelessness.

In many cases financial resources with less restrictions would prevent homelessness. To regain an apartment, people need security deposits and a first month's rent. To maintain one's home, there needs to be a program to help with a mortgage payment, even two. Our experience shows people lose their homes because of unpredictable circumstances. They lose a job and cannot meet mortgage payments, their husband leaves and they need help with a rent payments, because they opted to repair the vehicle that takes them to work, they cannot make this month's rent payment or their building was condemned and they do not have the money for a security deposit and first month's rent. Most people simply need temporary financial assistance to prevent homelessness.

In an attempt to prevent homelessness, we would like to operate demonstration programs that would provide financial assistance for security deposits, rent payments and mortgage payments as well as provide training and education for better service provider networking and information sharing.



TO: Jane E.

FROM: Sue

DATE: June 18, 1991

SUBJECT: At-Risk of Homelessness

Since homelessness has become an issue, there have been several questions regarding the cause of homelessness, the actual number of people who are homeless, where the homeless come from and what remedies or solutions are availabledo to eliminate the problem. In the early years homelessness became almost accepted because typically we would hear of a single individual who generally was either mentally ill or a substance abuser. Society simply found it easier to accept this population being homeless and even went so far as to say "those people chose to be homeless."

Unfortunately, there are many obstacles when we start to deal with the homeless situation. First, it is impossible to "count" the homeless. Even the Census Bureau tried, and failed. There is a growing passion to learn the exact number of people who are either homeless or facing homelessness. It is relatively simple to count the number of people who use homeless shelters. However, I am of the opinion that those using the shelters are the minority. The fastest growing "category" of homeless people are single women with children. Unless these families are victims of violence, they will not utilize a shelter. Secondly there is no absolute definition of homeless. Is a person homeless if they are living on the street, living in a vehicle, living in a shelter, living with relatives or friends, or have no permanent housing? Virtually every program developed to address the needs of the homeless has a different definition of homelessness. Thirdly, where do the homeless come from, are they mentally ill, substance abusers or families? In some instances where the homeless individual accesses a substance abuse shelter, we may be able to identify the cause for homelessness. However, with the Federal Fair Housing Laws, it would be considered discrimination to ask, for example, my consumers, if they are mentally disabled or alcoholics.

We are presently gathering data relevant to shelter users. Again, it is my belief that shelter users do not give a clear picture of the actual number of people who are homeless. As a result of my opinions and beliefs, I started logging information regarding where our "at-risk" population lives as well as information regarding family structure. The following is a

breakdown of consumers who were "at-risk" for the past year - that is June 1, 1990 through May 31, 1991.

During the past year the housing information line has received 334 calls from "at-risk of homelessness" consumers. The family structure of those consumers is, 208 single females, 41 single males, 85 couples (actual 170 people) and 489 children. Further 43 of the females who called were pregnant. This equates to a possible homeless population of 1,051.

Living with relatives	107
Displaced due to eviction	80
Living with friends	44
Displaced due to separation/divorce	21
Living in a shelter	13
Living in a vehicle	11
Living in a tent	7
Living in a camper	7
Homeownership default	6
Homeless	6
Burn out victims	6
Family violence victims	6
Substandard housing	5
Building has been condemned	5
Living in a summer rental	3
Living in a motel/hotel	3
Run away youth	1
Vacating due to severe harassment	1
Living in a garage	1
Living in the woods	1

The greatest trend change I have seen over the past year is that the single women with children are no longer trying to maintain their own apartments. Rent costs are high and the waits for low-income housing are lengthy. Consequently, people are living with relatives or friends. This has created over-crowded, unhealthy conditions as well as high vacancy rates. Landlords who traditionally have not wanted low-income tenants are now begging for them because their apartments are vacant. Obviously this impacts our economy.

Attached to this memo you will find a report that will also identify the geographic location of the callers. This will give you a better idea of what areas in the state are facing the greatest difficulty in providing alternatives for the homeless.

After you have had an opportunity to review this memo and attachments, I would be more than pleased to answer any questions you might have or the provide any additional information.

SC/s

Attachment

MSHA HOTLINE AT RISK REPORT

06/12/91

Calls For The Period: 6/1/90 - 5/31/91

The following is a list of calls received during the above period from residents who are at risk of becoming homeless.

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
1	0	0	1	-	Auburn	Androscoggin	Living with friends
0	0	1	1	-	Auburn	Androscoggin	Living with relatives
1	0	0	1	-	Auburn	Androscoggin	Living with relatives
0	1	0	2	-	Auburn	Androscoggin	Living with friends
1	0	0	2	-	Auburn	Androscoggin	Facing eviction
0	0	1	4	-	Auburn	Androscoggin	Living with family
1	0	0	3	-	Auburn	Androscoggin	Living with relatives
1	0	0	1	-	Auburn	Androscoggin	Living with friends
0	0	1	3	-	Jay	Androscoggin	Living in a car
1	0	0	1	-	Leeds	Androscoggin	Living in a car
0	0	1	2	-	Leeds	Androscoggin	Living with relatives
0	1	0	4	-	Lewiston	Androscoggin	Living with relatives
1	0	0	2	Y	Lewiston	Androscoggin	Living with relatives
1	0	0	0	Y	Lewiston	Androscoggin	Living with friends
0	0	1	0	-	Lewiston	Androscoggin	Facing eviction
1	0	0	4	-	Lewiston	Androscoggin	Living with friends
1	0	0	4	-	Lewiston	Androscoggin	Being displaced due to separation
1	0	0	0	Y	Lewiston	Androscoggin	Living with family
1	0	0	1	-	Lewiston	Androscoggin	Living in overcrowded conditions
1	0	0	0	-	Livermore	Androscoggin	Family violence victim
0	0	1	2	-	Livermore Falls	Androscoggin	Burn out victims
1	0	0	3	-	Livermore Falls	Androscoggin	Burn out victims
1	0	0	3	-	Poland	Androscoggin	Living in a camper
0	1	0	2	-	Caribou	Aroostook	Living with relatives
1	0	0	2	-	Caribou	Aroostook	Living in a shelter

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
0	0	1	3	-	Fort Fairfield	Aroostook	Facing eviction
0	1	0	0	-	Houlton	Aroostook	Facing eviction
0	0	1	2	-	Madawaska	Aroostook	Being evicted
0	0	1	5	-	Van Buren	Aroostook	Being evicted
0	0	1	6	-	Bridgton	Cumberland	Facing eviction
1	0	0	0	-	Brunswick	Cumberland	Living with relatives
0	0	1	1	-	Brunswick	Cumberland	Living with relatives
1	0	0	2	-	Brunswick	Cumberland	Living in a camper
0	1	0	2	-	Brunswick	Cumberland	Living in a motel
1	0	0	1	-	Brunswick	Cumberland	Living with relatives
0	1	0	0	-	Cumberland	Cumberland	Living with relatives
0	0	1	2	-	Cumberland	Cumberland	Ownership default
1	0	0	0	-	Falmouth	Cumberland	Displaced due to separation
1	0	0	0	Y	Freeport	Cumberland	Facing eviction
1	0	0	1	-	Freeport	Cumberland	Domestic violence victims
1	0	0	0	Y	Gorham	Cumberland	Living with relatives
1	0	0	2	-	Gorham	Cumberland	Living with relatives
0	0	1	2	-	Harrison	Cumberland	Living in a tent
1	0	0	2	-	Naples	Cumberland	Displaced due to separation
1	0	0	3	-	North Baldwin	Cumberland	Displaced due to ownership default
1	0	0	1	-	North Yarmouth	Cumberland	Living with relatives
1	0	0	5	-	Portland	Cumberland	Living in a shelter
1	0	0	1	-	Portland	Cumberland	Living with friends
1	0	0	0	-	Portland	Cumberland	Living on the streets
1	0	0	2	-	Portland	Cumberland	Living with relatives
0	0	1	4	-	Portland	Cumberland	Being evicted
0	1	0	0	-	Portland	Cumberland	Living in an automobile
1	0	0	2	-	Portland	Cumberland	Living with relatives
1	0	0	6	-	Portland	Cumberland	Living with relatives
1	0	0	3	-	Portland	Cumberland	Being evicted
1	0	0	2	-	Portland	Cumberland	Living in a camp
0	0	1	3	-	Raymond	Cumberland	Living with relatives
0	0	1	2	-	Raymond	Cumberland	Living with relatives

Family Structure

Single Female	Single Male	Couple	Kids	P?	Municipality	County	Comments
0	0	1	2	-	Raymond	Cumberland	Living in a shelter
1	0	0	1	-	Scarborough	Cumberland	Living with relatives
0	0	1	4	-	Scarborough	Cumberland	Being evicted
0	1	0	0	-	South Freeport	Cumberland	Living with relatives
1	0	0	2	-	South Portland	Cumberland	Living with relatives
0	1	0	4	-	South Portland	Cumberland	Living with friends
0	1	0	0	-	South Portland	Cumberland	Being evicted
1	0	0	2	-	South Portland	Cumberland	Family voilence victims
1	0	0	1	-	Standish	Cumberland	Living with relatives
1	0	0	5	-	West Baldwin	Cumberland	Facing eviction
1	0	0	0	Y	Westbrook	Cumberland	Living in a truck
1	0	0	0	Y	Westbrook	Cumberland	Facing eviction
0	0	1	1	-	Westbrook	Cumberland	Being evicted
1	0	0	2	-	Westbrook	Cumberland	Being evicted
1	0	0	2	-	Westbrook	Cumberland	Being evicted
0	0	1	0	Y	Westbrook	Cumberland	Living with family
1	0	0	4	-	Windham	Cumberland	Living with relatives
1	0	0	4	-	East Wilton	Franklin	Living with friends
1	0	0	2	-	Farmington	Franklin	Living with relatives
0	0	1	2	-	Farmington	Franklin	Living with relatives
1	0	0	2	-	Farmington	Franklin	Living with relatives
1	0	0	1	-	Farmington	Franklin	Have been evicted
0	0	1	1	Y	Strong	Franklin	Burn out victims
1	0	0	2	-	Temple	Franklin	Living with friends
0	1	0	0	-	Bar Harbor	Hancock	Living on the streets
1	0	0	1	-	Bass Harbor	Hancock	Living with relatives
1	0	0	3	-	Ellsworth	Hancock	Living with friends
1	0	0	2	-	Ellsworth	Hancock	Living with relatives
1	0	0	1	-	Ellsworth	Hancock	Displaced due to separation
0	0	1	0	-	Franklin	Hancock	Living with family
0	0	1	1	-	Hancock	Hancock	Being evicted
1	0	0	2	-	Stonington	Hancock	Displaced due to separation

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
1	0	0	2	-	Sullivan	Hancock	Living with relatives
1	0	0	3	-	Sullivan	Hancock	Facing eviction
1	0	0	1	-	Surry	Hancock	Living with friends
1	0	0	2	-	Surry	Hancock	Living in a camper
0	0	1	4	-	Trenton	Hancock	Facing eviction
1	0	0	1	-	Winter Harbor	Hancock	Living with relatives
1	0	0	2	-	Augusta	Kennebec	Displaced due to separation
0	0	1	1	-	Augusta	Kennebec	Being evicted
1	0	0	0	-	Augusta	Kennebec	Living in a shelter
1	0	0	0	-	Augusta	Kennebec	Living in a shelter
1	0	0	0	-	Augusta	Kennebec	Living in a shelter
1	0	0	1	-	Augusta	Kennebec	Living with family
0	0	1	1	-	Augusta	Kennebec	Living with relatives
1	0	0	2	-	Augusta	Kennebec	Displaced due to separation
1	0	0	2	Y	Augusta	Kennebec	Living with relatives
0	1	0	0	-	Augusta	Kennebec	Living with relatives
1	0	0	2	-	Augusta	Kennebec	Living with relatives
0	1	0	0	-	Augusta	Kennebec	Burn out victim
1	0	0	0	Y	Augusta	Kennebec	Living with relatives
0	1	0	0	-	Augusta	Kennebec	Homeless - no shelter
1	0	0	2	-	Augusta	Kennebec	Overcrowded conditions
0	1	0	0	-	Augusta	Kennebec	Living with relatives
0	1	0	0	-	Augusta	Kennebec	Living in a shelter
1	0	0	1	-	Augusta	Kennebec	Burn out victims
1	0	0	0	Y	Augusta	Kennebec	Facing eviction
1	0	0	3	-	Augusta	Kennebec	Living with friends
0	0	1	0	-	Augusta	Kennebec	Living with relatives
1	0	0	0	Y	Augusta	Kennebec	Living with relatives
0	0	1	0	-	Augusta	Kennebec	Building has been condemned
1	0	0	1	Y	Benton	Kennebec	Living with relatives
0	1	0	0	-	Gardiner	Kennebec	Living in a vehicle
0	0	1	2	-	Gardiner	Kennebec	Living with relatives
1	0	0	2	-	Gardiner	Kennebec	Living with relatives

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
1	0	0	2	-	Gardiner	Kennebec	Living with friends
0	0	1	0	-	Gardiner	Kennebec	Illegal eviction
1	0	0	1	-	Gardiner	Kennebec	Living with relatives
1	0	0	1	-	Litchfield	Kennebec	Living with friends
1	0	0	2		Oakland	Kennebec	Living with relatives
0	1	0	0	-	Oakland	Kennebec	Adolescent male - kicked out by parents - living in the woods
1	0	0	1	-	Oakland	Kennebec	Living with relatives
1	0	0	2	-	Oakland	Kennebec	Possible mortgage default
1	0	0	1	-	Pittston	Kennebec	Living with relatives
1	0	0	0	-	Sidney	Kennebec	Displaced due to separation
0	0	1	2	-	Vassalboro	Kennebec	Facing eviction
1	0	0	0	-	Waterville	Kennebec	Living with friends
0	0	1	0	Y	Waterville	Kennebec	Living with friends
1	0	0	1	-	Waterville	Kennebec	Living with friends
1	0	0	2	-	Waterville	Kennebec	Living with relatives
0	1	0	0	-	Waterville	Kennebec	Being evicted
1	0	0	1	-	Waterville	Kennebec	Living with friends
0	0	1	1	-	Waterville	Kennebec	Living in a shelter
0	0	1	2	-	Waterville	Kennebec	Facing eviction
0	0	1	0	-	Wayne	Kennebec	Living with friends
1	0	0	0	-	Weeks Mills	Kennebec	Being evicted
1	0	0	2	-	Winslow	Kennebec	Living with relatives
1	0	0	1	-	Winslow	Kennebec	Displaced due to separation
1	0	0	1	-	Winthrop	Kennebec	Living with friends
1	0	0	0	Y	Winthrop	Kennebec	Living with relatives
0	0	1	2	-	Camden	Knox	Facing eviction
1	0	0	2	-	Lincolnville	Knox	Displaced due to separation
1	0	0	1	-	Port Clyde	Knox	Living with relatives
1	0	0	0	-	Rockland	Knox	Living in a vehicle
1	0	0	1	-	Rockland	Knox	Living with family
2	0	0	5	Y	Rockland	Knox	Facing eviction
2	0	0	2	-	Rockland	Knox	Being evicted

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
0	1	0	1	-	Rockland	Knox	Living with relatives
0	0	1	1	-	Rockland	Knox	Living in a camper
1	0	0	3	-	Rockland	Knox	Living in a tent
1	0	0	0	-	Rockland	Knox	Facing eviction
1	0	0	1	-	Rockland	Knox	Being evicted
0	0	1	1	Y	Thomaston	Knox	Living with relatives
1	0	0	1	-	Thomaston	Knox	Facing eviction
1	0	0	2	-	Union	Knox	Living with relatives
0	0	1	2	-	Vinalhaven	Knox	Living in a camper
0	0	1	2	-	Washington	Knox	Substandard housing
1	0	0	2	Y	Boothbay	Lincoln	Being evicted
0	0	1	1	Y	Damariscotta	Lincoln	Being evicted
1	0	0	3	-	Damariscotta	Lincoln	Facing eviction
1	0	0	1	-	Damariscotta	Lincoln	Living with friends
0	1	0	3	-	Dresden	Lincoln	Living with relatives
1	0	0	1	-	Jefferson	Lincoln	At risk due to separation
0	0	1	0	Y	Jefferson	Lincoln	Being evicted
1	0	0	3	-	New Harbor	Lincoln	Living with relatives
1	0	0	2	-	North Whitefield	Lincoln	Substandard housing - building will be condemned
1	0	0	1	-	Waldoboro	Lincoln	Being evicted
0	0	1	1	-	Waldoboro	Lincoln	Being evicted
1	0	0	1	-	Warren	Lincoln	Being evicted
0	0	1	4	-	Buckfield	Oxford	Living with relatives
0	0	1	0	Y	Dixfield	Oxford	Living with relatives
1	0	0	2	-	Dixfield	Oxford	Living with relatives
1	0	0	1	Y	Fryeburg	Oxford	Living with relatives
1	0	0	2	-	Fryeburg	Oxford	Living with friends
1	0	0	1	Y	Fryeburg	Oxford	Living with relatives
1	0	0	2	-	Norway	Oxford	Living with relatives
1	0	0	1	-	Norway	Oxford	Living with friends
1	0	0	2	-	Oxford	Oxford	Living with relatives

Family Structure							
Single							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
1	0	0	1	-	Oxford	Oxford	Living with friends
0	0	1	1	Y	Rumford	Oxford	Living with relatives
0	0	1	3	-	Rumford	Oxford	Living in a summer rental
0	0	1	3	-	Rumford	Oxford	Being evicted
1	0	0	1	-	Sumner	Oxford	Displaced due to separation
1	0	0	1	Y	Alton	Penobscot	Living with friends
1	0	0	2	-	Anon	Penobscot	Living in a motel
1	0	0	2	-	Bangor	Penobscot	Displaced due to separation
1	0	0	2	-	Bangor	Penobscot	Living with relatives
1	0	0	0	Y	Bangor	Penobscot	Living in a shelter
1	0	0	0	-	Bangor	Penobscot	Building has been condemned
1	0	0	2	-	Bangor	Penobscot	Living in a shelter
1	0	0	0	Y	Bangor	Penobscot	Living with friends
1	0	0	2	-	Bangor	Penobscot	Living in a shelter
0	0	1	2	-	Bangor	Penobscot	Facing eviction
0	0	1	0	-	Bangor	Penobscot	Living in a garage
0	0	1	1	-	Brewer	Penobscot	Living in a house which has been condemned
0	1	0	1	-	Brewer	Penobscot	Living with relatives
0	1	0	2	-	Corinna	Penobscot	Facing eviction
0	0	1	0	-	Dexter	Penobscot	Being evicted
1	0	0	4	-	Dexter	Penobscot	Burn out victim
1	0	0	3	-	Dixmont	Penobscot	Displaced due to separation
1	0	0	3	-	Dixmont	Penobscot	Displaced due to separation
0	0	1	2	-	East Corrinth	Penobscot	Living with relatives
0	0	1	0	Y	Eddington	Penobscot	Living in a tent
1	0	0	1	-	Eddington	Penobscot	Living in a tent
0	0	1	4	-	Exeter	Penobscot	Living with friends
1	0	0	1	-	Greenbush	Penobscot	Living with relatives
1	0	0	0	Y	Howland	Penobscot	Living in a car
0	0	1	0	-	Lincoln	Penobscot	Building is being condemned
1	0	0	2	-	Medway	Penobscot	Displaced due to separation
1	0	0	1	-	Medway	Penobscot	Living with relatives
1	0	0	2	-	Old Town	Penobscot	Family violence victims
1	0	0	2	-	Old Town	Penobscot	Displaced due to separation
1	0	0	2	-	Old Town	Penobscot	Family violence victims

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
0	0	1	6	-	Old Town	Penobscot	Being evicted
0	0	1	2	-	Orono	Penobscot	Living in a camper
0	1	0	0	-	Orono	Penobscot	Living with friends
1	0	0	2	-	Dover	Piscataquis	Being evicted
1	0	0	3	-	Dover-Foxcroft	Piscataquis	Living with friends
1	0	0	0	Y	Bath	Sagadahoc	Homeless
0	0	1	0	-	Bath	Sagadahoc	Facing eviction
1	0	0	2	-	Bath	Sagadahoc	Living with friends
1	0	0	0	Y	Bath	Sagadahoc	Homeless - has no shelter
1	0	0	2	-	Bowdoin	Sagadahoc	Being evicted
1	0	0	1	-	Bowdoin	Sagadahoc	Being evicted
0	1	0	0	-	Bowdoinham	Sagadahoc	Living in his car
1	0	0	2	-	Richmond	Sagadahoc	Facing eviction
0	0	1	1	-	Richmond	Sagadahoc	Being evicted
1	0	0	2	-	Topsham	Sagadahoc	Being evicted
1	0	0	1	-	Topsham	Sagadahoc	Living with relatives
0	0	1	2	-	Anson	Somerset	Being evicted
0	0	1	4	-	Anson	Somerset	Living with friends
0	0	1	1	-	Canaan	Somerset	Landlord has sold the house they are renting
0	1	0	0	-	Fairfield	Somerset	Living in substandard housing
1	0	0	0	-	Fairfield	Somerset	Family violence victim
0	0	1	3	-	Harmony	Somerset	Living in a tent
1	0	0	0	Y	Hartland	Somerset	Living with friends
1	0	0	0	Y	Madison	Somerset	Living with relatives
0	1	0	0	-	Pittsfield	Somerset	Living on the streets
1	0	0	4	-	Skowhegan	Somerset	Living with relatives
1	0	0	1	-	Skowhegan	Somerset	Displaced due to separation
1	0	0	1	-	Skowhegan	Somerset	Living with relatives
0	1	0	0	-	Skowhegan	Somerset	Living in a car
1	0	0	1	Y	Skowhegan	Somerset	Living with friends
1	0	0	2	-	Skowhegan	Somerset	Living in a hotel

Family Structure							
— Single —							
Female	Male	Couple	Kids	P?	Municipality	County	Comments
0	0	1	2	Y	Skowhegan	Somerset	Living in a tent
0	0	1	4	-	Skowhegan	Somerset	Living with friends
1	0	0	1	-	Starks	Somerset	Living with relatives
0	1	0	0	-	Belfast	Waldo	Living with friends
0	1	0	0	-	Belfast	Waldo	Being evicted
1	0	0	2	-	Belfast	Waldo	Displaced due to separation
0	1	0	0	-	Belfast	Waldo	Homeless - no shelter
1	0	0	1	-	Belfast	Waldo	Living with friends
1	0	0	3	-	Belfast	Waldo	Living with relatives
1	0	0	1	-	Brooks	Waldo	Living with family
1	0	0	2	-	Morrill	Waldo	Living with relatives
1	0	0	3	-	Searsmont	Waldo	Displaced due to separation
0	0	1	1	Y	Searsmont	Waldo	Living in a camper
0	0	1	4	-	Searsport	Waldo	Living with friends
1	0	0	2	-	Searsport	Waldo	Living with relatives
0	1	0	0	-	Thorndike	Waldo	Living in an automobile
1	0	0	1	-	Unity	Waldo	Living with relatives
0	1	0	0	-	Unity	Waldo	Living on the street
1	0	0	2	-	Unity	Waldo	Being evicted
1	0	0	1	-	Unity	Waldo	Living with friends
1	0	0	3	-	Winterport	Waldo	Living with friends
0	0	1	2	-	Winterport	Waldo	Living with relatives
1	0	0	1	-	Winterport	Waldo	Facing eviction
1	0	0	1	-	Addison	Washington	Displaced due to separation
1	0	0	2	-	Calais	Washington	Being evicted
1	0	0	2	-	Dennysville	Washington	Living with friends
0	0	1	0	-	East Machias	Washington	Vacating unit due to severe harassment
0	1	0	0	-	Eastport	Washington	Being evicted
0	0	1	1	-	Lubec	Washington	Living with family
0	0	1	0	Y	Milbridge	Washington	Living in a tent

Family Structure

Single Female	Single Male	Couple	Kids	P?	Municipality	County	Comments
1	0	0	2	-	Milbridge	Washington	Rental unit being renovated into commercial rental
0	0	1	1	-	Princeton	Washington	Living with relatives
1	0	0	0	-	Woodland	Washington	Living with family
1	0	0	2	-	Biddeford	York	Living with relatives
1	0	0	1	-	Biddeford	York	Living with relatives
1	0	0	0	-	Biddeford	York	Her parents have thrown her out
0	1	0	0	-	Biddeford	York	Living in a car
0	1	0	1	-	Biddeford	York	Being evicted
1	0	0	1	-	Buxton	York	Living with relatives
1	0	0	2	-	Hollis	York	Living with relatives
1	0	0	2	-	Kennebunk	York	Ownership default
1	0	0	2	-	Kennebunk	York	Being evicted
1	0	0	2	-	Kennebunk	York	Being evicted
0	1	0	0	-	Kennebunkport	York	Being evicted
0	1	0	0	-	Kittery	York	Facing eviction
1	0	0	1	-	Old Orchard Beach	York	Living with relatives
1	0	0	2	-	Old Orchard Beach	York	Facing eviction
0	0	1	2	-	Old Orchard Beach	York	Living in a summer rental
1	0	0	0	Y	Old Orchard Beach	York	Living with relatives
0	0	1	0	Y	Old Orchard Beach	York	Living with friends
0	1	0	0	-	Parsonsfield	York	Building has been condemned
0	1	0	0	-	Saco	York	Run away youth
1	0	0	1	-	Saco	York	Living with relatives
1	0	0	1	-	Saco	York	Facing eviction
1	0	0	1	Y	Saco	York	Facing eviction
1	0	0	1	-	Sanford	York	Living with relatives
0	0	1	2	-	Sanford	York	Being evicted
1	0	0	1	-	Sanford	York	Facing eviction
1	0	0	5	-	Sanford	York	Living in a shelter
1	0	0	1	-	Sanford	York	Living with relatives
1	0	0	1	-	Sanford	York	Living with relatives
1	0	0	2	-	Sanford	York	Going through eviction
1	0	0	2	-	Sanford	York	Living with relatives
0	0	1	2	-	Sanford	York	Being evicted
1	0	0	2	-	Sanford	York	Living with relatives

Family Structure							
Single Female	Single Male	Couple	Kids	P?	Municipality	County	Comments
0	0	1	0	Y	Sanford	York	Facing eviction
0	0	1	2	-	South Berwick	York	Facing eviction
0	0	1	3	Y	South Berwick	York	Living with relatives
1	0	0	1	-	Waterboro	York	Living with friends
1	0	0	1	-	Waterboro	York	Being evicted
0	0	1	2	-	Wells	York	Foreclosure of home
0	0	1	0	-	Wells	York	Living with friends
0	0	1	2	-	Wells	York	Living with relatives
0	0	1	2	-	West Lebanon	York	Facing eviction
1	0	0	1	-	Anon	Anonymous	Living with relatives
1	0	0	6	-	Anon	Anonymous	Ownership default
1	0	0	2	-	Anon	Anonymous	Living with relatives
0	1	0	0	-	Anon	Anonymous	Living with relatives
1	0	0	0	-	Anon	Anonymous	Living in a shelter
1	0	0	0	-	Anon	Anonymous	Living with relatives
208	41	85					
208	41	170					

334 Total AT RISK Calls This Report

419 Total Adults Involved

489 Total Children Involved

HOMELESS AND UNDER-HOUSED

1. DUPLICATION/OVERLAP

One of the problems facing homeless individuals is that the existing service delivery system provides services to individuals based on "problem categories". Many homeless people do not fit neatly into some of these problem categories. Homelessness needs to be addressed from the perspective of the individual. Otherwise, the eligibility and service restrictions that are part of many public and private programs present barriers to the homeless person.

2. EMERGING ISSUES

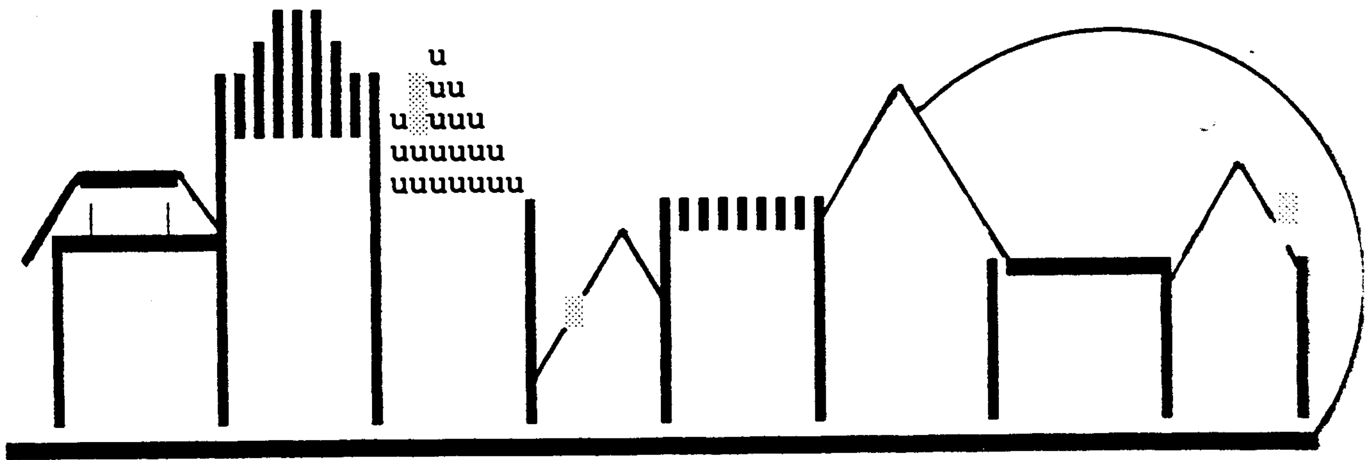
The Department of Human Services is concerned about the increasing numbers of people who are homeless in Maine. "Hands on" crisis oriented services like shelters and/or soup kitchens are often associated as the main area of assistance required by homeless people. However, even though homelessness is manifested by lack of safe shelter, the root causes of homelessness relate to multiple factors requiring multiple and flexible solutions to the problem. A concentrated effort needs to be made to provide services to people who are potentially homeless to reduce the need for crisis services, and then to provide remedial programs to assist people who are in short term shelters to be able to move into home-like environments. Homeless individuals need all of the existing services available to other people, such as full employment, safe housing, access to health and mental health services, education and access to transportation services.

3. NUMBER 1 CHANGE

The number one change I would make is that I would not allow children under the age of 16 to be homeless or on the streets. I would provide family or treatment options for those children on a voluntary basis. If those services were not accepted, I would place the children in an appropriate treatment program even though it may be against their will.

Topic	Sub-Category	Criteria	Service	Clients Served	State	Costs Federal	Total
Homeless/ Underhoused	Community Residential Svs. (Shelter)	Open protective cases. Children in care or custody of DHS. Homeless children.	Shelter, food, some medical services, referral to other service.		1,134,827		1,134,827

Dist 8/23 HSS



. . . *by Sundown*

John R. McKernan, Jr.
Governor

Lynn Wachtel
Commissioner

Leonard Dow
Director of Community Development

Department
of

ECONOMIC AND COMMUNITY DEVELOPMENT
OFFICE OF COMMUNITY DEVELOPMENT

March 25, 1991

Governor John R. McKernan, Jr.
Members of the 115th Legislature

Dear Governor McKernan, Members of the 115th Legislature:

The following report," by Sundown", is the result of the Maine Interagency Task Force on Homelessness and Housing Opportunities effort to define and find solutions to the problems facing people who are homeless or at risk of becoming homeless. It includes the identification of existing services, and the recognition of gaps that exist in those services.

This report is the initial step in finding solutions that will move us toward ending the tragedy of homelessness. Because the problems leading to homelessness and the complex needs of people who are homeless cut across so many agencies in the public and private sector, the Interagency Task Force believes that ideally it should transition into a board or similar body having staff support and a small grants program. However, it recognizes that in light of current economic conditions and budget constraints, this may not be possible at this time. With the understanding that the Task Force will have limited time and resources available, it feels that it can continue to address some gaps in services through better coordination. In Addition, it believes it can continue to disseminate information relative to programs under the federal Stewart B. McKinney Homeless Programs. The Task Force chairperson can continue to act as the point person in facilitating technical assistance inquiries with appropriate Task Force members.

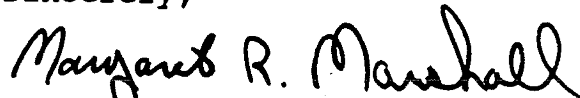
State House Station 130, Augusta Maine 04333 — *Offices Located at* 219 Capitol Street
Telephone (207) 289-6800

The Interagency Task Force has asked me to extend their appreciation to you, Governor McKernan and the members of the Legislature, for recognizing this problem and for your commitment to finding solutions toward ending homelessness in Maine.

The Task Force was moved by what it learned in talking to people that are homeless as well as those trying to help our less fortunate citizens. They, and so many others gave willingly of their time and interest to assist this initiative. This report would not have been possible without the cooperation and assistance the Task Force received from numerous sources. To all those who contributed, the Task Force is most appreciative.

Lastly, the members of the Task Force, working together, contributed an exceptional amount of time and effort to this initiative. Each participant should be commended for their continuing dedication and commitment.

Sincerely,



Margaret R. Marshall
Chairperson
Interagency Task Force
on Homelessness and
Housing Opportunities

BY SUNDOWN

A REPORT ON HOMELESSNESS IN MAINE

MARCH 1991

PREPARED BY:

The Interagency Task Force on Homelessness
and Housing Opportunities

INTERAGENCY TASK FORCE ON HOMELESSNESS
& HOUSING OPPORTUNITIES

REPORT

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   c. Directory of Services by State Agency
   d. Directory of Homeless Shelters and Services Provided
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HOMELESS

Tommy

Tommy is a 17-year-old with behavioral problems due to a stroke at age 15.

Tommy's behavior did not improve after two years of counseling. Although Tommy had not finished high school, he no longer attended. There was no transportation and a full day was too much for him. Tommy's family could no longer cope with his behavior as he became more difficult and started to abuse substances.

The family asked to have him psychologically evaluated and he was deemed not at risk of suicide or becoming violent; therefore, able to continue to live at home.

At that point Tommy's father gave the family a choice, either he leave or Tommy leave. The family took Tommy to an emergency shelter and signed him in. Stays at the shelter are limited to three weeks.

Tommy was abandoned by his family. The caseworker began contacting different agencies to obtain services: housing, food, funding, rehabilitation, etc.

After finding most facilities filled, he pieced together a plan. Because the caseworker was under time constraints and had a heavy case load, he was unable to investigate all the programs and services that might be available.

Tommy is 17, therefore, he does not qualify for most programs which are designed for adults. Social Security is available, but it can take up to eight weeks before a check arrives. Food stamps are not available without an address. Tommy does not qualify for protective services for children because he has not been abused; just abandoned.

Ken

Ken is a 22-year-old male diagnosed by the State Mental Health Institute as brain-damaged from chronic substance abuse and by the Community Mental Health Center as paranoid schizophrenic. He has been convicted of unlawful sexual contact with a minor and has been placed on probation. He receives a monthly Social Security check because of his disability. He is homeless.

The Tri-County Intensive Case Management Program has been working with Ken Trying to find him a place to stay, keep him on medication, and in treatment. He has been treated at Jackson Brook Institute and at the Augusta Mental Health Institute. He's gone to jail because he did not comply with the conditions of his probation: engaging in treatment. The Court has worked with the Mental Health Case Manager and his Probation Officer to mandate the treatment he needs; both mental health and substance abuse.

When he's not been in residential treatment or jail, the intensive case manager, probation officer, and an Area V Mental Health Program worker have tried to find housing for him. Ken has repeated the cycle of getting into some type of housing arrangement; with his parents, his sister, in his own apartment, at the YMCA. He does well for a few days, gets into drinking or drugs, spends all of his money, gets violent, and is moved to an inpatient unit or jail. He usually stays there for a short time, a few days to a week, and is discharged. When discharged, he has no money for food, housing, or clothing, and even if he did, no one wants him around because of his violent behavior. The cycles are beginning to change in that his inpatient stays are getting longer as his condition continues to deteriorate.

<u>Joe and Sally</u>

Joe and Sally are new to the problem of being homeless. They are self-conscious and keep apologizing for their problem. Joe and Sally owned their own construction company and were on top of the world one year ago. Now they have gone through bankruptcy and are homeless.

They lived in a van with their four children and then with Joe's brother and his family in one 9'x 10' room. Then they moved into a partially completed shell of a house; all that was left after the bankruptcy.

The weather turned cold and Joe and Sally realized that they could not stay in the shell any longer. They had tried everything they could to survive on their own. They were scared, tired, and didn't know where to turn. Luckily someone brought them to Rural Community Action Ministry (RCAM) in Leeds and again luckily, a family had just moved out of one of their two family shelters. Joe and Sally, with the four children moved into the trailer and now have a warm place, at least for awhile. They transported the children to the site of the house under construction so their education would not be interrupted while the house was being built.

Jane

Jane and her three children were living in an old shack which she inherited from her mother. The temperature outside was ten degrees; the temperature inside only thirty degrees. The children, two boys, ages 9 and 3 are both blind, and an 8 year old daughter, were inside, cold and tired.

Jane has some wood, but it was green and not burning well. There was no running water in the shack. The odor from the overused chemical toilet was very strong. A representative from Rural Community Action Ministries had been there before. RCAM had helped keep the shack standing for the past ten years, but this situation was the worst it had ever been. Although Jane did not want to leave her home, she agreed to move into RCAM's family shelter for the winter months. Since the shelter was located in her hometown, the children's education continued without interruption.

Jane is typical of the struggling single parent family in Maine. She spends her meager funds wisely and survives with as little as possible; she cannot afford more. RCAM, in cooperation with Community Concept's Community Action Agency, and Maine State Housing, will help get a trailer and a new well. But she is still in constant debt with medical bills for her children. In addition, transportation costs are very difficult for her but necessary, as the children must go into the city for treatment. Jane has no car and there is no regular transportation from her rural area. She is constantly in debt and in need of help.

FINDINGS

These cases were presented to the Task Force when, as part of a pilot project, members met with service providers and interested persons in Leeds and Lewiston. The Task Force wanted to learn about the extent of homelessness, the services available, problems encountered, and possible solutions. Members of the Task Force represent seven state agencies as well as several non-state agencies. Together, they had a wealth of information they could share with people struggling with finding the right service, at the right place, at the right time for clients on their caseloads threatened with homelessness.

It was gratifying to the Task Force members to provide information to case managers or service providers that would help them get services for a client or potential funding for a service. It was equally gratifying to hear from these same people how they managed to coordinate a group of services for an individual or family with their problems of homelessness.

The Task Force learned about a number of shelter facilities in urban areas. In Lewiston, there is a shelter for homeless men, another for alcoholic men, and one for adolescents. There is also a shelter for battered women, with or without children. A respite care unit is available on a limited basis for mentally ill adults suffering relapses. In Leeds the Rural Community Action Ministries, which serves 12 rural towns, has two trailers which can house families for up to three months.

Vacant apartments abound in substandard buildings in Lewiston. Costs for housing that meets even minimal standards is often beyond the financial means of those existing on SSI or AFDC or even those working for minimum wage. Adequate, vacant housing stock in the rural areas is almost non-existent. Trailers or mobile homes have been patched and "winterized" to provide basic, although unsafe, housing for some. Hand-built homes created over several generations often provide the only "affordable" housing.

Homelessness is easily seen in the shelters and on the streets of Lewiston as in other urban areas across the state and across the nation, but homelessness can not be seen in Leeds. People in rural areas move in with friends, neighbors, or relatives, and stay as long as they can; they move on to other homes unless they are fortunate enough to find a shack they can "fix up a little."

Lewiston and Leeds represent only two areas of the state; one urban and one rural. Each has its own character, population mix, and economic conditions. But the Task Force believed that the problems of people without homes in other urban areas are similar to those who live in Lewiston, and that those in rural areas would experience many problems similar to those

without homes in Leeds.

For those who are homeless, the need for financial assistance is paramount and immediate. Sources of help are limited. Often, specific criteria must be met before help is available. Many applications take weeks to process.

General assistance is administered by local municipalities using local funds and state tax dollars. This program has the most flexibility to help people who are threatened with losing their homes or those who have already lost them. Eligibility is based on need, people do not have to prove they fit into a certain category before applying for assistance. Youth under 18, although eligible for services on their own, often must prove they are emancipated or indicate that they are abused in some way by their parents before receiving assistance.

The general assistance program provides security deposits, help with rent or food, emergency shelter, and utility payments. But, especially for small towns, there is little information about existing services and rarely enough personnel to do more than provide funds to meet the applicant's request. There's never enough money to meet all the applicants' needs.

AFDC or Aid to Families with Dependent Children is limited to the provision of funds equal to 50% of the nation's poverty level, and is available only to families headed by single parents. The program contains a component that provides additional funds to meet emergencies, such as broken heating or plumbing systems, evictions, disconnection of utilities, or any crisis or disaster that may threaten families' basic needs. The program is limited to one payment of no more than $500 per year per family. Supplemental Security Income provides a monthly payment to persons with disabilities and limited or no other income. The application process is lengthy and requires extensive documentation of income and disability.

Food Stamps help families and individuals who have a mailing address; people living on the streets, in cars, or in shelters may have no address. The federally-funded Women, Infant, and Children's (WIC) program provides vouchers for nutrition supplements, such as milk and fruit juice to women with small children. Specific eligibility criteria limits this service to a relatively small group of people.

Community Action Programs (CAP'S) administer several programs funded by the state and federal governments including the Home Energy Assistance Program (HEAP), that provides a benefit to assist in paying winter heating bills. Benefits range from about $250 to $400 for the heating season depending on the area of the State and other factors. Because funding is

limited and the cost of fuel is high, the HEAP benefit often pays only a small portion of a household's total energy costs. Currently, while every eligible person who applies for a benefit receives one, there are many eligible people who do not apply.

CAP's also provide help with energy emergencies, weatherization activities, and furnace repair. CAPs administer the Temporary Emergency Food Assistance Program (TEFAP) and help with local food banks. Food banks, soup kitchens, and shelters also can apply to receive food commodities directly from the State.

Cap agencies and three other non-profit agencies operate Headstart programs. Children of families without homes receive high priority. However, even with increasing funds the program can serve only about 30% of the eligible children.

Local civic and religious organizations may help families facing the prospect of homelessness with food, clothing, shelter, and other needs; but few have sufficient resources to meet all the basic needs.

Job training employment can play an important role in breaking the cycle of homelessness. Unfortunately, many agency representatives and others who spoke at the Task Force meetings in Lewiston and Leeds reported that there are long waiting lists for most job training programs. The ASPIRE program, which provides the greatest hope for individuals receiving welfare benefits may have waiting periods of over two years in some areas. This program combines education, job training and supportive services to assist individuals, including those without homes to achieve self-sufficiency.

Current Job Training Partnership Act and Stewart B. McKinney regulations state that a person who is homeless is automatically assumed to be eligible for services. However, people without homes may find it difficult to make necessary appointments or wait for training programs to start.

One Department of Labor funded employment and training project in Portland is working because is works with people in shelters and on the streets and provides a range of supportive services as well as employment and training assistance.

Employment and job training programs lack the full range of services, which may be required to assist persons without homes. When families are faced with the problems of providing shelter and food, health care takes a back seat. However, it is just these factors that place people at great risk of serious illnesses, especially communicable diseases such as tuberculosis, hepatitis, bacterial and viral infections, as well as anemia, or chronic respiratory conditions.

People living in shelters rarely have access to regular health care services. Emergency rooms are frequently the only source of care. General assistance pays for emergency care at Medicaid rates. Although most who lose their homes may be eligible for Medicaid and/or SSI benefits, many do not apply. In some cases, there are outpatient clinic services, well-child clinics, or community health centers available to people without homes. Children in shelters often have not received recommended immunizations and, therefore, are at high risk for vaccine preventable diseases. Additional risks for these children include exposure to tuberculosis and HIV infection.

Good health depends on the ability to pay for health care with insurance or other funds. Without good health people can not work and provide food and shelter for themselves and their families. Those most at risk of homelessness, because of lack of adequate health care include teens, especially pregnant or parenting teens; families whose employers provide no insurance benefits or who rely on unemployment benefits; families who have high medical costs due to chronic illnesses or children with developmental abnormalities.

People will not use the system unless they are treated as individuals, without discrimination. In addition, completing applications and complying with all requirements present obstacles unless there is someone available to help.

Individuals with mental illness may access a variety or services including emergency/crisis services, case management, inpatient and outpatient, treatment, residential, supportive housing and vocational services. However, availability of these services throughout the state is uneven and not always accessible to people who are homeless and mentally ill. The Department of Mental Health and Mental Retardation is committed to the development of a comprehensive mental health system which makes sure that each person's needs are met within an individual's community, to the maximum extent possible.

The need for appropriate services to people who are mentally ill has caused considerable concern during the course of the Task Force's deliberations. This concern has heightened with the recent AMHI Consent Decree, which directs the development of the aforementioned comprehensive mental health system. It also requires that quality care be provided at AMHI and that there be fewer residents at AMHI as services are developed. Concern has been expressed about patients being returned to the community who are not able to live independently and whether community resources will, in fact, be available to meet their needs. Homeless shelters have reported serving people who have more serious mental illness.

A wide range of services are available for children including primary prevention, child development, family support, health services, foster care, out-of-home placements, treatment and child protection. However, access to these services is limited and many programs are only able to address part of the child's needs. Rarely is the entire fabric of a child's life taken into consideration with enough care to ensure supportive services are available at any given time and throughout the various transitions of a child's life.

Support services for those in need are limited in urban areas and rarely available in rural Maine, even when affordable housing is located. Transportation is a major problem. Without it, health care, day care, and working becomes difficult or impossible. Transportation is an important factor; with no job or a low paying job, the purchase and maintenance of reliable transportation becomes a drain on already limited resources. Some Transportation services are available statewide, but those services are usually limited to either specific client groups or for special purposes.

The Task Force found that in some cases the loss of housing is attributable to specific illnesses or problems. Large proportions of people in shelters were substance abusers, mentally ill, or both. In other cases, especially for women and children, they simply did not have the means, or the skills to support a household. Underemployment and the lack of well-paying jobs or job training drastically limits what people can pay for housing in rural areas. And, in all cases, the loss of a place to call home is connected with a loss of identity, a factor to a sense of hopelessness.

In other cases, the problem is simply a lack of affordable housing. The Task Force found that even though urban areas often had high housing vacancy rates, residential units were not affordable, because of the requirement of first and last month rent deposits. At times the cost of rental units may exceed a family's total income. Two adults working, part-time, at minimum wage, can not afford to pay average rent cost, a security deposit, as well as pay for utilities, fuel, food, clothing, and medical insurance.

There are more than 2100 Section 8 tenant-based Certificates and Vouchers available through Maine State Housing Authority and substantially more which are available through local public housing authorities. However, Maine State Housing Authority reports three thousand households currently on a waiting list for section 8 housing, with some of these households on the waiting list for a period of two years.

Another problem is landlords often are reluctant to renting to people discharged from mental health institutes, women who are

battered, single parents, and teenagers. They are fearful that those in these groups might cause damage to units, harm other tenants, or that partners of battered women will return. Finally, they all fear non-payment or late rental payments.

In rural areas, rental and permanent housing simply does not exist. Use of pre-1976 trailers, which are low cost, are often available, but are unsafe and a danger to the family. The purchase cost of a home in Maine has usually been beyond reach or a remote possibility for families on a fixed income. While the Task Force feels much has been accomplished in addressing the need for affordable housing, continued development of creative housing programs must remain a high priority.

The Task Force found teenagers, including teen parents, who lack safe, secure housing because they either do not qualify for assistance or processing applications for assistance takes too much time. Often they end up on the streets, using or selling drugs; prostitution may become a way of life for many of these teens. Survival on a day-to-day basis for teen parents allows little time for bonding and developing parenting skills, continuing education, or job training. Such deficits can lead child abuse, substance abuse, and neglect or abandonment of the children.

The Task Force compiled a listing of specific groups of people needing special or additional assistance when faced with the reality of homelessness:

- Adolescents
- Adults who abuse substances
- Adults with mental illness
- Single women
- Women with children
- Adolescents with children
- Families with underemployed wage-earners
- Women who are abused
- People with AIDS/HIV infection
- Migrant Workers
- Elderly Persons

Although each of these groups required specific clusters of services and a particular approach, the Task Force learned that people did not easily fit into these neat, distinct categories.

In fact, individuals frequently fit into several categories. Getting the services to people facing homelessness often required overcoming a series of obstacles.

The Task Force found time and time again that in order to qualify for particular services people needed to fit into

narrowly defined program guidelines, both in emergencies or when trying to become self-sufficient. Frequently people in need find they are the wrong age, the wrong sex, have the wrong illness, or the wrong problem to qualify for available assistance.

The Task Force realized that to address homelessness, the needs of the individuals must be looked at and programs developed to fit their needs, not fit individuals in the present "boxes" to get them basic needed services. A system is needed that is client-centered rather than problem or service oriented.

The Task Force found a lack of knowledge about many services that are available through state and federal agencies and more importantly within their own communities. Communities were often unfamiliar with the services or specific requirements for accessing them Funding sources often were not applied for, again, because the community, the agency, or the individual was unaware of the availability, or lack the resources (time, money, expertise) to pursue them.

The Task Force became aware that local groups had been formed to assess the extent of the homeless problem and develop strategies to deal with it. Yet, the Task Force was unaware of the extent of these efforts as were some of the service and shelter providers in the areas bring assessed.

Communication or the lack or it, in both rural and urban areas is a serious obstacle to solving the problem of homelessness. Housing development groups, liaisons from mental health institutions, and service providers need to talk with each other about how they can help each other. Landlords might accept more "risky" tenants if they understood the needs of women, teens, and people discharged from mental health facilities. Landlords should feel that help will be provided, if they respond to the housing needs of these populations.

Creative financing for construction of affordable housing by both profit and non-profit developers needs to be encouraged, especially in rural areas. The identification of a lead resource in each community needs to be established. Unsafe trailers have to be replaced with sound, safe housing.

Just as the Task Force found a lack of services and shelter for the teenagers who are neglected, there was a strong indication that the same holds true for single women. Women who become homeless do not fit in the correct "boxes". Little is out there to help them. While there seems to be sufficient shelter beds throughout the state; few are available to women. The same holds true for women with children. Very little emergency and long-term shelter is provided for this group.

The present service system cannot cope effectively with people who present multiple problems. People are in unsafe, inadequate shelter, or have no shelter, while state and federal statutes, policies, regulations standards, and resource limitations result in providing services by categories, such as mental illness, alcohol or drug abuse.

Perhaps more than anything else, the Task Force learned that providing houses for people without homes did not necessarily solve the problem of homelessness. As there are many reasons for losing a home or for being without a home - unemployment, poor health, substance abuse, mental illness - there are as many service needs to address the problems. The loss of a home is always accompanied by the need for associated services: food, clothing, health care, transportation, child care, continued education for the children, and employment. Provision of services to address these identified problems can not simply be imposed on an individual or family without coordination by the providers.

The Task Force found many more issues and concerns expressed during our visits, such as the AMHI consent decree and what this means communities, federal and state regulations that require changes to respond to homelessness, lack of day care, affordable health care, and many more. The case histories at the beginning of this report illustrate a number of issues and problems facing people without homes or those fearing loss of their homes. They also identify problems with the system that need to be overcome before the problem of homelessness can be solved.

Tommy's caseworker didn't know all the services that might help Tommy or how to access some other services. The present service system does not recognize adolescents' needs for safe and decent housing when abandoned by their parents.

Ken's dual diagnoses of mental illness and substance abuse presents a particularly troublesome problem. Historically the treatment methods have been based on different philosophies; in fact, diametrically opposing philosophies, which do not allow for the two conditions to be diagnosed in one person. To say that the Task Force found lack of coordination of services in this case is an understatement. There was every effort to coordinate, but there was no basis on which the services could be coordinated.

The homeless condition of Ken was not caused by a lack of housing or even by lack of funds to provide housing. It was the combined problems of violence and unacceptable behavior brought on by abusing substances and not taking his medication for his mental illness.

Joe and Sally are typical example of a new group of people faced with homelessness. Because they have gone through bankruptcy, they have no credit, no jobs, and no shelter. The local community group, Rural Community Action Ministries' Director, who serves on the Interagency Task Force, is very aware of programs and services to help Joe and Sally. RCAM took advantage of a grant program through MSHA and loaned the family enough money to finish their home. Because the family was able to provide transportation, the children were able to continue school uninterrupted. Joe and Sally found good jobs, and the whole family is well on their way to putting their lives back together.

Jane has safe temporary housing and with coordination by RCAM, MSHA, and the community action agency, Jane will get a trailer and new well in the spring. Since the shelter is located in the same town, the children's education continues uninterrupted. However, many more services need to be coordinated before Jane can meet the basic needs of her family, and stave off the threat of homelessness.

RECOMMENDATIONS

COLLABORATION

Members of the Task Force in its struggle to develop means for dealing with the multiple and overlapping problems associated with homelessness agreed that they needed to identify the values that would underlie their recommendations.

> "Every person in Maine has a right to decent and safe housing by sundown".

That value was adopted by the Task Force after completing the pilot project in Lewiston and Leeds. It's the bottom-line. Much needs to be done to develop affordable housing, to coordinate services to people threatened by homelessness, and to help people move into permanent housing arrangements. In light of the downturn of the economy and the dim prospects for immediate improvement, the very least that needs to be done is to assure that every person in Maine has or is offered shelter by sundown - every night.

The Task Force also recognizes that as the public budgets shrink in response to the general economic downturn, the number of people, adults and children, requesting shelter during 1991 will increase dramatically.

> "If you don't get any help, call me back."

The Task Force heard repeatedly that people facing homelessness, or those trying to help, often did not know where to go. Anyone looking for assistance should be able to get some help from the first agency contacted. Often times,, even though that agency can not directly help, staff know of people or agencies that might be able to help. Giving that information could solve the problem. The Task Force would like to see all agencies that provide services to people currently without homes, or in imminent danger of losing their homes, accept responsibility for assisting and advocating on their behalf, until help or shelter is obtained.

In other words, the agency, even if it only has information, can ask a caller to "call me back" if they don't get the help they need; the implied promise is to stay with them, advocate, or get more information until help is found.

> "People's needs should drive the services; not the funding sources."

People facing homelessness don't fit into the neat, categorical funding streams developed by state and federal legislatures and bureaucracies. Some suffer from mental illness; some have substance abuse problems; some have both. There are families with children and children without family.

Women leave abusive homes with no place to go. Young women who are pregnant can not remain with their families. Many have no job skills or worse no high school education. Health care my be needed, but access requires insurance or money.

Each situation requires a different set of services to meet a different set of needs. There needs to be a way that a package of services can be developed to meet the immediate needs of people facing homelessness without finding the proper "box" of an eligibility category.

RECOMMENDATION:

1. <u>The people of the State of Maine should accept these value statements as set out by the Task Force.</u>

The issue of homelessness cannot be addressed by any one agency at any one level of government. Public officials at the local level see people in their offices facing the reality or prospect of losing their homes, but have few resources to provide living arrangements or access other services needed to obtain or maintain a home. They have limited knowledge of various potential resources available or how to access them. On the other hand, agencies at the state level may have selected services for a targeted group of people, but little to assist them in keeping their homes.

The number and types of services needed vary widely. Specialized treatment philosophies control the delivery of many services. With all of these variables it is imperative that services to people facing homelessness need to be developed and delivered within a collaborative environment. To establish such an environment, the Task Force recommends that:

RECOMMENDATION:

2. <u>The Interagency Task Force on Homelessness and Housing Opportunities should be transition into a Board or similar body, the major function of which should be to support the development and maintenance of community groups organized to help people without homes or in danger of losing them.</u> Members of the Board should represent state agencies and the private sector, similar to the representation of the existing task force. Sufficient staff support will be needed to carry out the functions of the Board.

   Local community groups should include community members interested or involved in the problem of homelessness. Members could include persons at the local level responsible for administering General Assistance Funds and representatives of social service agencies, financial institutions, civic, religious organizations.

The Board would be responsible for the provision of technical assistance to these local community groups. The technical assistance would concentrate on accessing funds and packaging multiple funding sources and services to develop programs to meet local needs. It would provide the opportunity for various members of local groups and state groups to network with each other, to share ideas and information, to develop projects and programs, and to coordinate resources.

Technical assistance could be provided through the Board's staff in conjunction with a program of small grants ($1-2,000) to stimulate the development of planning groups, obtain professional assistance to write grants to meet local needs, provide for needed legal fees, or any other item to help local communities grapple with the problems of homelessness.

Local community groups would work closely with the Board and the Executive Director in all phases of improving communications, advocacy, coordination, collaboration, and capacity building.

The Board should also disseminate information about programs, services and funding sources that will enable groups to use existing services more effectively and to capitalize on the use of existing services, programs, and funds. Members of the State Board would not only share information amongst themselves regarding the development of new programs, changing rules and regulations, they could also share that information with the local community groups through the staff.

Another major function of the Board should be the review (not as part of the approval process) of funding applications related to services for people affected by homelessness, program policies for their efforts on this population, and coordination of services and programs developed to serve people without homes. As a first step the Board should review all applications for Stewart B. McKinney funds, emanating from the State of Maine.

Because of its role as reviewer, the Board would gather a great deal of information about local and state programs, therefore, it should also act as a clearinghouse, providing information to individuals and agencies interested in applying for McKinney or other funds related to the issues of homelessness and affordable housing.

The Board should advocate within existing systems for needs of people who are homeless. It could, through review of all plans and reports produced by its agency members, assure these reports address specific needs of persons who are homeless regardless of the population that are otherwise addressed in the reports.

Finally, in carrying out the responsibilities of this Board the staff might intervene with state agencies or local programs on behalf of persons facing homelessness, who have been unsuccessful in obtaining critical services. The staff would act as a contact or lifeline to persons and providers in need of assistance. Information obtained through these interventions would be provided to the Board for development of a more appropriate system response.

ACCESS TO ARRAY OF SERVICES

The first step in responding to the issue of homelessness must assure that existing emergency shelters remain in place. These shelters most often run on a shoestring budget and rely heavily on the voluntary efforts of local religious and civic organizations and interested citizens. The hard work, donated food and furniture has saved lives on cold winter nights. The piece of legislation providing assistance to the shelters also appropriated another $250,000 to assist people with the payment of security deposits. The second step is responding to homelessness is moving people from shelters to rents, which usually requires the payment of a security deposit. Therefore, the Task Force recommends that:

RECOMMENDATION:

3. <u>The Legislature should continue to fund the emergency shelters at the same levels, $500,000 per annum and the security deposit fund at least at the current level of $250,000 per annum.</u>

Once individuals and families end up in shelters a myriad of services are needed beyond just getting into a rent. Many families have no wage earner, and no means to pay for the rent. Without jobs there is no health insurance and, therefore, no health care. Children may have been moved out of their school districts to go into the shelter. The Task Force in keeping with its value of developing the services to meet the needs of the people in the shelters would like to see a variety of services available to people at the shelter.

RECOMMENDATIONS:

4. The Department of Labor should work closely with the staff in shelters, as well as with representatives of other service agencies, such as mental health centers, Community Action Programs, Department of Human Services, and city and town welfare programs to ensure the provision of a variety of services needed for people threatened by homelessness to achieve self-sufficiency.

5. Statutory changes to 20-A MRSA, submitted to the 115th Legislature by the Department of Education, to assure access to education for children and youth without homes should be supported. These statutes protect the rights of these children to a free and appropriate education, regardless of residence, in accordance with the Stewart B. McKinney Homeless Assistance Act, P.L. 100-77, Title VII, Subtitle B.

6. Educational programs regarding the life situations of people who are homeless need to be developed for health care providers. These programs should include:

   - Modification of immunization or physical examination schedules to maximize the present visit;

   - Modifying medication or treatment schedules, with a focus on on-site distribution of medication or treatments;

   - Objectively addressing the person's health condition as presented, including possibly more advanced stages of diseases and infectious conditions.

Of particular concern to this Task Force is society's response to children and their caretakers (mostly women) who represent the future as a society and are also its most vulnerable members. While there are many services available to children who are identified through a system such as education, mental health, and human services, there is no comprehensive system concerned about the basic shelter needs of children and families, which can act as a conduit and catalyst to bring together other service supports needed by individual children to be safe and to receive care and nuturance to grow to healthy adulthood.

RECOMMENDATION:

7. The Task Force recommends the child serving system include recognition and advocacy for basic shelter needs

The Task Force heard in particular about the needs of pregnant and parenting teens who find themselves without suitable housing and support. The needs of teen parents transcend the traditional boundaries of the educational, health delivery, community and social service system. Teen parents bring highly diverse backgrounds to the programs they may enter, particularly with respect to previous work experience, educational attainment, vocational aptitudes and interest, physical and emotional health status, child care needs, and overall life experience. It is safe to assume that the knowledge, skills, and abilities that they possess in these areas will be seriously deficient when related to age.

Because teen parents, by definition, are still children themselves, with limited life experience, their needs in many realms will frequently conflict with the needs of their young children. Because of their limited (and many times inappropriate) life experiences, teen parents require a great deal of assistance in using existing services. To attain meaningful success for teen parents often calls for a high degree of collaboration between and among many programs. Unfortunately, issues of confidentiality, mandated eligibility, service definitions, focus of control, and "territorial boundaries" frequently impede such collaboration.

The Task Force understands that currently there is an effort entitled "Success for Teen Parents" involving state and local representatives. The purpose of this effort is to use existing state and local resources to encourage and help facilitate Interagency case management, personal growth, access to health services (physical and emotional), education, training, and employment.

RECOMMENDATION:

8. The Task Force recommends continued development of this project and an emphasis on service development for pregnant and parenting teens.

While the Task Force explored the issues of homelessness, members were also confronted with the problems presented by persons who suffer from the effects of mental illness, substance abuse, or both. Provision of housing to persons in these categories will not alone solve the problem of homelessness.

The Task Force understands that the Department of Mental Health distinguishes between housing services and residential support services. The latter are oriented to enabling and assisting adults with serious and persistent mental illness to live successfully in the community. These programs are structured and staffed with an integral treatment and/or rehabilitation component. These programs also commonly have a clinically-based screening for admission with staffing and other structures appropriate to service-oriented environments.

Housing services operate as subsidize housing linked to services. The consumers tenancy in the housing is not conditioned on service considerations. While it is understood that the majority of the AMHI Consent Decree class members live independently, experience dictates that a large number of class members, including many of those now institutionalized, will require structured residential facilities. It is anticipated that the assessments now underway will underscore the need for such facilities to meet the downsizing requirements in the Decree.

RECOMMENDATION:

9. This Task Force supports the DMHMR philosophy to develop new housing resources to "bring people home" and make it possible for persons who have been institutionalized to live in safe, decent, affordable housing in their own chosen communities. Specifically, the Task Force supports the development of a comprehensive community mental health system fcr persons who are seriously mentally ill that responds to individual needs including those individuals who are homeless.

The Task Force heard the need for a responsive system for people exhibiting difficult, challenging behavior. The issues relating to people, who are not deemed to have a mental illness (after screening) but who present challenging behavior that puts their housing in jeopardy, need to be identified and addressed. Research shows that behavior which appears to come from mental illness may, in fact, be the result of substance abuse. Symptoms of psychosis will frequently subside after a short period (3 - 7 days) of detoxification and stabilization.

The Department of Mental Health and Mental Retardation has developed a series of monographs on the issue of dual disorders (mental illness and substance abuse). These monographs provide information and guidance on strategies for effective service delivery. This is particularly important, given the "walls" that separate the two professional systems. These walls include differences in historical development, treatment philosophies ("support" vs. "enable"), funding streams, and prescribed medications.

RECOMMENDATION:

10. This Task Force supports placement of much more emphasis in planning coordinating, funding, and delivery of services among mental health, substance abuse, and homeless provider agencies.

PREVENTION:

The Task Force found it extremely difficult to discuss the issues of homelessness without also discussing various means of prevention. It is not enough to come up with a coordinated response with appropriate resources after a person or family has lost a home. There were many areas where it seemed that either simple solutions or complex responses were indeed necessary to avoid losing an existing home.

Many people at risk of losing their homes live on the edge. As long as things remain on an even keel these people can retain their homes. However, even small events can become major catastrophes eventually resulting in the loss of their home. Many, although employed, work only part-time at minimum wage. They do not receive fringe benefits such as health insurance coverage. Any illness may threaten them with homelessness. Transportation may present a major hurdle. If the car, often an older model, breaks down, there is not enough money to fix it. Without transportation there may be no job.

RECOMMENDATIONS:

11. The Task Force recommends supporting those financial assistance programs, which are going to be increasingly critical in the current economic situation.

12. Establish advocacy for women, teens and people discharged from AMHI, with landlords. Recognize landlords' needs to feel that back-up help will be provided if they respond to needs.

Just the fact that a child's family does not have safe, decent ongoing shelter puts a child at risk in many domains. Maine has a national reputation for developing innovative, collaborative programming for children in need. However, continued categorical funding for children's services causes overburdened provider agencies to concentrate their creative resources to find dollars - diverting valuable attention away for the children in need.

RECOMMENDATION:

13. This Task Force recommends child serving agencies provide the community with the capacity to meet individual child needs.

The Governor's Task Force to Improve Services for Maine's Children, Youth and Families and the President's and Speaker's Blue Ribbon Commission on Children and Families are meeting to address the broad range of children's services. Also, The Department of Mental Health and Mental Retardation is working on an initiative which can build an array of services for school-aged children and adolescents with severe emotional disturbances, and provide support for their families. The recently completed research for the Bureau of Children with Special Needs provides the start of a data base on the problems of adolescents who are homeless.

RECOMMENDATION:

14. This Task Force supports all efforts made to improve the lives of children, youth, and their families, especially those most in need and without adequate and safe shelter.

Education, job skills, and job training are all critical service needs for many people at risk of homelessness. In addition, those with small children also face the need for child care to hold a job or obtain training for a better-paying job.

Adolescent parents face a nearly impossible task to try to complete their own education in order to become self-supporting adults, while caring for the needs of very young children. Those that are able to remain in school have a much greater chance of success in this endeavor. The additional assistance with child care and parent education can make this task possible.

RECOMMENDATION:

15. The State Board of Education should review school construction regulations and consider possible incentives for proposals which include child care and/or parenting centers for new construction and renovations of public schools.

Lack of housing stock posed a major problem in the rural areas. In some cases there simply is no housing, while in others the available housing not only does not meet minimum standards, it poses serious health and safety threats. Dealing with these problems requires a myriad of creative approaches.

RECOMMENDATIONS:

16. Encourage creative financing for construction by both profit and non-profit developers.

17. Identify a lead resource in each community and pool other resources through that one.

18. Build "self-help" housing with cooperation of lead agency and private industry, banks, and others by establishing partnerships with discretionary abilities to generate new housing.

19. Destroy unsafe trailers; these are not safe or financially sound replacement housing.

20. Encourage Comprehensive Plan writers to look at manufactured housing, rehabilitation, self-help stick built housing for the low-income portion of their plans.

PROGRESS REPORT

The Interagency Task Force on Homelessness and Housing Opportunities was established as part of the Maine Affordable Housing Alliance legislation, L.D. 1809 in August of 1989.

The charge of the Task Force has been to identify the resources available to persons who are homeless, persons at risk of becoming homeless and persons with special needs who fit either category. In addition the mission of the Task Force is to identify the gaps that exist in the delivery of those services and to make recommendations to the Governor and the Legislative Committee concerning the policies and programs serving this population.

The Task Force on Homelessness and Housing Opportunities comprises thirteen members representing seven state agencies which include Department of Corrections, Education, Human Services, Labor, Mental Health, Economic and Community Development, and the Division of Community Services. Maine State Housing Authority, Community Action Agencies, non profit housing development corporations, homeless shelters, municipalities, and low income residents also have a represented on the Task Force. A list of members is included in this report for your reference.

An organizational meeting was held in September of 1989 to elect a Chair and review the charge of the Task Force. Since that first meeting the Task Force has met on a monthly basis. In addition, subcommittees were formed and met in a series of planning meetings for special projects.

During the early part of 1990, the Task Force on Homelessness and Housing Opportunities worked to identify existing services for people who are homeless or those at risk of homelessness. A wide array of services provided by several State agencies, and a compendium of these services is included in this report. While many of these services have excellent track records in meeting the needs of this population, the Task Force recognized that much remains to be done in terms of filling gaps and expanding outreach efforts.

In March of 1990, to help identify the gaps in services, the Task Force visited homeless shelters and other facilities in Cumberland, York, and Penobscot Counties. The Task Force was impressed with local organizations efforts and levels of commitment to serving people who are homeless. We found that

this was often carried out with limited resources. Individually and as a group, Task Force members made a commitment to continue communication with shelter and service providers in an effort to find solutions to problems as they were identified. We concluded that through continued communication we could arrive at a better understanding of the gaps in services and how to begin to focus in on bridging those gaps.

In June of 1990, a subcommittee was formed to develop and submit an application for funding of a transitional housing demonstration project. The application was submitted to the Department of Health and Human Services, Office of Community Services, on July 2, 1990. The proposal requested funding of $ 2,025,000. for four transitional sites in the State of Maine. The grant, if successful, will provide housing for fifty AFCD families in Augusta, Bangor, Biddeford, and Lewiston. * As of January, 1991, the State of Maine is still being considered for funding.

The Task Force continued to meet on a monthly basis and a plan was developed for a pilot project to be held in the fall of 1990. After several planning meetings, in September and October of 1990 the pilot project took place. Three meetings each were held in the City of Lewiston and the Town of Leeds. The purpose of the meetings was to communicate with local officials, area service and shelter providers on their concerns, issues and recommendations on the delivery of services to people who are homeless or at risk of homelessness. The Task Force was deeply moved by the plight of people who are homeless and the frustrations of those people trying to help. The findings from the meetings are included in the beginning of this report.

During the past sixteen months the Task Force on Homelessness and Housing Opportunities has met approximately thirty times. We will continue to meet in our efforts to finding solutions to the many problems that face people who are homeless or at risk of homelessness.

Upon request agendas and minutes from meetings are available.

*
The U.S. Department of Health and Human Services, Office of Community Services (OCS) notified Governor McKernan in February that Maine's application was not selected for funding. OCS selected three states which are New York, New Jersey, and Massachusetts. Upon further communications with OCS it was learned that while Maine was not selected, it was one of eight applications considered for funding in the final review.

APPENDICES

INTERAGENCY TASK FORCE ON HOMELESSNESS
AND HOUSING OPPORTUNITIES

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STATISTICS OF HOMELESS IN MAINE

Characteristics of Homeless Shelter Guests: 12/89-6/90

Emergency shelters served an estimated 4,713 different persons between 12/1/89 and 6/30/90. These figures will be conservative - the Oxford Street Shelter, located in the City of Portland, did not provide detailed information until May and June of 1990.

Median age of guests was 30 years. The youngest guest was less than 1 year old. The oldest guest was 90 years of age.

	Number	%
<18	818	19.7
18-29	1166	28.0
30-39	1014	24.4
40-49	619	14.9
50-59	322	7.7
60-69	161	3.9
70-79	46	1.1
80 +	11	0.3

Education:

	Number	%
8th grade or less	970	21.5
9th	422	9.4
10th	526	11.6
11th	297	6.6
12th	1764	39.2
13 - 15	378	8.4
16 +	147	3.3
	4504	100.0

1199 persons reported monthly income. The average income for those reporting was $475 monthly.

Primary sources of income:

Source	Number Reporting
AFDC	130
City	44
Food Stamps	11
Social Security	752
VA	67
Job	367

Average length of stay was 27 days.

1 night	1450	34%
2 - 7 nights	1217	29%
8 - 30 nights	938	22%
> 30 nights	641	15%
	4246	100.0%

A number of persons admitted themselves to homeless shelters on more than one occasion.

Number of times admitted	Number of persons
2x	307
3 or 4x	171
5 + x	91

County of primary residence:

	Number	%
AND	300	6.8
ARO	193	4.4
CUM	1151	26.2
FRA	40	0.9
HAN	117	2.7
KEN	287	6.5
KNO	58	1.3
LIN	42	1.0
OXF	94	2.1
PEN	1088	24.8
PIS	32	0.7
SAG	80	1.8
SOM	72	1.6
WAL	77	1.8
WAS	75	1.8
YOR	297	6.8
OUT OF STATE	388	8.8
TOTAL	4391	100.0

DIRECTORY OF SERVICES

MAINE INTERAGENCY TASK FORCE ON HOMELESSNESS AND HOUSING OPPORTUNITIES

MAINE DEPARTMENT OF LABOR

SERVICES

The Maine Department of Labor continues to provide services to homeless individuals in Maine through several programs.

Maine Job Service

The Maine Job Service provides employment related services to homeless individuals in the seventeen (17) local offices situated throughout the State. Five (5) of the offices have Employment Counselors on their staff to assist homeless individuals in overcoming barriers to employment. All of the offices are staffed with Employment and Training Specialists who may assist the homeless person find suitable employment by entering the individual into the statewide computerized Job Service Job Matching System. By registering for employment at any on Job Service, it is possible to access jobs throughout the State and, in some instances, across the nation.

In addition, there are eleven (11) Disabled Veterans Outreach Programs (DVOP) Specialists and ten and one-half (10½) Local Veterans Employment Representatives (LVER) positions in the Job Services offices. The veterans staff provides outreach, counseling and job placement services to veterans, including those who are homeless. The Job Service has begun working with homeless groups, service providers and shelters in some areas such as Portland. However, coordination between Job Service offices and homeless groups should be expanded.

The City of Portland's Homeless Employment Project is working with the Portland Job Service Office. A representative of the Homeless Employment Project recently spoke to the Job Service Employer Committee.

The Rural Farm Labor Committee has expressed interest in coordinating with Homeless groups and shelters to explore the feasibility of employing homeless individuals in farm labor. The group with representatives from the Department of Labor and the Department of Agriculture is considering a demonstration project at this time.

The Maine Job Training System

Maine's three (3) Private Industry Councils (PICs) implement Maine's Job Training System, in partnership with the Maine Department of Labor through a variety of State and federally funded programs, which provide for the training and upgrading of Maine workers. Recognizing that the needs of Maine's workers and businesses are changing as they adapt to new technologies and more competitive regional and worldwide markets, the goal is to provide every Maine citizen who needs

it, with an opportunity for training or retraining so that he or she will be better able to compete for the jobs in the future.

JTPA Federal Initiatives

IIA

The cornerstone of the Job Training System, provides education skills training and employment for economically disadvantaged people. Participants must meet federal eligibility guidelines. A recent U.S. DOL Guidance Letter states that a homeless individual is automatically considered economically eligible for JTPA programs unless proven otherwise.

Summer Youth Employment and Training Program (SYTEP IIB)

Places disadvantaged and at risk youth in public and private sector employment and provides many with basic educational training. This program coordinates with the Maine Job Service to place thousands of Maine youth each summer in the Governor's Summer Youth Jobs Program.

The Economic Dislocation and Worker Adjustment Assistance Act (EDWAA)

A comprehensive new dislocated worker training program that replaced Title III of JTPA on July 1, 1989. This new program requires increased local level planning and reinforces the importance of rapid response to displacement via the Rapid Employment and Training Initiatives (RETI) Team. It also encourages close coordination with the Trade Adjustment Assistance (TAA) program administered through the Job Service Division.

JTPA Set Asides

Three JTPA special grants are set aside from IIA funds for use at the Governor's discretion.

8% Funds

Set aside and targeted for education initiatives such as basic skills remediation, occupational training and upgrading.

6% Funds

Set aside to create incentives for Service Providers and generally used for unique program development and capacity building activities and to offset training costs.

3% Funds

Targeted to programming for older workers.

New Initiatives

Additional Support for People in Retraining & Education (ASPIRE)

This program builds upon the Department of Human Service's welfare and employment programs and the Department of Labor's and Private Industry Council's training system. By coordinating their services, this new initiative doubles the training and employment opportunities for welfare recipients. Basic education and training, combined with support services, will enable dependent adults to move into the workforce.

Strategic Training for Accelerated Reemployment (STAR)

STAR provides training and retraining for unemployed or displaced workers. By providing new skills to laid off workers, the program helps alleviate the mismatch between workers skills and the skills required in the workplace.

Maine Training Initiative (MTI)

The MTI provides funds for Occupational Training, On-the-Job Training, and Customized Training. The program allows the Jobs Training System to serve such groups as the working poor, displaced homemakers, older workers and others who may not qualify for federal JTPA programs. The program designs reflect local needs and local labor market conditions.

Health Occupations Training Project (HOT)

Responding directly to industry need, this project is intended to increase the supply of qualified workers in the health professions by providing recruitment, training, financial assistance and placement services to people entering the field. The project also contains a loan pay back plan for registered nurses, administered by the Department of Human Services.

Governor's Contingency Fund

This provides funding for labor intensive new or expanding businesses. This fund was increased in 1988 to provide more resources to new and expanding businesses in Maine. As the nature of jobs continues to change and business expand, this fund will ensure that there is a supply of skilled workers. This program is operated in conjunction with the Department of Economic and Community Development.

Maine Occupational Information Coordinating Committee

The MOICC provides computerized career guidance information to the Job Service, the Job Training System, Adult Education programs, Vocational Technical Colleges and the State University system. Homeless individuals enrolled in the above programs benefit from updated career and educational guidance information.

MAINE STATE HOUSING AUTHORITY

SERVICES

The Maine State Housing Authority administers the following programs which provide funding for the homeless and at risk populations.

HUD Emergency Grants Program

MSHA awards annual state allocation to shelters statewide for rehabilitation of buildings, operating costs and supportive services. Grants are made to local governments or non-profit shelter providers.

Shelter Operating Subsidy Program (SOS)

MSHA grants state appropriated funds to shelters statewide based on beds and occupancy rates. Grants go directly to shelters to provide and enhance services to homeless populations.

Partnerships to Aid the Homeless (PATH)

A commitment made in 1986 of Section 8 rental assistance to local housing authorities who network with community social services to comprehensively assist and house homeless families. Rental assistance is recycled to new homeless families upon turnover.

Homeless Family Transitional and Living Demonstration Pilot

A program instituted in 1989 to finance transitional housing for families with children. The program also includes a case management component for comprehensive assistance. Six Community Action Agencies participating in the program have produced 18 units of housing so far.

Matching Funds

MSHA has provided commitments for 50% development financing at 1% interest, 30 year terms, to applicants for HUD's Transitional Housing and Permanent Handicapped Homeless Programs since 1987.

Housing Preservation Grants (HPG)

MSHA provides grants to community-based non-profits for use in replacing or rehabilitating severely sub-standard housing of very low income or at risk persons. Grants and deferred loans are offered for 40% of the project cost.

Boarding Care Facility Program

MSHA offers below market interest rate loans to non-profit sponsors of group supportive homes that are subsidized by State contract. Permanent financing is offered for 100% of development costs.

DEPARTMENT OF HUMAN SERVICES

SERVICES

The Department of Human Services categorizes services to the homeless (or potentially homeless) within three phases along the continuum of need: preventative programs, acute or crisis services and remedial/rehabilitative programs. Traditionally, the public often associates the "hands-on" crisis-oriented services such as homeless shelters and soup kitchens as the main areas of assistance required by the homeless. What follows is a brief summary of DHS services. Additional information is available upon request.

The Department of Human Services is making a coordinated effort through many of its bureaus and offices to provide services to the potentially homeless in order to reduce the need for crisis services, and to provide remedial programs which assist homeless persons in leaving short-term shelters and moving into home-type environments.

Prevention Services

These services maintain people in a living environment which at least meets minimal health and safety standards. Homeless prevention programs are aimed at the portions of the population that could be potentially homeless:

* General Assistance
* Emergency Assistance
* Nutrition Services (Food Stamps and WIC)
* AFDC
* Health Services
* Teen Pregnancy and Health Services
* Substance Abuse
* AIDS/HIV Infection
* Elderly Services
* Refugees and Migrant Services
* Family Violence Victims and Children

Major assistance to the potentially homeless is provided by municipalities using general assistance funds administered by the DHS Bureau of Income Maintenance (BIM). These funds provide the means for local government agencies to keep the potentially homeless in their homes. In FY 1990, more than half of the $8.5 million in budgeted general assistance funds will be spent on housing and utilities. General Assistance funding is also the major source of financing for crisis and acute services for the homeless by providing a large portion of the operations costs of municipal shelters.

Acute or Crisis Services

These services assist an individual when an abrupt change in circumstance threatens or causes loss of shelter and other necessities of life. The change in circumstances is usually short term but requires immediate assistance. These services include:

* Health Services
* Teen Services
* Substance Abuse
* Elderly
* Crime Victims Assistance Program
* Migrant Services
* Family Violence Victims

Remedial or Rehabilitative Services

These services allow the individual to become as self-sufficient as possible and to reduce dependence on private or government support. Services include:

* ASPIRE
* Teen Services
* Substance Abuse
* Elderly
* Refugees and Migrants
* Family Violence Victims and Children

DHS shares remedial and rehabilitative responsibility for the homeless with a number of other agencies including the Maine State Housing Authority and the Department of Mental Health and Mental Retardation, as well as with local municipal social service departments and private non-profit groups.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

SERVICES

The Maine Department of Mental Health and Mental Retardation serves adults with mental illness, children and adolescents with special needs and persons with mental retardation. The following homelessness and at risk of homelessness program summaries are limited to those population groups.

Non-Facility Based Programs Providing Treatment and Services

Adults With Mental Illness

Holy Innocents

Operates a large case management program for adults with serious mental illness in the Portland area.

York County Counseling Services

This Independent Living Program consists of three major components: subsidized living in apartments for five persons with severe and prolonged mental illness who are homeless; intensive community living counseling and supports; and services to assist clients secure and maintain affordable housing.

Shalom House Supported Apartments

Provides supports to up to ten persons in scattered community apartments in Portland, to eight persons in a rooming house (Spring Street), and to thirteen persons in a congregate living facility (Brackett Street). Each of these clients is directly from the AMHI inpatient population.

Area IV Mental Health Services Coalition

Community workers assist adults to find decent affordable housing and provide support in maintaining that housing.

Motivational Services Inc. Homeless Program

A staff person links with the shelter in Augusta to provide housing assistance and referral services to adults who are homeless and mentally ill.

Children and Adolescents with Special Needs

Portland Area Children's Mental Health Project

This multi-agency, collaborative project provides mental

health counseling, substance abuse counseling and case management to homeless youth at several sites in Portland.

Children and Adolescent Homeless Outreach Programs

Four separate programs in Bangor (Atrium), Rockland (Home Counselors), Sanford (York County Shelters), and Lewiston (New Beginnings) provide coordination, linkages and referrals to homeless or at risk youth.

BCSN/DMHMR Children's Outpatient Services

Although these outpatient programs do not target homelessness specifically, they do serve a prevention function by keeping families intact and include the following services: Homebased family services, family support, respite services, child and family mediation and day treatment.

Facility-Based Residential Programs

A variety of facility-based programs are funded/operated by the Department for the vulnerable population groups it serves. These supportive housing programs are designed to enable individuals to maintain stable, decent and affordable housing in the community.

Adults With Mental Illness

There are over twenty residential facilities throughout Maine for adults with severe and prolonged mental illness. These programs range from crisis intervention respite programs to independent apartments with as-needed supportive services to highly structured group homes with on-site staff and services. There has been a substantial increase in residential programs for adults with mental illness over the past two years, however, the bulk of these residential programs are small and have waiting lists.

The Transitional Housing Demonstration Program for Adolescents provides supervised group and semi-independent living, as well as supportive services, for up to two years in the Bath Children's Home for 12-16 children, ages 16 and up at time of admission, who are homeless or at risk of homelessness, within a Portland-Lewiston-augusta triangle. In addition, the children's mental health community system includes three well-established residential treatment centers, a network of teaching family homes based on the model at Boy's Town, and two or three experienced therapeutic foster home providers.

A $7,000,000 housing bond was approved by Maine voters in November, 1989 for housing and capital improvement needs of community-based nonprofit organizations serving persons with mental illness. The bond is to be implemented jointly by the

Department of Mental Health and Mental Retardation and the Maine State Housing Authority. Guidelines and philosophy for the fund, which will create housing options for both youth and adults, are being developed in collaboration with a mandated advisory committee, which includes representatives of consumers of mental health services, family members and providers of community services.

For persons with mental retardation there are six residential respite centers providing temporary housing, up to 21 days at a time, for adults with mental retardation. Five are operated by private non-profit agencies, one is State operated. In addition there are supervised apartments with varying levels of staff supervision (less than 24 hours per day) as well as foster, boarding and waiver homes available statewide. Intermediate Care Facilities provide care and active treatment to persons with mental retardation who, due to the complexity of their needs, cannot be served in foster boarding homes.

Community-Based Services

In addition, the Department provides for a variety of community-based services to assist individuals in realizing their potential and to lead stable and productive lives within the community. Such services include the development of programs for employment opportunities, case management services and comprehensive crisis stabilization services.

DEPARTMENT OF CORRECTIONS

SERVICES

The Department of Corrections supervises nearly 7,000 adults on probation in the community. Males are a majority, 88% of the total. Little information is available on an aggregate basis for this target population. Assumptions can be drawn regarding their risk of homelessness in view of the number and types of problems they present, which include:

* Alcohol and substance abuse
* Lack of education (high school dropouts)
* Lack of employment skills
* Mental health problems
* Low Income
* Lack of independent living skills

The Department's correctional facilities which include the State Prison, the Correction Center, two correctional facilities and three pre-release centers house 1500 to 1600 adults.

The Department also supervises over 2,200 juveniles, about 220 of which are in the care of the Department's Youth Center. As with the adult population, the majority, or 85% are male. Children come into the correctional system with a number of personal and family problems including:

* Substance abuse
* Sexual and physical abuse victimization
* Special education disabilities
* Dysfunctional families
* Truancy and dropping out of school
* Emotional disorders

The Department contracts with a number of different agencies to provide services to inmates and probationers, both adults and juveniles. The services are provided with the goal of reducing criminal behavior. The same services could be used to reduce the risk of homelessness for those already in the community (probationers) and those who will be released from correctional facilities.

Contracted Services to Inmates of Correctional Facilities

Substance Abuse Treatment and Counseling

These services are provided by Affiliated Chemical Dependency, Kennebec Valley Regional Health and Washington County Psychotherapy Association Agencies. Day One provides substance abuse treatment services to residents of the Maine Youth Center.

Substance abuse and other counseling services are provided to probationers in the community by Crisis and Counseling Services, York County Counseling, Aroostook Mental Health Center, Downeast Community Hospital, Bath Memorial Hospital, Northeast Substance Abuse Services, Inc., Chemical Alternative Program, Waldo County Community Social Action, Freedom Counseling and various private practitioners.

Homebased Family Services

These programs provide crisis intervention services by a team of counselors geared to preventing placement of children outside the families' homes. Services are provided by Aroostook Mental Health Center, Bath-Brunswick Mental Health Center, Day One, St. Michael's Center, Families United, Home Counselors, Inc., Sweetser's Children's Home, Tri-County Mental Health Services and Youth and Family Services.

Emergency Shelter Services

These services are provided for children by the following:

* New Beginnings, Lewiston
* Halcyon House, Skowhegan
* YWCA Fair Harbor Shelter of Portland, Maine
* Youth Alternatives of Southern Maine

Long-Term Residential Care

These services are provided by the following group homes:

* Community Schools, Inc., Camden
* Project Atrium, Inc., Bangor
* Christopher Home, Caribou
* Rumford Group Home, Rumford
* Day One, Bar Mills
* Wellspring, Inc./Project Rebound
* Goodwill Home Associates, Fairfield
* Weymouth Houses, Bristol and Jefferson
* Merrymeeting Farm, Kezar Falls
* Youth Alternatives, Portland
* Northern Maine General Hospital, Eagle Lake and Winterville homes

Semi-Independent Living Skills

These services are provided in transitional residential facilities at New Beginnings in Lewiston, Rumford Group Home and Goodwill Hinckley Home School Farm.

MOTUS, Inc. of Augusta

This program assists inmates leaving correctional facilities to find jobs and support services they need to retain these jobs.

H.O.M.E.

This residential program located in Orland assists in the development of independent living and employment skills along with a variety of support services.

DIVISION OF COMMUNITY SERVICES

SERVICES

The Division of Community Services provides services aimed at both the homeless and at risk populations through funding to the eleven Community Action Agencies that are located throughout Maine.

Emergency Community Services Homeless Grant Program

The Division receives federal McKinney funding to be used for expansion of comprehensive services for homeless individuals to help them make the transition out of poverty, provision of assistance in obtaining social and maintenance services, income support services and promotion of private sector and other available assistance. Funds are often used for administrative costs to provide staff who coordinate resources for the homeless. In addition, up to 25% of the funds can be used for direct services. In federal fiscal year 1991, Maine is receiving $222,238 under this program.

Temporary Housing Assistance Program (THAP)

The State has provided $250,000 in each of the past two years for temporary assistance for people who need shelter or who are at risk of becoming homeless. Assistance may include security deposits, rent, back rent, or other expenses necessary to prevent eviction or establish a person in a rental.

Weatherization (Federal and State Funds)

This program provides energy conservation services to eligible low-income households. Measures include insulation, storm doors and windows, caulking, weatherstripping, and chimney repairs. Services are delivered through Community Action Agencies and two Technical Colleges.

Clients who apply for the Low-Income Home Energy Assistance Program are referred to weatherization services. Priority is given to those low-income households which include someone who is elderly, disabled, or under two years of age.

Low-Income Home Energy Assistance Program (LIHEAP)

The primary purpose of LIHEAP is to provide a financial benefit to low-income households to assist them in paying a portion of their winter heating bills. Some of the LIHEAP funds are set aside for the Energy Crisis Intervention Program (ECIP) to assist with emergency energy needs, for weatherization and for the Central Heating Improvement Program (CHIP), to assist with the repair or replacement of heating

systems. Funds are sub-granted to Community Action Agencies and participating towns.

For a household to be eligible, total household income must be less than or equal to 125% of the Federal Poverty Guidelines. However, if the household has individuals who are elderly, handicapped, or under two years of age, income can be at or below 150%. In determining eligibility, health insurance payments are deducted from gross income for those who pay their own health insurance.

The Emergency Food Assistance Program (TFAP) & Hunger Prevention Program

Under TFAP, food commodities are provided by the U.S. Department of Agriculture and distributed to eligible low-income individuals by Community Action Agencies. Under the Federal Hunger Prevention Act, the Division was designated in FY 1989 to receive certain food commodities from the USDA and distribute them to soup kitchens, shelters and food banks, with priority given to those serving homeless persons.

Generally, Two TFAP distributions are held each year, while Hunger Prevention foods are available on a year-round basis.

Head Start

Head Start is a child development program for children between the ages of three and six and their families. Family income and available space are the criteria for services. Most programs operate four or five hours a day, four days a week for 32 weeks. Along with quality preschool education, attention is paid to the health and social service needs of the children and their families. Parental involvement is strongly encouraged. Services are provided by ten Community Action Agencies and three private, non-profit agencies.

In 1990-1991, 2,724 children are being served with a combination of over $8.6 million in State and federal funding.

MAINE DEPARTMENT OF EDUCATION

SERVICES

The Department of Education has received federal funds under the Stewart B. McKinney Homeless Assistance Act since 1988. These funds have provided programs for Homeless Adult Education under the Bureau of Adult and Secondary Vocational Education and for Assuring Access to Education for Homeless Children and Youth under the Office of Truancy, Dropout and Alternative Education.

Maine Homeless Adult Education Project

The Homeless Adult Education Project will continue and expand current homeless education projects from 16 in the past year to 27 sites in 1991. These projects will serve homeless adults in Augusta, Bangor, Hancock County, Lewiston, Portland, Somerset County and York County. Each project will be supervised by the local adult basic education program coordinated with shelters, agencies and programs that provide services to the homeless. All instruction is provided at the shelters, soup kitchens, transitional housing sites and other locations. These projects focus on adult homeless who are victims of spousal abuse, recovering alcoholic men and women, single parents, chronically mentally ill and transitional, destitute and unemployed. Instructional services are provided to individuals who lack basic literacy skills or who have not finished high school.

Children and Youth

Maine's State Plan for Assuring Access to Education for Homeless Children and Youth has served as a guide for implementing strategies and programs coordinated by the Department. Workshops, forums and collaborative projects have begun, primarily in the Greater Portland Area. Expansion of activities to other regions of the State will be carried out in the next year. McKinney funds have been restricted to special short term projects and demonstration projects and have not been available for direct services.

The Coordinator of Education for Homeless Children and Youth provides technical assistance to the Department, the schools and other agencies or Departments with regards to planning and implementing educational services to homeless children and youth.

Recent funds under the McKinney Act have allowed the Department to develop and implement two Regional Demonstration Projects (one rural and one urban). These collaborative projects are expected to be underway in the Spring of 1991 and continue for up to eighteen months. Each project will link

schools, agencies and other providers to focus on homeless children and youth and those at risk of becoming homeless.

Other Department Services for Homeless

Services of Department of Education consultants and staff are available to schools, both public and private. Coordination of efforts to serve homeless populations, adults and children, some of who are enrolled in public education and many who are not, is encouraged by the Department for providers at the local levels. The adult homeless project director and the children and youth coordinator have met frequently about their projects. As funds become available through McKinney Act and/or other sources, grants will be available to schools through the Department for direct services to children and youth who are either homeless or at risk of becoming homeless.

DEPARTMENT OF ECONOMIC AND COMMUNITY DEVELOPMENT

SERVICES

The Department of Economic and Community Development (DECD) has been designated as the agency through which the State Contact Person for Homeless Issues, the Task Force on Homeless and Housing Opportunities, the Comprehensive Homeless Assistance Program, and the Permanent Housing for Homeless Handicapped Persons programs are centered. The Affordable Housing Alliance and the Community Development Block Grant Program both are located in DECD and offer opportunities for direct assistance to homeless persons and persons at risk of homelessness.

State Contact Person/Task Force on Homelessness

The State Contact Person is the liaison between the National Interagency Council on the Homeless and State agencies and is responsible for disseminating information on McKinney and non-McKinney homeless programs. In Maine, the State Contact Person fulfills multiple functions, including staffing the Task Force, coordinating CHAP and Annual Program Reports, overseeing administration of DECD homeless projects, and presenting reports to local, state, and national agencies. The Task Force on Homeless and Housing Opportunities was established by the Legislature and given the responsibility of dealing with the problem of homelessness. DECD is the contact agency in the State for homeless programs and has been appointed as the lead agency in staffing the Task Force.

Comprehensive Homeless Assistance Program

The Comprehensive Homeless Assistance Program and Annual Performance Report requirements are responsibilities of the Task Force. Both are necessary for continued eligibility for McKinney Act funds. All McKinney Act proposals have to be consistent with an approved CHAP. The State Contact Person coordinates submission of these to HUD.

Homeless Assistance Through Community Development Block Grants

The CDBG program includes eligible activities that can serve homeless persons. Shelter acquisition, rehabilitation, and operations may be funded as eligible activities. HUD has determined that construction of emergency shelter facilities and transitional housing are public facilities and eligible for CDBG funding.

Bangor, Lewiston, Auburn, and Portland receive CDBG funds annually. Remaining municipalities and plantations compete for CDBG Small Cities funding on an annual basis. The program is administered by the DECD Office of Community Development.

Local governments may pass through funds to not-for-profit corporations for implementing activities directly assisting homeless persons. Many local housing, public facilities, and economic development activities included in local programs indirectly impact homeless persons and those at risk of homelessness.

Permanent Housing for Handicapped Homeless Program

DECD is the designated state agency eligible to apply for funds on behalf of a project sponsor. The project sponsor has to be a private non-profit organization or a public housing authority. States must certify that a 50 percent non-federal match will be provided. MSHA has provided mortgages as match for four projects funded in Maine. Acquisition, rehabilitation, operation, and support services are fundable activities.

Projects may be group homes or units in a multi-family building designed solely for housing handicapped homeless persons. Sponsors are required to provide community-based housing and support services for a minimum of ten years. The program continues to adapt to changing needs and to adjust to requirements. Applications are accepted annually.

Affordable Housing Alliance

Staffed in February of 1990, the Maine Affordable Housing Alliance joins with DECD and MSHA in meeting affordable housing needs. The Alliance assists municipalities through revolving loan funds to purchase land, provide infrastructure, or improve deteriorating urban neighborhoods in support of affordable housing development. The Alliance also assists local groups to establish local housing alliances. These groups establish the local housing strategies that guide affordable housing efforts. As the Alliance fulfills its mission, availability of housing affordable to families in Maine will help prevent homelessness. Projects assisted with Alliance funds may include shelters, transitional housing, or permanent housing for homeless persons.

LISTING OF PLACES AVAILABLE FOR PERSONS WHO ARE HOMELESS OR AT RISK OF BECOMING HOMELESS

The attached was developed from listings of shelters provided by the Maine Coalition for the Homeless and the Maine State Housing Authority. The intent is to identify places where people who are homeless or at risk of becoming homeless may receive shelter and services. Places are listed by county and then by municipality, thereby organizing it geographically.

Inclusion on the list is neither a recommendation of nor an endorsement by members of the Task Force, the agencies represented on the Task Force, and the State of Maine. Places have been included regardless of licensure and, in some cases, regardless of completeness of information.

There is a need for consistent and continued updating of listings such as this one. Additional information is necessary also. Updating and expanded data on each place are essential before the list can become a comprehensive representation of facilities available for Maine people.

ABUSED WOMEN'S ADVOCACY PROJECT
P.O. BOX 713
AUBURN 04210 795-4020

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE: WOMEN AND THEIR CHILDREN (BOYS UP TO AGE 13), MUST BE FUNCTIONAL AS STAFF IS NOT ON SITE 24 HOURS.

SERVICES: Kitchen facility with emergency food. Legal advocacy, support groups, empowerment groups and educational groups form women and children, housing referral, referral for other services as needed, transportation, clothing; child care is available during groups. Handicap accessible.

HOURS: ACCESSIBLE 24 HOURS; STAFF ON SITE M-TH.
STAY: TWO WEEKS
BEDS: 15 PLUS CRIBS
FEE: NONE
ACCESS: CALL HOTLINE NUMBER 795-4020; FARMINGTON OUTREACH 778-6107
COUNTY: ANDROSCOGGIN

ST. FRANCIS HOUSE
88 THIRD STREET
AUBURN 04210 784-2011

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: MEN AGES 18 AND OLDER WITH A SUBSTANCE ABUSE PROBLEM, MUST HAVE BEEN SOBER FOR 7 DAYS

SERVICES: Meals, medication monitoring, case management, individual and group counseling, independent living skills, housing referral, job training and location referral. Not handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: AVERAGE 3 MONTHS, MAXIMUM 6 MONTHS
BEDS: 15
FEE: NOT REQUIRED, SLIDING FEE SCALE
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL, SCREENED ON WEDNESDAYS
COUNTY: ANDROSCOGGIN

RURAL COMMUNITY ACTION PROGRAM
RFD #1, BOX 2900
LEEDS 04263 946-5096

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY

CLIENTS: NO RESTRICTIONS, MUST BE SCREENED THROUGH INTERVIEW COMMITTEE, NEED TRANSPORTATION.

SERVICES: Kitchen facility, some food available, outreach program through RCAM. Housing, adolescent pregnancy program, parenting classes, and other service referrals as needed. Not handicap accessible.

STAY: 8AM-4PM MON-FRI
BEDS: 10-5 IN EACH MOBILE HOME
FEE: NOT REQUIRED/$100 MONTH IF POSSIBLE
ACCESS: SELF REFERRAL OR OUTSIDE REFERRAL; CALL FOR AN APPOINTMENT
COUNTY: ANDROSCOGGIN

ANCHOR HOME FOR CHILDREN
209 LINCOLN STREET
LEWISTON 04240 783-6086

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS AGES 4-12

SERVICES: Home setting with house parents, case management, counseling, referral. Attend Christian school.

STAY: LONG TERM, UNTIL 18
BEDS: 4, PLAN TO EXPAND
FEE: DEPENDS ON ABILITY TO PAY
ACCESS: NEED OUTSIDE REFERRAL, SCREENING PROCESS
COUNTY: ANDROSCOGGIN

FELLOWSHIP HOUSE
95 BLAKE STREET
LEWISTON 04240 784-2901

CLASSIFICATION: EMERGENCY SHELTER-SUBSTANCE ABUSE

CLIENTS: WOMEN AND MEN OVER 18 WITH A SUBSTANCE ABUSE PROBLEM -- NO DETOX FOR HEROIN

SERVICES: Emergency shelter and detox, meals, medical care, case management, individual and group counseling, substance abuse counseling, hosing referral, clothing. Open AA meeting every day, educational groups, aftercare. Handicap accessible. No detox for heroin abuse.

HOURS: STAFFED 24 HOURS
STAY: EMERGENCY 24 HOURS, DETOX 7-10 DAYS
BEDS: EMERGENCY 3; DETOX 12; 9M & 3FEMALE
FEE: NOT REQUIRED, MEDICAID, SLIDING FEE
ACCESS: WALK IN, SELF REFERRAL AND OUTSIDE REFERRAL
COUNTY: ANDROSCOGGIN

HOPE HAVEN GOSPEL MISSION
209 LINCOLN STREET
LEWISTON 04240 783-6086

CLASSIFICATION: EMERGENCY SHELTER-FAMILY/ADULT

CLIENTS: FAMILIES, SINGLE WOMEN AND MEN, (EMANCIPATED YOUTH POSSIBLY BY SPECIAL EXCEPTION)

SERVICES: Meals (residents do cooking), case management, counseling, independent living skills, housing referral, job training: work rehab consists of kitchen help, professional maintenance, woodworking skills, retail, clothing, household items and furniture available.

HOURS: STAFFED 24 HOURS; BUILDING OPEN 7AM-10PM
STAY: MEN, INDEFINITE, WOMEN & CHILDREN ONE DAY
BEDS: 30: 24 MALE, 6 WOMEN, 2 CRIBS
FEE: NOT REQUIRED, SLIDING SCALE
ACCESS: WALK-IN, SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: ANDROSCOGGIN

NEW BEGINNINGS
491 MAIN STREET
LEWISTON 04240 795-4070

CLASSIFICATION: EMERGENCY SHELTER-ADOLESCENT

CLIENTS: GIRLS AND BOY AGE 13-18

SERVICES: Meals, medication monitoring, structured program, case management, individual and group counseling, family counseling, independent living skills, housing referral, transportation, clothing, outside referral as needed. Not handicap accessible.

HOURS: STAFFED 24 HOURS/DAY
STAY: 21 DAYS; FAMILY CONFLICT RESPITE - 3 DAYS
BEDS: 12 6-MALE 6-FEMALE
FEE: NONE
ACCESS: SELF REFERRAL OR OUTSIDE REFERRAL
COUNTY: ANDROSCOGGIN

ST. ANDRE'S GROUP HOME
188 SABATTUS STREET
LEWISTON 04240 783-8003

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: EMOTIONALLY AND BEHAVIORALLY TROUBLED ADOLESCENT GIRLS, AGES 13-18

SERVICES: Residents cook meals. Medication monitoring, group and individual counseling, clinical and psycho-social planning, family counseling, independent living skills, recreational activities, transportation, clothing, aftercare plan. Resident required to attend school.

HOURS: 24
STAY: EMERGENCY UP TO 3 WKS. LONG TERM 1 1/2 YEARS
BEDS: EMERGENCY ONE LONG TERM SEVEN
FEE: NOT REQUIRED, SLIDING SCALE
ACCESS: EMERGENCY: REFERRAL AND A CASEWORKER
COUNTY: ANDROSCOGGIN

SUPPORTIVE APTS. AREA IV MENTAL HEALTH
100 PINE STREET
LEWISTON 04240 782-2273

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH PSYCHIATRIC DISABILITIES

SERVICES: Assist to locate apartment, move in, coordinate other services, short term case management. Encourage involvement of a primary care provider.

HOURS: OFFICE 9-5 MON-FRI
STAY: INDETERMINATE
FEE: NEED TO PAY SECURITY DEPOSIT/RENT
ACCESS: SELF & OUTSIDE REFERRAL; PRIMARY CARE PROVIDER ASSIST
COUNTY: ANDROSCOGGIN

HOPE HOUSE NETWORK, INC.
RFD 2, BOX 1 MECHANIC FALLS 04256 345-3027

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PARENT

CLIENTS: PREGNANT AND PARENTING SINGLE MOTHERS AND THEIR CHILDREN, NO AGE RESTRICTIONS

SERVICES: Meals, case management, child birth classes, parenting classes, support group for single mothers, free pregnancy tests, baby clothes, transportation, referral to other services as needed. Not handicap accessible.

HOURS: 24
STAY: AS LONG AS NEEDED
BEDS: 3 WOMEN WITH CHILDREN; OTHER AVAIL.
FEE: NOT REQUIRED, 30% OF INCOME
ACCESS: SELF REFERRAL, CALL FOR AN APPOINTMENT
COUNTY: ANDROSCOGGIN

FRANKLIN ACADEMY
OLD LISBON ROAD, RR 1 BOX 3124
SABATTUS 04280 375-8162

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS, AGE 9-18, WHO ARE "NOT FUNCTIONING UP TO POTENTIAL EITHER ACADEMICALLY OR SOCIALLY"

SERVICES: General high school, remedial and alternative education, agricultural training, supportive residential setting, other services in the community.

STAY: AVERAGE 9 MONTHS-3 YEARS
BEDS: 53
FEE: MUST PAY TUITION
ACCESS: SELF REFERRAL AND OUTSIDE REFERRAL
COUNTY: ANDROSCOGGIN

BATTERED WOMEN'S PROJECT
P.O. BOX 1358
CARIBOU 04736 498-6570

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS:

SERVICES:

BEDS: 12 AND SAFE HOUSES
COUNTY: AROOSTOOK

CARIBOU APARTMENTS
P.O. BOX 1018
CARIBOU 04736 498-6431

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 DIAGNOSED W/ A MENTAL ILLNESS

SERVICES: Clients cook for themselves. Case management, counselling, substance abuse counseling, independent living skills, housing referral, job training, transportation. Staffed 8 hours a day, 5 days a week, clients must spend 20 hours/week working or in a program. Handicap accessible.

STAY: VARIES, AVERAGE ONE YEAR - 18 MONTHS
BEDS: 10
FEE: NOT REQUIRED, BASED ON INCOME
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: AROOSTOOK

CHRISTOPHER HOME
18 PLEASANT STREET, PO BOX 748
CARIBOU 04736 493-3343

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS 12-18

SERVICES: Safe environment. Individual, family, and group therapy; preparation for family reunification or independent living; operates under the Boys Town, Family Teaching Model.

STAY: MUST COMPLETE PROGRAM, AVERAGE ONE YEAR
BEDS: 7
ACCESS: REFERRED: DEPT OF HUMAN SERVICES OR DEPT OF CORRECTION
COUNTY: AROOSTOOK

FAMILY SUPPORT CENTER

CARIBOU 04736 498-6146

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: DOMESTIC VIOLENCE VICTIMS: WOMEN AND THEIR CHILDREN (BOYS UNDER 14); SAFE HOUSING IS FOUND FOR MEN

SERVICES: Meals, referrals, support group, independent living skills, housing referral, parenting classes, transportation, clothing, children's program.

HOURS: 24
STAY: 30 DAYS
BEDS: 14 PLUS 3 CRIBS
FEE: NONE
ACCESS: SELF OR OUTSIDE REFERRAL; HOTLINE 769-8251
COUNTY: AROOSTOOK

FAMILY SUPPORT CTR.TRANSITIONAL HOUSING

CARIBOU 04736 498-6570

CLASSIFICATION: TRANSITIONAL HOUSING-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE, WOMEN & THEIR CHILDREN (BOYS UNDER 14)

SERVICES: Meals, referrals, support group, independent living skills, self esteem classes, housing referral, transportation, clothing, children's program.

HOURS: 24 HOURS
STAY: 18 MONTHS
BEDS: 6
FEE: 15% OF INCOME (AROUND $40 MONTH)
ACCESS: SELF AND OUTSIDE REFERRAL; HOTLINE 769-8251
COUNTY: AROOSTOOK

MADAWASKA GROUP HOME
PO BOX 1018
CARIBOU 04736 498-6431

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 DIAGNOSED WITH A MENTAL ILLNESS

SERVICES: Meals, medication monitoring, case management, counseling, substance abuse counseling, housing referral, job training, job location, transportation. Handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: AVERAGE 1 TO 1 1/2 YEARS
BEDS: 6
FEE: NOT REQUIRED; BASED ON INCOME
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: AROOSTOOK

SKYHAVEN TRANSITIONAL LIVING RESIDENCE
PO BOX 1018
CARIBOU 04736 498-6431

CLASSIFICATION: TRANSITIONAL HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 DIAGNOSED WITH A MENTAL ILLNESS

SERVICES: Meals, mediation monitoring, case management, counseling, substance abuse counseling, housing referral, job training and location, transportation. Handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: AVERAGE 1 TO 1 1/2 YEARS
BEDS: 12
FEE: NOT REQUIRED; BASED ON INCOME
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: AROOSTOOK

JOSEPHINE GAGNON YOUTH HOME
P.O. BOX 188
EAGLE LAKE 04739 444-5152

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: ADOLESCENT BOYS, AGE 11-17

SERVICES:

ACCESS: BY REFERRAL ONLY
COUNTY: AROOSTOOK

PHILLIP BLANCHETTE YOUTH HOME
P.O. BOX 188
EAGLE LAKE 04739 444-5480

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS AGE 11-17

SERVICES: Meals, medication monitoring, case management, independent skills, transportation. Referrals to other services as needed. Handicap accessible.

STAY: 9-18 MONTHS
BEDS: 6
ACCESS: REFERRAL: DEPT. OF HUMAN SERVICES OR DEPT. OF CORRECTIONS
COUNTY: AROOSTOOK

BATTERED WOMEN'S PROJECT
P.O. BOX 986
HOULTON 04730 532-4004

CLASSIFICATION: EMERGENCY SHELTER DOMESTIC VIOLENCE

CLIENTS:

SERVICES:

BEDS: 14 AND SAFE HOME
ACCESS: BY REFERRAL ONLY
COUNTY: AROOSTOOK

TEMPORARY SHELTER FOR THE HOMELESS
SKYWAY INDUSTRIAL PARK, P.O. BOX 1753
PRESQUE ISLE 04769 764-4125

CLASSIFICATION: EMERGENCY SHELTER-FAMILY, ADULT

CLIENTS: SINGLE WOMEN AND MEN, YOUTH OVER 15 WITHOUT PARENTS, FAMILIES

SERVICES: Meals, referral for support services, independent living skills, housing referral, job training, job location, transportation, clothing. Handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: INDEFINITE
BEDS: 21: 14 MALE, 7 FEMALE
FEE: NONE
ACCESS: WALK-IN SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: AROOSTOOK

WINTERVILLE BOYS GROUP HOME

WINTERVILLE 444-4530

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS, AGES 11-17

SERVICES: Live-in house parents trained in effective parenting. Psychological consultation, evaluation, individual, family, and group therapy. Education prescriptive program by SAD #27; recreational and pre-vocational experiences.

STAY: 9-18 MONTHS
BEDS: SIX
ACCESS: REFERRAL FROM DHS OR DEPT. OF CORRECTIONS
COUNTY: AROOSTOOK

TEDFORD HOUSE
10 PLEASANT STREET
BRUNSWICK 04011 725-4871

CLASSIFICATION: EMERGENCY SHELTER-FAMILY, ADULT

CLIENTS: SINGLE WOMEN AND MEN OVER 18; FAMILIES

SERVICES: Breakfast and dinner provided (clients do cooking), medication monitoring, case management, housing referral, job location, transportation, clothing, help with furnishing new apartment. Not handicap accessible.

HOURS: 24 HOURS/DAY
STAY: 5 DAYS, LONGER WITH APPROVAL
BEDS: 15 ADULT; LEASED MOTEL FOR FAMILIES
FEE: NONE
ACCESS: WALK-IN
COUNTY: CUMBERLAND

EDGEFIELD AND NAPLES SPURWINK SCHOOL
PO BOX 311
CASCO 04015 892-3686

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS, 13-18, EMOTIONALLY DISTURBED

SERVICES: Residential treatment center. Therapeutic milieu, special education program with individualized plans, individual, group, and/or family therapy, psychiatric/psychological evaluations; recreation program.

STAY: UNTIL 9 MONTHS PAST 18TH BIRTHDAY
BEDS: EDGEFIELD 10; NAPLES 4
FEE: PAID BY SCHOOL, STATE, OR DHS
ACCESS: PET REFERRAL, MENTAL HEALTH REFERRAL, AND DHS OR PARENTAL CONSENT
COUNTY: CUMBERLAND

OPPORTUNITY FARM FOR BOYS
P.O. BOX 65
NEW GLOUCESTER 04260 926-4532

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS 6 TO 13 WHEN ENTER; FROM BROKEN HOME DUE TO DEATH, DIVORCE, OR PERMANENT SEPARATION FROM ONE OF NATURAL PARENTS

SERVICES: Residential program with emphasis on academics and social adjustment, active recreation and sports program; minimal counseling.

STAY: THROUGH HIGH SCHOOL
BEDS: 37
FEE: SLIDING SCALE, PAYMENT NOT REQUIRED
ACCESS: SELF OR OUTSIDE REFERRAL
COUNTY: CUMBERLAND

AIDS LODGDING HOUSE

PORTLAND 04101 874-1000

CLASSIFICATION: TRANSITIONAL HOUSING-ADULT AIDS

CLIENTS: ADULTS DIAGNOSED WITH AIDS WHO CAN CARE FOR THEMSELVES

SERVICES: Kitchen facility, referral to needed services, house support group. No on site staff. Not Handicap accessible.

HOURS: 24
STAY: NO TIME LIMIT
FEE: $67/WEEK, GEN. ASSIST. VOUCHERS
ACCESS: MUST COMPLETE APPLICATION AND SCREENING PROCEDURE
COUNTY: CUMBERLAND

ALEXANDER HOUSE
275 STATE STREET
PORTLAND 04101 773-1914

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WHO ARE PSYCHIATRICALLY DISABLED.

SERVICES: Meals, some referral to other services. Not handicap accessible.

HOURS: MANAGED 24 HOURS
STAY: INDETERMINATE
BEDS: 8
FEE: GENERAL ASSISTANCE AND S.S.INCOME
ACCESS: NEED A REFERRAL
COUNTY: CUMBERLAND

ARNIE HANSON CENTER
65 INDIA STREET
PORTLAND 04101 871-7452

CLASSIFICATION: EMERGENCY SHELTER-SUBSTANCE ABUSE

CLIENTS: WOMEN AND MEN WHOSE PRIMARY PROBLEM IS SUBSTANCE ABUSE. CLIENTS MAY BE INTOXICATED.

SERVICES: SHELTER: Evening and morning meals, shower, laundry, medical care, case management - referrals to other agencies, crisis intervention. DETOX: Ten day program used medical mode AA group counseling, educational films. Not handicap accessible.

HOURS: SHELTER: 6PM -6AM; DETOX: 24 HOURS
STAY: SHELTER: DETERMINED DAILY; DETOX 10 DAYS
FEE: SLIDING SCALE FOR CLIENTS W/INCOME
ACCESS: SELF REFERRALS FROM 6PM, REFERRALS FROM SOCIAL SERV. PROVIDERS
COUNTY: CUMBERLAND

BRENTWOOD HOME YOUTH ALTERNATIVES
53 BRENTWOOD STREET
PORTLAND 04103 874-1175

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS, AGE 12-15

SERVICES: Meals, medication monitoring, case management, counseling. Must attend school.

STAY: 3 YEARS
BEDS: 7
FEE: REIMBURSED BY DHS OR BLOCK GRANTS
ACCESS: OUTSIDE REFERRAL
COUNTY: CUMBERLAND

BRIDGE PROGRAM
247 VALLEY STREET
PORTLAND 04101 874-1055

CLASSIFICATION: EMERGENCY SHELTER-MENTAL HEALTH

CLIENTS: WOMEN AND MEN WITH PSYCHIATRIC HISTORY WHO DO NOT NEED CONSTANT SUPERVISION.

SERVICES: Evening meal prepared, residents prepare breakfast and dinner individually. Crisis intervention through the Ingraham Volunteer Hotline; unstructured independent living skills; case management and housing referral done outside. Prepared to serve hearing impaired guests. Not handicap accessible.

HOURS: OPEN 24 HOURS. STAFFED MON-FRI 8AM-9PM
STAY: THREE WEEKS MORE OR LESS
BEDS: 12
FEE: $104/WK FOR RM. & BOARD, GEN. ASSISTANCE
ACCESS: SELF REFERRAL OR FROM SOCIAL SERVICE AGENCY
COUNTY: CUMBERLAND

CARLETON AND PRIDE HOUSES-GOODWILL
PO BOX 8600
PORTLAND 04101 774-6323

CLASSIFICATION: PERMANENT HOUSING MENTALLY RETARDED

CLIENTS: MENTALLY RETARDED WOMEN AND MEN OVER 18 WHO CAN PERFORM OWN PERSONAL CARE AND RECEIVE SSI

SERVICES: Clients cook. Case management, independent living skills, housing referral, referral to other services as needed. Vocational evaluation services, work adjustment training, life skills program, job placement and follow-up services, support employment. Clients must participate in a day program.

HOURS: OFFICE 7AM-4PM M-F; HOUSE 24 HOURS
STAY: UNLIMITED
BEDS: 15 (CARLETON); 18 (PRIDE)
FEE: SSI REIMBURSEMENT/EARNINGS CONTRIBUTION
ACCESS: SELF AND OUTSIDE REFERRAL; SCREENING REQUIRED
COUNTY: CUMBERLAND

CARON ST HOME-GOODWILL OF MAINE
PO BOX 8600
PORTLAND 04101 774-6323

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH EMOTIONAL, PSYCHIATRIC DISABILITIES AND BILATERAL HEARING LOSS

SERVICES: Clients cook. Case management, independent living skills, housing referral, referral to other services as needed. Vocational evaluation services, work adjustment training, life skills programs, job placement and follow-up services, support employment.Clients must participate in a day program.

HOURS: OFFICE 7AM-4PM M-F; HOUSE 24 HOURS
STAY: 2 YEARS
BEDS: 8
FEE: COST REIMBURSEMENT THROUGH SSI
ACCESS: SELF & OUTSIDE REFERRAL; SCREENING REQUIRED
COUNTY: CUMBERLAND

CASA, INC., NORTH STREET
26 NORTH STREET
PORTLAND 04101 773-4357

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: YOUNG WOMEN AND MEN, AGES 15-22, SEVERELY TO MODERATELY DEVELOPMENTALLY DISABLED, NEED NURSING LEVEL CARE

SERVICES: Home care, attend day programs, recreational activities. Licensed nursing staff 24 hours.

STAY: VARIES; UNTIL ANOTHER PLACEMENT IS APPROPRIATE
BEDS: THREE
ACCESS: NEED TO HAVE A BMR CASEWORKER
COUNTY: CUMBERLAND

CITY OF PORTLAND ADULT SHELTER
16 ALDER STREET
PORTLAND 04101 761-2072

CLASSIFICATION: EMERGENCY SHELTER-ADULT

CLIENTS: HOMELESS WOMEN AND MEN OVER 18; PHYSICALLY HANDICAPPED WILL BE PLACED IN A HANDICAP ACCESSIBLE MOTEL.

SERVICES: Case management, crisis intervention, no meals, most services provided through general assistance.

HOURS: SUMMER: 9PM-7AM; WINTER 8PM - 8AM
STAY: VARIES
FEE: NONE; GENERAL ASSISTANCE GUIDELINES
ACCESS: SELF REFERRAL, 5:30PM - 8PM
COUNTY: CUMBERLAND

CITY OF PORTLAND FAMILY CENTER
48 CEDAR STREET, 51 CHESTNUT STREET
PORTLAND 04101 775-6313

CLASSIFICATION: EMERGENCY SHELTER-FAMILY

CLIENTS: PARENTS MUST BE 18 OR OVER. PRIORITY GIVEN TO GENERAL ASSISTANCE RECIPIENTS. PHYSICALLY HANDICAPPED PERSONS REFERRED TO ACCESSIBLE MOTELS.

SERVICES: Kitchen facility, case management, counseling, substance abuse counseling, independent living skills, some family planning, housing referral, referral on job training, food stamps, clothing and some transportation available through General Assistance. Not handicap accessible.

HOURS: NO STAFF ON SITE; OFFICE HOURS 8AM - 5PM
STAY: AVERAGE TWO WEEKS
FEE: NONE, GUESTS ADHERE TO GA GUIDELINES
ACCESS: WALK IN OR CALL; SELF REFERRAL. 775-6314; 775-6315
COUNTY: CUMBERLAND

CITY OF PORTLAND TRANSITIONAL HOUSING
14 STONE STREET
PORTLAND 04101 775-6313

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY

CLIENTS: FAMILIES IN NEED OF TRANSITIONAL HOUSING, PARENTS MUST BE 18 OR OLDER NO ACTIVE USE OF DRUGS OR ALCOHOL.

SERVICES: Project Self Sufficiency Programs: self-management, counseling, crisis intervention, independent living skills. Housing referral, family planning, some parenting class, educational and vocational counseling kitchen facility.

HOURS: 24 HOURS, NO STAFF ON SITE
STAY: VARIES
FEE: SLIDING SCALE FOR GUESTS WITH INCOME
ACCESS: WALK IN OR CALL, PROJECT SELF SUFFICIENCY
COUNTY: CUMBERLAND

COMMUNITY HEAD INJURY PROGRAM-GOODW
PO BOX 8600
PORTLAND 04101 774-6323

CLASSIFICATION: TRANSITIONAL HOUSING-HEAD INJURY

CLIENTS: WOMEN AND MEN 16 AND OLDER WITH A HEAD INJURY

SERVICES: Residents shop and cook. Case management, Mental Health head injury support groups, assertiveness training, vocational evaluation and counseling, work adjustment training, recreational therapy, daily living skills. Handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: 6 MONTHS TO 2 YEARS
BEDS: 8
FEE: FUNDING SOURCE WOULD PAY
ACCESS: SELF AND OUTSIDE REFERRAL; SCREENING REQUIRED
COUNTY: CUMBERLAND

CUMBERLAND COUNTY SHELTER (JAIL)
122 FEDERAL STREET
PORTLAND 04101 774-5939

CLASSIFICATION: EMERGENCY SHELTER

CLIENTS:

SERVICES:

HOURS: WINTER MONTHS ONLY
COUNTY: CUMBERLAND

EVODIA HOUSE
79 ALLEN AVENUE
PORTLAND 04103 871-7458

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: WOMEN 18 AND OVER WITH A SUBSTANCE ABUSE PROBLEM, MUST HAVE BEEN SOBER 7 DAYS, PRIOR REHAB EXPERIENCE REQUIRED.

SERVICES: Meals, medication monitoring, case management, individual and group counseling, substance abuse counseling, independent living skills, treatment, education and relapse prevention groups, referral for other services as needed. Must attend a 12 step program.

HOURS: STAFFED 24 HOURS, OFFICE MON-FRI 8-4
STAY: 3 1/2 TO 6 MONTHS
BEDS: 13
FEE: DEPENDS ON INCOME
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL, SCREENING REQUIRED
COUNTY: CUMBERLAND

FAIR HARBOR - YWCA
87 SPRING STREET
PORTLAND 04101 874-1130

CLASSIFICATION: EMERGENCY SHELTER-ADOLESCENT

CLIENTS: GIRLS AND BOYS AGES 7-17, WHO ARE IN CRISIS, MUST HAVE THE CONSENT OF LEGAL GUARDIAN

SERVICES: Advocacy, medication between guest and her family, recreational activities.

HOURS: 24 HOURS/DAY
STAY: UP TO 30 DAYS
BEDS: 8
FEE: NONE
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: CUMBERLAND

FAIR HARBOR RESIDENTIAL PROGRAM
555 CUMBERLAND AVENUE
PORTLAND 04074 874-1137

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS UNABLE TO LIVE AT HOME OR IN A FOSTER HOME AND HAVE NO ACCEPTABLE ALTERNATIVE

SERVICES: Semi-independent living. Independent living skills, in-depth case management, individual and group counseling, family work when possible, group recreational activities.

STAY: UNTIL 18
FEE: WHEN ABLE
ACCESS: SELF OR OUTSIDE REFERRAL
COUNTY: CUMBERLAND

FAMILY CRISIS SHELTER
P.O. BOX 704
PORTLAND 04104 874-HELP

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS:

SERVICES:

BEDS: 13 & 3 CRIBS
COUNTY: CUMBERLAND

FRIENDSHIP HOUSE
232 BRACKETT STREET
PORTLAND 04101 772-8876

CLASSIFICATION: EMERGENCY SHELTER-ADULT

CLIENTS: HOMELESS WOMEN AND MEN

SERVICES: Evening Meal, community kitchen, clothes closet, AA meetings, educational programs.

HOURS: 5 PM - 9 AM
STAY: UP TO ONE MONTH
FEE: NONE
ACCESS: REFERRAL FROM SOCIAL SERVICE PROVIDER NEEDED
COUNTY: CUMBERLAND

GRACE HOME
134-136 GRANT STREET
PORTLAND 04101 774-5122

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH A MENTAL DISABILITY

SERVICES: Apartments with kitchen facilities. Case management through Holy Innocents, housing referral, job location, transportation, clothing. Not handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: INDEFINITE
BEDS: 24 (4 IN EACH OF 6 APTS.)
FEE: $325/MONTH, NO FREE BEDS
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL, CALL FOR AN INTERVIEW
COUNTY: CUMBERLAND

GROUP HOMES SPURWINK SCHOOL
98 RACKLEFF ST., 194 MASS. AVE., 42 JACKSON STREET
PORTLAND 04101 871-1200

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS, AGES 7-20, EMOTIONALLY DISTURBED/BEHAVIORALLY DISORDERED

SERVICES: Residential treatment center. Therapeutic milieu, special education program with individualize plans, individual, group, and/or family therapy; recreation program, psychiatric/psychological evaluations.

STAY: DEPENDS ON INDIVIDUAL TREATMENT PLAN
BEDS: RACKLEFF 5, MASS 4, JACKSON 2
FEE: CONTRACT WITH BMHR
ACCESS: REFERRAL THROUGH PET PROCESS
COUNTY: CUMBERLAND

HASKELL STREET BOARDING HOME-GOODWI
P.O. BOX 8600
PORTLAND 04101 774-6323

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH A DISABILITY

SERVICES: Must participate in a day program. Clients cook. Case management, independent living skills, housing referral, referral to other services as needed, vocational evaluation services, work adjustment training, life skills program, job placement and follow-up services, support employment.

HOURS: OFFICE 7AM-4PM MON-FRI;(HOUSE 24 HOURS)
STAY: 6-18 MONTHS
BEDS: 10
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL, MUST GO THROUGH SCREENING
COUNTY: CUMBERLAND

JORDAN HOUSE
11 MELLEN STREET
PORTLAND 04101 773-1914

CLASSIFICATION: EMERGENCY SHELTER-ADULT

CLIENTS: HOMELESS WOMEN AND MEN

SERVICES: Three meals per day, weekly workshops.

HOURS: 24 HOURS
STAY: NO TIME LIMIT
FEE: FUNDING THROUGH GENERAL ASSISTANCE
ACCESS: REFERRAL FROM SOCIAL SERVICE PROVIDER NEEDED
COUNTY: CUMBERLAND

MCAULEY RESIDENCE
194 SPRING STREET
PORTLAND 04101 773-5289

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PAREN

CLIENTS: PREGNANT AND PARENTING SINGLE MOTHERS AND THEIR CHILDREN, NO AGE RESTRICTIONS

SERVICES: Meals, case management, child birth classes, parenting classes, support group for single mothers, free pregnancy tests, baby clothes, transportation, referral to other services as needed. Not handicap accessible.

HOURS: 8:30-4:30 SOME EVENINGS NOT STAFFED AT NIGHT
STAY: UP TO 18 MONTHS
BEDS: 3 APTS FOR UP TO 9 PEOPLE
FEE: 20% OF MONTHLY INCOME
ACCESS: WALK IN, SELF AND OUTSIDE REFERRAL, SCREENING PROCESS
COUNTY: CUMBERLAND

MCKAY HOUSE
102 WESTERN AVENUE
PORTLAND 04101 773-1914

CLASSIFICATION: EMERGENCY SHELTER-MENTAL HEALTH

CLIENTS: SINGLE, PSYCHIATRICALLY DISABLED, HOMELESS ADULTS

SERVICES: Ancillary support from local social service agencies, three meals per day, weekly workshop, literacy program.

HOURS: 24 HOUR HOUSE MANAGEMENT
FEE: MUST BE ELIGIBLE FOR GENERAL ASSIST
ACCESS: REFERRAL NEEDED FROM A SOCIAL SERVICE AGENCY
COUNTY: CUMBERLAND

OXFORD STREET SHELTER
203 OXFORD STREET
PORTLAND 04101 761-2072

CLASSIFICATION: EMERGENCY SHELTER-ADULT

CLIENTS: SINGLE ADULTS

SERVICES:

STAY: WINTER MONTHS ONLY
COUNTY: CUMBERLAND

ROADS GROUP HOME YOUTH ALTERNATIVES
288 EASTERN PROMENADE
PORTLAND 04101 874-1188

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS AGES 15-17

SERVICES: Meals, medication monitoring, case management, counseling, independent living skills, housing referral at time of graduation; must attend school and work part-time. Not handicap accessible.

STAY: UP TO AGE 18
BEDS: 10
FEE: REIMBURSED DHS OR BLOCK GRANTS
ACCESS: OUTSIDE REFERRAL; ALSO 874-1175
COUNTY: CUMBERLAND

SALVATION ARMY LIGHTHOUSE
65 ELM STREET
PORTLAND 04101 774-6304

CLASSIFICATION: EMERGENCY SHELTER-ADOLESCENT

CLIENTS: HOMELESS BOYS AND GIRLS, AGES 10-17

SERVICES: Showers, evening snacks and weekend breakfast, emergency clothing, access to social service providers.

HOURS: 9pm-7:30 am
STAY: VARIES
BEDS: 16
FEE: NONE
ACCESS: SELF REFERRAL
COUNTY: CUMBERLAND

SERENITY HOUSE
30 MELLEN STREET
PORTLAND 04101 774-2722

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: MEN 18 AND OLDER (UNDER 18 W/PARENTAL CONSENT) W/A SUBSTANCE ABUSE PROBLEM, MUST HAVE GONE THROUGH DETOX AND A REHABILITATION PROGRAM

SERVICES: Meals, medication monitoring, medical care, case management, individual and group counseling, must attend AA or NA twice a week, independent living skills.

HOURS: STAFFED 24 HOURS, OFFICE 8-4 MON-FRI
STAY: 3-6 MONTHS
BEDS: 31
FEE: BASED ON ABILITY TO PAY
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL, SCREENING TUESDAY 12:45 BY APPOINTMENT
COUNTY: CUMBERLAND

SHALOM APARTMENTS
180 AUBURN STREET
PORTLAND 04101 874-1090

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18, DIAGNOSED MENTALLY ILL

SERVICES: Apartments with kitchen facilities, case management, independent living skills, referral to other services.

HOURS: OFFICE 9-5 MON-FRI
STAY: UNLIMITED
BEDS: 11 INDIVIDUAL UNITS
FEE: 30% OF INCOME
ACCESS: SELF AND OUTSIDE REFERRAL, SCREENING PROCESS
COUNTY: CUMBERLAND

SHALOM HOUSE
90 HIGH STREET
PORTLAND 04101 874-1080

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18, DIAGNOSED MENTALLY ILL

SERVICES: Meals, case management, independent living skills, housing referral, referral to other services as needed.

HOURS: OFFICE 9-5 MON-FRI, HOUSE STAFFED 24 HRS
STAY: 1 YEAR
BEDS: 15
FEE: 30% OF INCOME
ACCESS: NEED REFERRAL, SCREENING PROCESS
COUNTY: CUMBERLAND

SPRING STREET (SHALOM HOUSE, INC.)
124 SPRING STREET
PORTLAND 04101 874-1080

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH A CHRONIC MENTAL ILLNESS

SERVICES: Case management, independent living skills.

HOURS: STAFFED 24 HOURS
STAY: UNLIMITED
BEDS: 8
FEE: $260/MONTH, GENERAL ASSIS. ACCEPTED
ACCESS: SELF AND OUTSIDE REFERRAL, INTERVIEW REQUIRED
COUNTY: CUMBERLAND

YMCA RESIDENCE PROGRAM
10 FOREST AVENUE, PO BOX 1078
PORTLAND 04104 874-1111

CLASSIFICATION: TRANSITIONAL HOUSING-ADULT MALES

CLIENTS: MEN OVER 18

SERVICES: Voluntary use of referral service for job placement, alcohol and drug rehabilitation, meals, housing. Social activities. Access to YMCA facilities. Not handicap accessible.

HOURS: STAFF AVAILABLE 24 HOURS
STAY: UP TO ONE YEAR
FEE: $60/WK 18/DAY PLUS 15/DEPOSIT
ACCESS: WALK IN
COUNTY: CUMBERLAND

YWCA WOMEN'S RESIDENCE
87 SPRING STREET
PORTLAND 04101 874-1130

CLASSIFICATION: TRANSITIONAL HOUSING-ADULT WOMEN

CLIENTS: WOMEN AGE 18 AND OVER

SERVICES:

STAY: UP TO 2 YEARS
BEDS: 64
FEE: SINGLE $55/WEEK; DOUBLE $45/WEEK
ACCESS: SELF OR OUTSIDE REFERRAL
COUNTY: CUMBERLAND

YWCA WOMEN'S SHELTER
87 SPRING STREET
PORTLAND 04101 874-1130

CLASSIFICATION: EMERGENCY SHELTER-ADULT WOMEN

CLIENTS: ADULT WOMEN AND TEEN MOTHERS WITH A CHILD UP TO ONE YEAR OLD

SERVICES: Travelers aid room (access through Salvation Army and Ingraham Volunteers), emergency food bank, emergency clothing, community kitchens, pool privileges.

HOURS: 24 HOURS
STAY: UP TO THREE WEEKS; POTENTIAL 3 MONTH EXTENSION
BEDS: 10
FEE: 1 FREE BED PER NIGHT/OTHERS $11.00
ACCESS: REFERRALS FROM SALVATION ARMY OR INGRAHAM VOLUNTEERS
COUNTY: CUMBERLAND

CASA, INC., SCARBOROUGH
PO BOX 58
SCARBOROUGH 04074 883-6333

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: WOMEN AND MEN, AGES 15-22, SEVERELY TO MODERATELY DEVELOPMENTALLY DISABLED, NEED NURSING LEVEL CARE

SERVICES: Home care, attend day programs, licensed nursing staff 24 hours, recreational activities.

STAY: UNTIL ANOTHER PLACEMENT IS APPROPRIATE
BEDS: 8
ACCESS: NEED TO HAVE A BMR CASEWORKER
COUNTY: CUMBERLAND

YOUTH ALTERNATIVES
677 WESTBROOK STREET
SO. PORTLAND 04106 874-1184

CLASSIFICATION: EMERGENCY SHELTER-ADOLESCENT

CLIENTS: BOYS, AGES 7-17, WHO ARE IN A CRISIS

SERVICES: Outreach family counseling, family follow-up for six months after discharge; educational services. Must have consent of legal guardian for participation.

HOURS: OPEN 24 HOURS
STAY: UP TO THREE WEEKS
BEDS: 9
FEE: NONE
ACCESS: SELF, FAMILY & COMMUNITY MEMBERS, SOCIAL SERVICE PROVIDERS
COUNTY: CUMBERLAND

CROSSROADS FOR WOMEN
144 MAIN STREET
SO. WINDHAM 04082 892-2192

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: WOMEN AGES 14 AND UP WITH A SUBSTANCE ABUSE PROBLEM

SERVICES: Meals, medical care, individual and group counseling, educational program of lectures and assignments, housing referral, aftercare plan. Not handicap accessible.

HOURS: STAFFED 24 HOURS
STAY: 28 DAYS
BEDS: 13
FEE: NOT REQUIRED, SLIDING SCALE
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: CUMBERLAND

HOUSING PROGRAM, TRI COUNTY M.H.S.
2 MIDDLE STREET
FARMINGTON 04938 778-3556

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH MENTAL OR EMOTIONAL DISABILITIES, READY TO LIVE INDEPENDENTLY.

SERVICES: Clients must have been with a primary therapist for at least months. Assist to find housing and financial aid, independent living skills, follow up until established in new residence.

ACCESS: REFERRAL FROM PRIMARY THERAPIST
COUNTY: FRANKLIN

MOUNT DESERT ISLAND YWCA
36 MOUNT DESERT STREET
BAR HARBOR 04609 288-5008

CLASSIFICATION: EMERGENCY SHELTER-ADULT WOMEN

CLIENTS: WOMEN, NO YOUNG CHILDREN WITHOUT PARENT

SERVICES: Kitchen facility; referral to community agencies. Child care on a sliding fee scale; access to exercise programs for a fee. Strict rules: no men, no alcohol and no drugs. Not handicap accessible.

HOURS: 24 HOURS
STAY: DEPENDS ON ABILITY TO PAY
BEDS: 3
FEE: NONE FOR A SHORT TIME, SLIDING FEE
ACCESS: WALK IN, SUMMER ANYTIME, WINTER 9:30 - 4:30
COUNTY: HANCOCK

MANDALA FARM
P.O. BOX 44
EAST ORLAND 04431 469-3018

CLASSIFICATION: EMERGENCY SHELTER-TRANSITIONAL HOUSING

CLIENTS: WOMEN, MEN, CHILDREN, FAMILIES

SERVICES: Therapeutic community detting, counseling, substance abuse counseling, independent living skills, housing referral, parenting classes, job training, transportation, clothing, HOME Co-op social worker does some case management. Handicapped accessible.

HOURS: 24
STAY: UNLIMITED
BEDS: 22
FEE: NONE
ACCESS: SELF REFERRAL
COUNTY: HANCOCK

ST. FRANCIS INN
ROUTE 1
EAST ORLAND 04431 469-7658

CLASSIFICATION: EMERGENCY SHELTER-TRANSITIONAL HOUSING

CLIENTS: SINGLE WOMEN AND MEN OVER 18, FAMILIES

SERVICES: Kitchen facility, referral to food assistance; housing referral, transportation; HOME Inc. provides outreach work. Child care available at HOME Inc. Handicap accessible.

HOURS: OPEN 24 HOURS
STAY: NOT MORE THAN ONE YEAR
BEDS: 12
FEE: NONE
ACCESS: WALK IN OR CALL, REFERRAL ACCEPTED
COUNTY: HANCOCK

HOMESTEAD PROJECT
P.O. BOX 663
ELLSWORTH 04605 667-7073

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS, AGES 13-17, BEHAVIORALLY HANDICAPPED, RESIDENTS OF MAINE, VERMONT, OR NEW HAMPSHIRE

SERVICES: Special education. Group work focusing on oppositional, identity and conduct disorders; specialized group and individual counseling as needed, individual treatment plans; positive reinforcement of appropriate behavior. Camping, hiking, canoeing.

STAY: BASED ON INDIVIDUAL TREATMENT PLAN
BEDS: 38
FEE: PAID BY DHS
ACCESS: DHS OR SPEC. ED DIRECTOR; ALSO CALL 667-2021
COUNTY: HANCOCK

DOROTHY HANCE HOME
P.O. BOX 10
ORLAND 04472 469-2886

CLASSIFICATION: EMERGENCY SHELTER-TRANSITIONAL HOUSING

CLIENTS: WOMEN AND MEN OVER 40, MAY BE VICTIMS OF DOMESTIC VIOLENCE

SERVICES: Food provided at first, then responsible for own food. Crisis intervention, some independent living skills, housing referral, family planning, job location, transportation, clothing, referral to other services as needed. Access to all HOME Inc. services, including day care. Handicap accessible.

HOURS: 24
STAY: NO LIMIT, SHORT AND LONG TERM POSSIBLE
BEDS: NORMALLY 7-14, UP TO 32 POSSIBLE
FEE: DONATION ACCORDING TO INCOME
ACCESS: MUST BE REFERRED BY SOMEONE
COUNTY: HANCOCK

BREAD OF LIFE MINISTRY
157 HOSPITAL STREET
AUGUSTA 04330 622-2946

CLASSIFICATION: EMERGENCY SHELTER-FAMILY, ADULT

CLIENTS: SINGLE WOMEN AND MEN, FAMILIES

SERVICES: No meals. Case management, counseling, housing referral, referral for other services. Not handicap accessible.

HOURS: 6PM - 9AM SEVEN DAY/WEEK
STAY: 7 DAYS
BEDS: 10 (2 DBL); 2 WOMEN, 6 MEN, 2 CRIBS
ACCESS: MUST HAVE AN OUTSIDE REFERRAL
COUNTY: KENNEBEC

ELM ST HOUSE-MOTIVATIONAL SERVICES
114 STATE STREET
AUGUSTA 04330 626-3465

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH PSYCHIATRIC DISABILITY

SERVICES: Independent living skills, case management, crisis intervention, some group activities. 24 hour support.

HOURS: 24 HOUR SUPPORT
STAY: LONG TERM BUT NOT PERMANENT
BEDS: 11
FEE: 20% OF INCOME PLUS FOOD & PHONE
COUNTY: KENNEBEC

FAMILY VIOLENCE PROJECT
P.O. BOX 304
AUGUSTA 04330 623-8637

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE: WOMEN AND THEIR CHILDREN (BOYS UNDER 14 YEARS OLD)

SERVICES: Kitchen facilities (provide own food), crisis intervention, support groups, housing referral, children's program, clothing, free child care on side. Not handicap accessible. CRISIS LINE 623-3569.

HOURS: 24 HRS. STAFFED MON-FRI 8:30AM - 5PM
STAY: 4 WEEKS
BEDS: 10 BEDS, 4 CRIBS
FEE: NONE
ACCESS: SELF, OUTSIDE REFERRAL; WALK IN OR CALL HOTLINE 1-800-452-1930
COUNTY: KENNEBEC

HEARTHSIDE
RFD #4, BOX 609
AUGUSTA 04330 547-3065

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: LATE AND FINAL STAGE CHEMICALLY DEPENDENT WOMEN AND MEN OVER 25, HAVE TO HAVE BEEN THROUGH DETOX

SERVICES: Meals prepared by clients. Mediation monitoring, substance abuse counseling, independent living skills, housing and employment referral, transportation, recreational activities.

HOURS: 24
STAY: 9 MONTHS - 1 YEAR
BEDS: 6 MALE AND 6 FEMALE
FEE: SLIDING FEE SCALE
ACCESS: SELF AND OUTSIDE REFERRAL, CALL FOR AN APPOINTMENT
COUNTY: KENNEBEC

MIDDLE STREET HOUSE-MOTIVATIONAL SE
114 STATE STREET
AUGUSTA 04330 626-3465

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH A PSYCHIATRIC DISABILITY

SERVICES: Independent living skills, case management, 24 hour support, crisis intervention, some group activities.

HOURS: 24 HOUR SUPPORT
STAY: 1 TO 1 1/2 YEARS
BEDS: 10
FEE: 30% OF INCOME
ACCESS: SELF REFERRAL POSSIBLE; PREVIOUS SERVICE PROVIDER INPUT NEEDED
COUNTY: KENNEBEC

SUNRISE HOUSE-MOTIVATIONAL SERVICES
114 STATE STREET
AUGUSTA 04330 626-3465

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18, HEARING IMPAIRED AND PSYCHIATRICALLY DISABLED

SERVICES: Independent living skills, case management, 24 hour support, crisis intervention, some group activities.

STAY: UNLIMITED
BEDS: 5
FEE: MINIMAL CLIENT PARTICIPATION
COUNTY: KENNEBEC

VETERAN'S ADM. CTR. TREATMENT PROG.

TOGUS 04330 623-8411

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: SUBSTANCE ABUSE, VETERANS WITH PROOF OF SERVICE, WOMEN AND MEN OVER 18

SERVICES: Meals, medication monitoring, case management, individual, group and family counseling, independent living skills and job training available in hospital, educational program. Handicap accessible.

HOURS: 24 OFFICE 7:30-4 MON-FRI
STAY: 21 DAYS
BEDS: 22
FEE: NOT REQUIRED, SLIDING SCALE
ACCESS: SELF AND OUTSIDE REFERRAL, CALL FOR AN INTERVIEW
COUNTY: KENNEBEC

KENNEBEC VALLEY MENTAL HEALTH CENTER
NORTH STREET
WATERVILLE 04901 873-2136

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: HOMELESS WOMEN AND MEN OVER 18 WITH PERSISTENT MENTAL ILLNESS

SERVICES: Housing committee coordinates support services, independent living skills, all other services referred.

HOURS: OFFICE 8-4:30 M-F, EMERGENCY SERV.24 HRS
BEDS: 7 APARTMENTS
FEE: 30% OF INCOME
ACCESS: SELF AND OUTSIDE REFERRAL, SCREENING
COUNTY: KENNEBEC

KVCAP, TRANSITIONAL LIVING DEMONSTR
P.O. BOX 278
WATERVILLE 04901 873-2122

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY

CLIENTS: FAMILIES WITH AT LEAST ONE CHILD UNDER 16

SERVICES: Case management, counseling, independent living skills, housing referral, referral to other services as needed, follow-up counseling.

HOURS: WEEKLY VISITS BY CASE WORKER
STAY: 6 MONTHS-2 1/2 YEARS
BEDS: 2 APTS W/2 BDRMS.,2 APTS W/ 3 BDRMS
FEE: $0 -$150/MONTH
ACCESS: SELF OR OUTSIDE REFERRAL; CALL FOR AN APPT/SCREENING
COUNTY: KENNEBEC

KVCAP-TRANS. LIVING FOR TEENS
P.O. BOX 278
WATERVILLE 04901 596-0361

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PAREN

CLIENTS: TEENAGE PARENTS

SERVICES: Adolescent pregnancy counseling, in depth case management, counseling, independent living skills, housing referral.

STAY: 6 MONTHS - 2 1/2 YEARS
BEDS: 4 UNITS
FEE: $0-$150/MONTH
ACCESS: SELF AND OUTSIDE REFERRAL, SCREENING PROCESS
COUNTY: KENNEBEC

WATERVILLE COOPERATIVE APARTMENTS
14 LLOYD ROAD
WATERVILLE 04901 872-7661

CLASSIFICATION: PERMANENT HOUSING MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 WITH A HISTORY OF MENTAL ILLNESS

SERVICES: Unsupervised apartments, staff available for crisis intervention.

BEDS: 2 APTS. WITH 2 BEDROOMS EACH
FEE: $175/MONTH
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: KENNEBEC

COMMUNITY SCHOOL
P.O. BOX 555
CAMDEN 04843 236-3000

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: FEMALE/MALE ADOLESCENTS AGES 16-20 WHO ARE HIGH SCHOOL DROP OUTS

SERVICES: One on one teacher/counselor relationship, case management, counseling. Students cook, work and attend school, group rap with MSW facilitator. Camping trips, aftercare programs, graduates with high school diploma.

STAY: 6 MONTHS
BEDS: 8
ACCESS: SELF OR OUTSIDE REFERRAL, INTERVIEW PROCESS
COUNTY: KNOX

MID-COAST HUMAN RESOURCES COUNCIL
P.O. BOX 808, 43 PARK STREET
ROCKLAND 04841 596-0361

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY

CLIENTS: LOW-INCOME FAMILIES W/AT LEAST ONE PARENT OVER 18 AND HOMELESS OR AT IMMEDIATE RISK OF BECOMING SO; MUST AGREE TO WORK WITH CASE MANAGER.

SERVICES: Bi-weekly meetings with case manager, case management, independent living skills, housing referral.

HOURS: 8-4:30 MON-FRI; NO ON SITE SUPERVISION
STAY: UP TO 2 1/2 YEARS
BEDS: 2 APTS. WITH 2 BEDROOMS EACH
FEE: $150/MONTH
ACCESS: SELF AND OUTSIDE REFERRAL, SCREENING PROCESS
COUNTY: KNOX

KENNEBEC COUNTY

NEW HOPE FOR WOMEN
P.O. BOX 642, 459 MAIN STREET
ROCKLAND 04841 594-2128

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE, WOMEN (OVER 18 OR EMANCIPATED) AND THEIR CHILDREN

SERVICES: Women and children placed in safe homes. Crisis counseling, information and referral, housing referral, legal advocacy, survivors of sexual abuse group in Belfast. Not handicap accessible.

HOURS: 24 HOURS, OFFICE MONDAY THROUGH FRIDAY
STAY: 1 TO 2 NIGHTS
BEDS: 6 TO 10 SAFE HOUSES AT ANY TIME
FEE: NONE
ACCESS: CALL 24 HOUR NUMBER 594-2129
COUNTY: KNOX

MID-COAST HOSPITALITY HOUSE
P.O. BOX 155
ROCKPORT 04856 594-1422

CLASSIFICATION: EMERGENCY SHELTER-FAMILY, ADULT

CLIENTS: WOMEN AND MEN OVER 18, FAMILIES

SERVICES: Dinner and breakfast, referrals, transportation.

HOURS: STAFFED 24 HOURS; CLIENTS STAY 5PM -9AM
STAY: SHORT TERM, DEPENDS ON INDIVIDUAL
BEDS: 10
FEE: NOT REQUIRED; SLIDING SCALE
ACCESS: MUST HAVE A REFERRAL **COUNTY:** KNOX

KENNEBEC COUNTY

WEYMOUTH HEINRICK HOUSE
ROUTE 130
BRISTOL 04539 563-1444

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS AGES 12-17 WITH A HISTORY OF PROBLEMS WITH PARENTS, SCHOOLS, LEGAL AUTHORITIES, OR PEERS

SERVICES: Group homes segregated by sex, run by live in professional teaching couple. Motivational system, counseling, community based therapeutic services and education available.

COUNTY: LINCOLN

WEYMOUTH CURTIS HOUSE
MOUNTAIN ROAD
JEFFERSON 04348 563-1444

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AGES 12-17 WITH A HISTORY OF PROBLEMS WITH PARENTS, SCHOOLS, LEGAL AUTHORITIES, OR PEERS

SERVICES: Group home segregated by sex, run by professional live-in teaching couple. Motivation system, counseling, community based therapeutic services and education available.

COUNTY: LINCOLN

CHISHOLM FAMILY SHELTER
100 YORK STREET
RUMFORD 04257 364-4551

CLASSIFICATION: EMERGENCY SHELTER-FAMILY, ADULT

CLIENTS: SINGLE WOMEN AND MEN OVER 18, FAMILIES

SERVICES: Kitchen facility with food provided, case management, housing referral, transportation, clothing, referral to services as needed. Not handicap accessible.

HOURS: ACCESSIBLE 24 HOURS/DAY (STAFFED-DAY)
STAY: 3 DAYS
BEDS: 6 AT ALL TIMES; 20-25 COTS
FEE: NONE
ACCESS: WALK IN, CALL, REFERRALS ACCEPTED
COUNTY: OXFORD

RUMFORD GROUP HOME
346 PINE STREET
RUMFORD 04276 364-3551

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS 13-18

SERVICES: Family reunification and family counseling, meals, medication monitoring, case management, counseling, independent living skills, housing referral, family, job training, recreational activities. Have to be in some educational program.

STAY: UNLIMITED
BEDS: 10
FEE: $56.75/DAY PAID BY RESPONSIBLE PARTY
ACCESS: MUST HAVE A REFERRAL SOURCE
COUNTY: OXFORD

RUMFORD GROUP HOME, INC.
346 PINE STREET
RUMFORD 04276 364-3551

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS 16-20, SEMI-INDEPENDENT LIVING PROGRAM FOR HOMELESS YOUTH

SERVICES: Structured program. Medication monitoring, case management, counseling, independent living skills, housing referral, family planning, job training, recreational activities. Must be in an educational program.

STAY: 2 YEARS
BEDS: 4
FEE: $45/DAY
ACCESS: MUST HAVE A REFERRAL SOURCE
COUNTY: OXFORD

COMMUNITY CONCEPTS TRANSITIONAL LIVING
P.O. BOX 278, MARKET SQUARE
SOUTH PARIS 04281 743-7716

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY, ADULT

CLIENTS: SINGLE ADULTS, FAMILIES; PRIORITY TO FAMILIES; HOMELESS OR AT RISK OF HOMELESSNESS; LOW INCOME

SERVICES: In depth case management, counseling, independent living skills, housing referral, job training, transportation, referral to other services as needed.

HOURS: OFFICE: 8-4:30 MON-FRI
STAY: 6 MONTHS TO 2 YEARS
BEDS: 4 APTS WITH 2 BEDROOMS EACH
FEE: 30% OF INCOME
ACCESS: SELF AND OUTSIDE REFERRAL, CALL FOR AN APPOINTMENT
COUNTY: OXFORD

BANGOR HEALTH AND WELFARE
103 TEXAS AVENUE
BANGOR 04401 941-0257

CLASSIFICATION: EMERGENCY SHELTER-FAMILY

CLIENTS: SINGLE WOMEN AND MEN OVER 18, FAMILIES

SERVICES: Two shelters: one for men, one for women, children go with their parent(s). Meals, case management, transportation, clothing. Not handicap accessible.

HOURS: WOMENS SHELTER: 24; MENS SHELTER: 5PM-8AM
STAY: 30 DAYS
BEDS: WOMEN: 10; MEN: 4
FEE: NONE
ACCESS: WALK-IN, SELF AND OUTSIDE REFERRAL
COUNTY: PENOBSCOT

BANGOR RESCUE MISSION
126 THIRD STREET
BANGOR 04401 942-4161

CLASSIFICATION: EMERGENCY SHELTER-ADULT

CLIENTS: MEN OVER 18; NEED TO BE ABLE TO WORK, MUST ATTEND CHURCH SERVICES.

SERVICES: Meals, counseling, substance abuse counseling, job location, transportation, clothing educational assistance.

STAY: INDEFINITE
BEDS: 4
FEE: NONE; $5 IF THEY HAVE INCOME
ACCESS: WALK IN, SELF REFERRAL, OUTSIDE REFERRAL.
COUNTY: PENOBSCOT

GREATER BANGOR AREA SHELTER
26 CEDAR STREET
BANGOR 04401 947-0092

CLASSIFICATION: EMERGENCY SHELTER-FAMILY, ADULT

CLIENTS: SINGLE WOMEN AND MEN, FAMILIES

SERVICES: Evening meal, medical care, case management, counseling, independent living skills, housing referral, clothing. Not handicap accessible.

HOURS: SUMMER 7PM TO 7AM; WINTER 5:30PM TO 8AM
STAY: 5 NIGHTS PER MONTH
BEDS: 15, ASSIGNED AS NEEDED
FEE: NONE
ACCESS: WALK-IN, SELF REFERRAL
COUNTY: PENOBSCOT

HOPE HOUSE, INC.
179 INDIANA AVENUE
BANGOR 04401 941-2879

CLASSIFICATION: EMERGENCY SHELTER-SUBSTANCE ABUSE

CLIENTS: WOMEN AND MEN OVER 18 WITH A SUBSTANCE ABUSE PROBLEM

SERVICES: Emergency shelter, detox, extended treatment; meals, medical care, counseling, substance abuse counseling, management, life skills, 12 step program, transportation, clothing.

HOURS: STAFFED 24 HOURS
STAY: EMERGENCY-24 HRS.; DETOX 3-10 DAYS; EXTEND UP TO 45 DAY
BEDS: 44; EMERGENCY 25, DETOX 19
FEE: NONE
ACCESS: WALK IN, SELF AND OUTSIDE REFERRALS
COUNTY: PENOBSCOT

OPPORTUNITY HOUSING
359 PERRY ROAD
BANGOR 04401 947-2730

CLASSIFICATION: EMERGENCY SHELTER-ADOLESCENT, ADULT

CLIENTS: BOYS AGES 14-17; WOMEN AND MEN OVER AGE 18

SERVICES: Meals. Referral to support services possible.

HOURS: 7A.M.-6P.M. FOR REFERRALS
STAY: 30 DAYS MAXIMUM
BEDS: ONE FOR ADOLESCENT; TWO FOR ADULTS
FEE: $30 PER NIGHT
ACCESS: WALK-IN, SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: PENOBSCOT

ORONO GROUP HOME
43 ILLINOIS AVENUE
BANGOR 04401 947-0366

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: MENTAL HEALTH DIAGNOSIS, WOMEN AND MEN OVER 18

SERVICES: Kitchen facilities. Case management, counseling available, housing referral, referral to other services as needed. Handicapped accessible.

HOURS: 24
STAY: NO LIMIT
BEDS: 8
FEE: 30% OF INCOME
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: PENOBSCOT

PENOBSCOT JOB CORPS CENTER
P.O. BOX 1136
BANGOR 04401 842-1700

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT, AD

CLIENTS: WOMEN AND MEN, AGES 16-24, RESIDENTS OF U.S., IN NEED OF VOCATIONAL TRAINING, OUT OF SCHOOL OR UNABLE TO BENEFIT FROM PUBLIC SCHOOLS

SERVICES: Self-paced academics, "Hands on Training" in various vocations, basic health and medical services, pre-employment training classes, job placement counseling, off center work experience, clothing allowance.

STAY: UP TO 24 MONTHS
FEE: FREE ROOM AND BOARD + EARN $40/MONTH
ACCESS: SELF REFERRAL; 1-800-842-1700 JOB CORPS
COUNTY: PENOBSCOT

PROJECT ATRIUM
265 HAMMOND STREET
BANGOR 04401 941-2825

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS, AGES 14-18

SERVICES: Group and individual counseling; referral to other services as needed. Attend an education program.

STAY: AVERAGE 8-12 MONTHS
COUNTY: PENOBSCOT

PROJECT REBOUND--WELLSPRING, INC.
98 CUMBERLAND STREET
BANGOR 04401 941-1600

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: SUBSTANCE ABUSERS, GIRLS AND BOYS AGES 14-19

SERVICES: Meals, medication monitoring, case management, counseling, substance abuse counseling, independent living skills, some housing referral, outside referral for other services. Handicap accessible.

HOURS: 24
STAY: 6-12 MONTHS
BEDS: 12
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: PENOBSCOT

SPRUCE RUN ASSOCIATION
P.O. BOX 653
BANGOR 04401 947-0496

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE: WOMEN AND THEIR CHILDREN.

SERVICES: Counseling, support group, crisis intervention, children's program, outreach and referral.

HOURS: 24
STAY: 30 DAYS AVERAGE
BEDS: 5 FAMILIES AT ONCE COMFORTABLY
FEE: $1 PER DAY PER FAMILY
ACCESS: SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: PENOBSCOT

ST. ANDRE GROUP HOME
87 OHIO STREET
BANGOR 04401 945-5021

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PAREN

CLIENTS: YOUNG WOMEN WITH INFANTS, ONLY ONE CHILD PER MOTHER

SERVICES: Residents cook meals. Medication monitoring, case management, independent living skills, family planning, parenting classes including parenting skills, self-esteem, assertiveness, healthy relationships, discipline. Housing referral, clothing.

HOURS: 24
STAY: 3 MONTHS-2 YEARS
BEDS: 4 PLUS 4 CRIBS
FEE: NOT REQUIRED, SLIDING FEE SCALE
ACCESS: SELF AND OUTSIDE REFERRAL, INTERVIEW NECESSARY
COUNTY: PENOBSCOT

TRANSITIONAL LIVING APARTMENTS
43 ILLINOIS AVENUE
BANGOR 04401 947-0366

CLASSIFICATION: TRANSITIONAL HOUSING-MENTAL HEALTH

CLIENTS: WOMEN AND MEN OVER 18 DIAGNOSED WITH A MENTAL ILLNESS

SERVICES: Case management, counseling, substance abuse counseling, independent living skills, housing referral.

HOURS: SUPERVISED 4 HRS/DAY 5 DAYS/WEEK,ON CALL
STAY: NOT SET BUT ENCOURAGED TO "MOVE ON"
BEDS: 6
FEE: $125/MONTH
ACCESS: SELF AND OUTSIDE REFERRAL, SCREENING
COUNTY: PENOBSCOT

WELLSPRING, INC.
319 STATE STREET
BANGOR 04401 941-1600

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: WOMEN AND MEN OVER 18 WITH SUBSTANCE ABUSE PROBLEM; SEPARATE HALFWAY HOUSES

SERVICES: Meals, medication monitoring, case management, counseling, substance abuse counseling, independent living skills, referral to other services as needed.

HOURS: 24
STAY: 6 MONTHS
BEDS: WOMEN 13, MEN 13
FEE: 25% OF INCOME WHEN EMPLOYED
ACCESS: SELF AND OUTSIDE REFERRAL, INTERVIEW
COUNTY: PENOBSCOT

KID'S KORNER
RFD #2, BOX 82
BREWER 04412 843-6141

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT DD

CLIENTS: GIRLS AND BOYS, AGES 5-18, WITH DEVELOPMENTAL DISABILITIES/MENTAL RETARDATION

SERVICES: RESPITE: self care, A.D.L., personal independence, play and leisure skills. LONG TERM: program coordination of ongoing medical psycho-social, educational and administrative services.

STAY: LONG TERM TO AGE 18: RESPITE 18-21 DAYS MAX 60/YR
BEDS: 3 IN RESPITE; 3 IN LONG TERM
FEE: IN REGION $32/NIGHT; OUT $39/NIGHT
ACCESS: SELF AND OUTSIDE REFERRALS; APPLICATION PROCESS
COUNTY: PENOBSCOT

BIRTHCREST FARM -R.T.A.
RFD #2, BOX 76
LEVANT 04456 884-7346

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT MH

CLIENTS: BOYS, AGES 11-15, FOR WHOM NO LESS RESTRICTIVE ALTERNATIVE IS AVAIL- ABLE, MODERATE TO SEVERE INTERPERSONAL AND INTRA-PSYCHIC DIFFICULTIES

SERVICES: Behavioral interventions, treatment/teaching plan, multi-disciplinary supportive services, education, family integration strategy. Case review team, community integration.

STAY: UNTIL 18
BEDS: 4
FEE: PAID BY DHS
ACCESS: REFERRAL FROM DHS
COUNTY: PENOBSCOT

WOMENCARE/AEGIS ASSOCIATION
P.O. BOX 192, MAIN STREET ABOVE KORSKY'S
DOVER-FOXCROFT 04426 564-8165

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCES: WOMEN AND THEIR CHILDREN (NO BOYS OVER 16 YEARS OLD)

SERVICES: Clients are placed in safe homes. Women's support group, case management, individual and group counseling, court advocacy, housing referral, children's program.

HOURS: SHELTER 24 HOURS; OFFICE M-F 8AM TO 4 PM
STAY: 72 HOURS
BEDS: SAFE HOMES
FEE: NONE
ACCESS: WALK IN OR CALL; AFTER HOURS NUMBER 564-8401
COUNTY: PISCATAQUIS

RIVERSIDE ST. SPURWINK SCHOOL
RR BOX 1131, RIVERSIDE STREET
BRUNSWICK 04011 729-6692

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: BOYS, AGE 5-12; EMOTIONALLY DISTURBED/BEHAVIORALLY DISORDERED

SERVICES: Residential treatment center. Therapeutic milieu, special education program with individualized plan, individual, group and/or family therapy, psychiatric/psychological evaluations, recreation programs.

STAY: UP TO AGE 12
BEDS: 16 IN PROCESS OF BEING COMPLETED
FEE: USUALLY PAID BY SCHOOL DISTRICT
ACCESS: SELF OR OUTSIDE REFERRAL, SCREENING
COUNTY: SAGADAHOC

GROUP HOME-MILITARY & NAVAL CHILDREN
103 SOUTH STREET
BATH 04530 289-3555

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS AGES 10-16

SERVICES: Public school education, in-house counseling, dormitory living, common meals, recreational activities. 24-hour supervision.

HOURS: 24 HOUR SUPERVISION
STAY: ONE YEAR OR LESS
BEDS: 8
FEE: SLIDING SCALE
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: SAGADOHOC

TRANSITIONAL I&II CHILDREN & NAVAL CHILDREN
103 SOUTH ST
BATH 04530 289-3555

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENTS

CLIENTS: GIRLS AND BOYS AGES 16-17 REASONABLY CAPABLE OF INDEPENDENT LIVING WITHIN 2 YEARS (PHASE I); AGES 17-18 (PHASE II)

SERVICES: PHASE I: Public School education or GED activities; ion-house counseling and training, contracted therapies as needed, pre-vocational work experiences, health education, a vocational & leisure time activities, dormitory living, common meals, 24 hour supervision. PHASE II: Community job placement and support, completion of educational program, continued counseling, therapy, training, in-house apartment living with independent cooking, housekeeping, budgeting requirements, 24 hour supervision.

HOURS: 24 HOUR SUPERVISION
STAY: 2 YEARS
BEDS: 8
FEE: SLIDING SCALE
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: SAGADOHOC

TRANSITIONAL III MIL & NAVAL CHILDREN
1093 SOUTH STREET
BATH 04530 289-3555

CLASSIFICATION: TRANSITIONAL HOUSING

CLIENTS: WOMEN AND MEN AGE 18 AND OVER

SERVICES: Independent living anywhere in the midcoast, Bath-Brunswick or Kennebec Valley area, with aftercare worker support for linking with community service agencies.

BEDS: 8
COUNTY: SAGADOHOC

GOODWILL HINCKLEY
P.O. BOX 129
HINCKLEY 04944 453-7335

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS, AGES 12-GRADUATION, IN NEED OF A HOME

SERVICES: Residential home with a wife/husband team. Residents attend Averill School in special education, cooperative education or accelerated learning program. Residents work in some aspect of the facility; recreational opportunities.

STAY: 8 MONTHS TO 1 1/2 YEARS
BEDS: 90
FEE: SCHOLARSHIPS AVAILABLE
ACCESS: SELF AND OUTSIDE REFERRALS
COUNTY: SOMERSET

HOSPITALITY HOUSE
ROUTE 201, P.O. BOX 62
HINCKLEY 04944 453-6846

CLASSIFICATION: EMERGENCY SHELTER-FAMILY

CLIENTS: WOMEN AND MEN, FAMILIES, MINORS IF CLEARED BY THE STATE

SERVICES: Meals, medication monitoring, case management, independent living skills, housing referral, transportation, clothing, referral to other services as needed, TDD machine for the hearing impaired.

HOURS: 24
STAY: UNLIMITED
BEDS: UNKNOWN AT THIS TIME
FEE: NONE
ACCESS: WALK IN, SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: SOMERSET

PITTSFIELD TRANSITIONAL HOUSE

PITTSFIELD 04967

CLASSIFICATION: TRANSITIONAL HOUSING

CLIENTS:

SERVICES:

COUNTY: SOMERSET

HALCYON HOUSE
P.O. BOX 502
SKOWHEGAN 04976 474-8574

CLASSIFICATION: EMERGENCY SHELTER-ADOLESCENT

CLIENTS: GIRLS AND BOYS, AGE 10-17, MUST HAVE CONSENT OF GUARDIAN; NO ONE ON PSYCHOTROPIC MEDICATION

SERVICES: Three meals/day, individual and group counseling, crisis intervention, independent living skills, transportation, clothing, teacher on staff for schooling. The referring agency or guardian must provide information and referral. Not handicap accessible.

HOURS: OPEN 24 HOURS
STAY: 21 DAYS MAXIMUM
BEDS: 10
FEE: DETERMINED CASE BY CASE
ACCESS: WALK-IN, SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: SOMERSET

SKOWHEGAN TRANSITIONAL HOUSE

SKOWHEGAN 04976

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PAREN

CLIENTS: PREGNANT TEENS AND TEEN MOTHERS; HOMELESS OR AT RISK OF HOMELESSNESS

SERVICES:

BEDS: 4 APARTMENTS
COUNTY: SOMERSET

PENQUIS COMMUNITY ACTION PROGRAM
P.O. BOX 1162
BANGOR 04401 941-2830

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY

CLIENTS: LOW INCOME, HOMELESS FAMILIES WILLING TO PARTICIPATE IN SERVICES

SERVICES: Case management, referral to services as needed, weekly meeting with case manager.

HOURS: OFFICE 8:15-4:30 MON-FRI
STAY: UP TO 2 1/2 YEARS
BEDS: 1 APT. W/3 BEDROOMS, 1 APT. WITH 2
FEE: $150/MONTH
ACCESS: SELF AND OUTSIDE REFERRAL, WAITING LIST, SCREENING PROCESS
COUNTY: WASHINGTON

WOMANKIND SATELLITE OFFICE
MAIN STREET, UNITED METHODIST CHURCH
CALAIS 04619 454-2311

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE

SERVICES: Shelter in Machias; support group, court advocacy, community work through Calais Office.

HOURS: MON.- THURS. 9-3; CALL FOR APPOINTMENT
ACCESS: CRISIS NUMBER 1-800-432-7303
COUNTY: WASHINGTON

WOMANKIND, INC.
P.O. BOX 493
MACHIAS 04654 255-4785

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE: WOMEN AND THEIR CHILDREN

SERVICES: Crisis line staffed with volunteers for counseling and referrals. Kitchen facility with some food available. Doctor available to come to shelter. Case management, counseling crisis intervention, support groups for women in shelter and in community, court advocacy, children's program, transportation, clothing, referral for other services as needed. Not handicap accessible.

HOURS: 24 HOURS, STAFFED DURING THE DAY ONLY
STAY: 4 WEEKS, NEGOTIABLE
BEDS: 6 PLUS CRIBS
FEE: NONE
ACCESS: WALK IN OR CALL; CRISIS LINE 1-800-432-7303
COUNTY: WASHINGTON

YORK COUNTY SHELTER EXTENDED CARE
SMITH APTS, P.O. BOX 20
ALFRED 04002 324-1137

CLASSIFICATION: TRANSITIONAL HOUSING-ADULT

CLIENTS: WOMEN AND MEN OVER 18

SERVICES: Meals, medication monitoring, medical care, case management, counseling, substance abuse counseling, independent living skills, housing referral, job training in Notre Dame Bakery, job location, transportation, clothing. Handicap accessible.

HOURS: 24
STAY: 6-18 MONTHS; BMR RESPITE CLIENTS 1-5 DAYS
BEDS: 10
FEE: NO REQUIRED BASED ON ABILITY TO PAY
ACCESS: TRANSFER FROM YORK CO. EMERGENCY SHELTER
COUNTY: YORK

YORK COUNTY SHELTERS, INC.
P.O. BOX 20, OLD JAIL ON ROUTE 11
ALFRED 04002 324-6591

CLASSIFICATION: EMERGENCY SHELTER-ADULT

CLIENTS: SINGLE WOMEN AND MEN OVER 18

SERVICES: Meals, medication monitoring, case management, individual and group counseling, independent living skills, housing referral, job training in Notre Dame bakery, clothing.

HOURS: STAFFED 24 HOURS
STAY: 2 WEEKS EMERGENCY SHELTER, 45 DAYS EXTENDED STAY
BEDS: 30: 24 MALE, 6 FEMALE
FEE: NONE REQUIRED; SLIDING SCALE/CLIENT
ACCESS: WALK IN, SELF REFERRAL, OUTSIDE REFERRAL
COUNTY: YORK

DAY ONE JAMES C. HARROD CENTER
P.O. BOX 41
BAR MILLS 04004 929-5166

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT SUB

CLIENTS: YOUNG WOMEN AND MEN AGES 16-24 WITH A SUBSTANCE ABUSE PROBLEM, NEED TO BE SOBER

SERVICES: Meals, medical care, case management, individual and group counseling, substance abuse counseling, independent living skills, housing referral, accredited. High school on site, job training, job location, transportation, clothing.

HOURS: 24
STAY: 9 MONTHS TO ONE YEAR
BEDS: 11
FEE: NOT REQUIRED, SLIDING SCALE
ACCESS: SELF AND OUTSIDE REFERRAL, INTERVIEW PROCESS
COUNTY: YORK

ST. ANDRE HOME, INC.
283 ELM STREET
BIDDEFORD 04005 282-3351

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PAREN

CLIENTS: PREGNANT WOMEN, NO AGE RESTRICTIONS

SERVICES: Meals, individual and group counseling, parent education training, child care skills, child development, health and nutrition, communication skills, stress management, self-esteem, adoption services, case management. Involvement in an education program leading to a high school diploma or GED.

HOURS: 24
STAY: UP TO 6 MONTHS--MUST BE AT LEAST 3 MONTHS PREGNANT
BEDS: 8
FEE: NOT REQUIRED, SLIDING SCALE
ACCESS: SELF AND OUTSIDE REFERRAL, SCREENING PROCESS
COUNTY: YORK

MILESTONE FOUNDATION, INC.
88 UNION AVENUE
OLD ORCHARD BCH 04064 934-5231

CLASSIFICATION: TRANSITIONAL HOUSING-SUBSTANCE ABUSE

CLIENTS: LATE TO FINAL STAGE ALCOHOLICS, MEN ONLY, MUST BE SOBER AND ABLE TO CARE FOR THEMSELVES.

SERVICES: Three meals/day prepared by clients. Medication monitoring, consulting physician. Case management, crisis intervention, substance abuse counseling, informal independent living skills, recreational activities, referrals for counseling, job location, transportation. Home work with families of clients, aftercare needs. Clients do volunteer work outside agency. No detox program on site. Would accommodate client with handicap.

HOURS: 24
STAY: AVERAGE 8 MONTHS - ONE YEAR
BEDS: 20
FEE: PAYMENT NOT REQUIRED, SLIDING SCALE
ACCESS: MUST BE SCREENED TO DETERMINE STAGE OF ALCOHOLISM. CALL APPOINTMENT
COUNTY: YORK

SWEETSER'S RESIDENTIAL TREATMENT
50 MOODY STREET
SACO 04072 284-5981

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT

CLIENTS: GIRLS AND BOYS, AGES 6-18

SERVICES: Interdisciplinary team provides 24 hours therapeutic experience; individual, group, family therapy, physical and mental health services, special education programing, recreational activities, life-skills training.

BEDS: 67 IN FIVE COTTAGES
ACCESS: INTAKE SERVICES 284-5981 EXT. 255; 883-2749, 772-7479
COUNTY: YORK

SWEETSER'S THERAPEUTIC GROUP HOME
50 MOODY STREET
SACO 04072 284-5981

CLASSIFICATION: TRANSITIONAL HOUSING-ADOLESCENT MH

CLIENTS: GIRLS AND BOYS, AGES 13-17, WHO ARE IN CONFLICT WITH THEIR HOME AND COMMUNITY ENVIRONMENTS

SERVICES: Full-time academic or vocational program, structured group living, independent living skills, individual counseling.

BEDS: 6
ACCESS: ADMINISTRATIVE ASSISTANT, INTAKE SERVICES, CALL 284-5981, EXT 255
COUNTY: YORK

CARING UNLIMITED
P.O. BOX 590
SANFORD 04073 282-2182

CLASSIFICATION: EMERGENCY SHELTER-DOMESTIC VIOLENCE

CLIENTS: VICTIMS OF DOMESTIC VIOLENCE: WOMEN OVER 18 OR EMANCIPATED WOMEN AND THEIR CHILDREN

SERVICES: Kitchen facility with food, laundry. Case management, counseling, crisis intervention, housing and job referral through newspaper. Transportation, clothing, in-house support groups as needed, support groups for women and children outside shelter, court advocacy. Handicap accessible.

HOURS: 24 HRS., STAFF ON SITE 9AM - 5PM
STAY: 2-4 WEEKS
BEDS: 11 PLUS 4 CRIBS
FEE: NONE, ASK FOR $5 DONATION PER WEEK
ACCESS: CALL HOTLINE, 324-1802 OR 282-2182
COUNTY: YORK

W.I.T.H.I.N. (YORK COUNTY SHELTERS)
23 RIVERSIDE
SANFORD 04073 324-3600

CLASSIFICATION: TRANSITIONAL HOUSING-PREGNANT/PAREN

CLIENTS: WOMEN AND THEIR CHILDREN, NO AGE RESTRICTIONS

SERVICES: Meals, medication monitoring, case management, counseling, substance abuse counseling, independent living skills, education, job training, group skills, socialization skills, house management, house referral.

HOURS: 24
STAY: 18 MONTHS
BEDS: 9 PLUS 5 CRIBS, EXPANSION TO 11
FEE: SLIDING SCALE
ACCESS: SELF AND OUTSIDE REFERRAL, INTERVIEW
COUNTY: YORK

YORK COUNTY COMMUNITY ACTION CORP.
P.O. BOX 72
SANFORD 04073 324-5762

CLASSIFICATION: TRANSITIONAL HOUSING-FAMILY

CLIENTS: LOW INCOME HOMELESS FAMILIES; PARENTS OVER 18 AND CHILDREN UNDER 16, WILLING TO PARTICIPATE IN PROGRAM

SERVICES: Case management, housing referral, budgeting skills, referral to other services as needed.

HOURS: OFFICE 8-5 MON-FRI
STAY: UP TO 2 1/2 YEARS
BEDS: 3 SMALL 2 BEDROOM UNITS
FEE: $150 MONTH
ACCESS: SELF AND OUTSIDE REFERRAL
COUNTY: YORK

STUDIES ON HOMELESSNESS

Independent and Federal Studies:

Families on the Move
Breaking the Cycle of Homelessness
The Edna McConnell Clark Foundation - 1990

Programs to Help the Hungry & Homeless
What Corporations Can Do to Help End Homelessness
The National Alliance to End Homelessness - 1990

Education for Homeless Adults: The First Year
U.S. Department of Education - 1990

Reaching Out Across America
Mentally Ill Veterans Programs
U.S. Department of Veterans Affairs - 1989

Homelessness in the States
Council of State Governments - 1989

Community Care for Homeless Families
The Better Homes Foundation
Interagency Council on the Homeless - 1990

Homelessness - Changes in the Interagency Council on the Homeless
Homelessness - Too Early to Tell What Kinds of Prevention Assistance Works Best
Homelessness - Access to McKinney Act Programs
Homelessness - McKinney Act Reports Could Improve Federal Assistance Efforts
U.S. General Accounting Office - 1990

Dropout Prevention for Homeless & Foster Care Youth
Metropolitan Center for Educational Research - N.Y.U
*funded by - U.S. Dept. of Health & Human Services
U.S. Dept. of Labor - 1989

Financing Services for Homeless Mentally Ill Persons
National Resource Center on Homelessness and Mental
*funded by
National Institute of Mental Health - 1989

Creative Sources of Funding for Programs for Homeless Families
Georgetown University
*funded by - National Institute of Mental Health &
U.S. Dept. of Health & Human Services - 1990

State of Maine:

Educational Access for Homeless School Age Children
University of Southern Maine
State of Maine Department of Education - 1990

Selected Children's Group Home Review - 1990
Children's Emergency Shelter Program Review - 1989
Interdepartmental Council - Subcommittee on
Residential, Group & Community Care

Homeless Not Helpless in Maine
Legal Right Directory
Pine Tree Legal - 1989

Poverty Today
Blue Ribbon Commission on Energy Policy - 1990

Homeless Shelter Survey
City of Portland, Maine - 1989

Executive Summary: Mental Health and Other
Characteristics of Homeless Adolescents:
A Descriptive Analyzes of Multi-Agency Case Records.
University of Southern Maine: Department of
Mental Health & Mental Retardation - 1991

MENTALLY ILL CHILDREN

1. DUPLICATION/OVERLAP

   There is a fundamental lack of a coordinated approach to the provision of services to mentally ill children. Each state agency seeks legislative or federal funding for children whom they serve and who are either mentally ill or emotionally disturbed. There is no coordinated, comprehensive plan for the provision of services to mentally ill or emotionally disturbed children.

2. EMERGING ISSUES

   More children today are seriously emotionally disturbed or mentally ill and many more of them are so at a much younger age. Many of the existing agencies do not have the resources to appropriately be able to treat these children. The question of payment of services for emotionally disturbed children is fragmented and uncoordinated. Because of the lack of a coordinated approach to the delivery of service to emotionally disturbed and mentally ill children, more and more children are being institutionalized.

3. NUMBER 1 CHANGE

   There needs to be one agency that is responsible for the planning, development and implement of a full range of mental health services for all of Maine's children who need them.

WORK DONE BY DIVISONS IN THE BUREAU OF HEALTH

TOPIC	SUB-CATEGORY	CRITERIA	SERVICE	CLIENTS SERVED	STATE	COSTS FEDERAL	TOTALS FY'89
Others needing health care (Bureau of Health)	Health & Env. Testing Lab.	Maine citizen, Healthcare provi- ers, water utilit- ies, state agenc.	Testing water, env. samples, and medical samples	1.2 million	2,800,000 (2,100,000 dedicated 700,000 State)	30,000	2,830,000
	Dental Health	Maine Residents Health Ed. Screen	Fluorides, sealants	200,000	262,326	207,360	620,797
	Health Promo. & Education	Maine Resident	Educational inter- ventions includ individual, community based health promotion public ed. and media	1,2 million	62,000 (Diabetes)	397,000	459,000
	Div. of Public Health Nursing	Maine Resident & Refugees resett- ling in Maine	Preventive Nursing	1.2 million Approx. 12,000 direct visits to 6,000 clients 420 clinics 329 refugees	1,715,773	1.2 million	2,915,773
	Health Engineering	Environmental health & Hazards	Inspections & regulations Quality assurance	1.2 million	1,271,780	346,780	2,067,534
	Maternal and Child Health	Maine families Especially women & children	infant, child care, prenatal care family planning, WIC Teen/Young Adult programs, School- based programs	1.2 million	3,776,000	24,000,000	27,776,000
	Div. Disease Control	Maine resident Disease Survei- llance Primary prevention Ed. and Preventive Intervention	Acute & Chronic	1.2 million	1,000,000 approximate	2,000,000 approximate	3,000,000 approximate

TOPIC	SUB-CATEGORY		SERVICE	CLIENTS SERVED	STATE	COSTS FEDERAL	TOTAL
Others needing health care	Bur. of Health -public health	Maine Resident	Prevention of Disease and dis-ability	1.2 Million	7,716,065 2,205,295 (dedica.)	20,080,867	FY'90 30,002,227

For: Subcommittee on Health, Social Services and Economic Security - Special Commission on Governmental Restructuring

Date: August 23, 1991

Bureau of Health - Public Health/Prevention

Issue: Duplication of Services - problems posed for clients.

1. As we serve the entire population of the State, there is some duplication with other state agencies and the private sector. However, as our professional responsibilities are highly unique, the duplication rarely presents problems for consumers. The problems are more internal for government agencies/employees or private providers. However, in addition to classic public health functions, the Bureau of Health takes responsibility for certain function also performed in the private sector because these functions are expensive, difficult, or central coordination is needed for adequate disease control (Laboratory tests, the Tuberculosis program and Public Health Nursing are all examples of this). Occasionally, when we in prevention get involved in complicated care of the already ill, clients are served by several state agencies. This was described in our involvement with the chronically ill. Another example of the same clients being served by several state agencies would be food service inspections and alcohol licensure, or plumbing codes and environmental concerns. But, since health issues are generally the most complicated technically, it seems unlikely that those health functions could be safely performed by other agencies.

Issue: Emerging Issues for Year 2000 - Structural Changes needed.

2. Sick care is overemphasized and not enough resources are allocated to prevention. From a policy point of view, physical and mental health should be combined, and liaison employees should be established in other departments to facilitate work on common areas of concern, for which health professionals have leadership responsibility (examples: Departments of Education, Environment, Agriculture, Corrections, Public Safety).

Issue: Number one thing I would change.

3. Resource allocation should be shifted toward prevention and primary care.

MENTAL HEALTH

1. Identify duplication and/or overlap of services for this group of consumers. What problems do they present to the client?

   DHS provides protective services, including public guardianship/conservatorship, to adults with mental illness. DHS acts as public guardian for 110 adults who are patients at AMHI and BMHI. Approximately 20% community clients have a mental health diagnosis. The problem for this population and for the elderly, is lack of appropriate mental health services, not duplication. There is a potential for duplication as BMH case management for persons with mental illness becomes more available.

2. What do you see as the emerging issues/nees of your clients by the year 2000? And what structural changes are needed to meet those needs?

   *More housing with services options, both for elderly and other adults.

   *More creative approaches to design and delivery of mental health services.

   *More mental health professionals trained to work with special populations.

3. What is the number one thing you would change?

   Consolidate programs for adults in a single department whose mission is to foster maximum feasible independence for all adults, regardless of disabling condition or functional impairment.

TOPIC	SUBCATEGORY	CRITERIA	SERVICE	CLIENTS SERVED	FY 90 STATE	FY 90 FEDERAL	TOTAL
Mentally Ill	Protective Services	Incapacitated & dependent adult	Evaluation of incapacitation, mental health services based on assessment	n/a*	n/a	n/a	
	Guardianship/ Conservatorship	Incapacitated & dependent adult	Evaluation of incapacitation, mental health services based on assessment				
	Home Based Care	60+ yrs. Functional impairment	Home health, PCA, case mgmt., day care, mental health				
	Nutrition Meals on Wheels	60+ yrs. Functional impairment	Meals, sociali- zation & public education				
	Community Meal Sites	60+ yrs.					
	Social Services	60+ yrs.	Outreach, info. & assistance, legal, transportation, housing, benefits applications.				

*BEAS does not track clients by disability. We estimate that 20% of our protective/guardianship clients have a mental health diagnosis other than dementia. The proportion is significantly lower for aging services.

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John R. McKernan, Jr.
Governor

Robert W. Glover, Ph.D.
Commissioner

DEPARTMENT OF
MENTAL HEALTH AND MENTAL RETARDATION

August 23, 1991

TO: Rosalyne S. Bernstein and Roland Caron, Co-Chairs, Special Committee on Governmental Restructing Subcommittee on Health, Social Services and Economic Security

FROM: Robert W. Glover, Ph.D., Commissioner

RE: Answer to Three Questions - Mental Health

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1. Duplication and overlap of services is <u>not</u> the issue for persons with mental illness.

   The lack of a responsive, and coherent mental health service system <u>is</u> an issue, including both the severe paucity of available services, and the inadequate capacity to support the consumer and his/her family in getting <u>to</u> the services they need.

   Issues of coordination with public and private groups outside of the traditional mental health community warrant action as well. This includes general hospitals, law enforcement agencies and general assistance programs regarding housing and nutrition.

   The consumer consequently faces a battlefield, rather than a pasture of support.

2. The need for many persons with mental illness by the year 2000 is to have the support they need to <u>live productive lives in their own home communities.</u>

   Structural changes required to meet this emerging need include:

   - <u>Development of a broader array of services</u> including treatment, in-patient care, housing, vocational opportunities and social and recreational opportunities.

   - Develope and deliver services <u>at the local</u> level through Regional Boards.

   - Examine and <u>maximize third party reimbursement</u> for new community service opportunities.

   - Implementation of the AMHI Consent Decree.

State House Station 40, Augusta, Maine 04333 — *Offices Located on* 4th Floor, State Office Building
(207) 289-4223
(207) 289-2000 TDD for Hearing Impaired

3. The required structional changes for the mental health service system, as listed above, will only be accomplished if they are initiated in the context of a pervasive effort to reorient mental health professionals, providers and the general population to a consumer-driven focus.

   Consumer choice is a non-negotionable, if persons with mental illness are to benefit from services and live lives which are meaningful and rewarding.

   Consumer choice will require everyone who provides supports to persons with mental illness, to rethink how they do what they do, but more fundamentally it will also require them to understand the values they bring to their jobs.

   Regarding the general public and its attitudes toward mental illnesses, <u>far reaching anti-stigma efforts</u> must accompany changes in provider perspectives, if persons with mental illness are to continue to become part of the general public and not social isolates in state hospitals.

RWG/g

Roland DIST 8/23
me HHS

John R. McKernan, Jr.
Governor

DEPARTMENT OF
MENTAL HEALTH AND MENTAL RETARDATION
Bureau of Mental Retardation

Robert W. Glover, Ph.D.
Commissioner

Roger A. Deshaies
Director

August 23, 1991

TO: Rosalyne S. Bernstein and Roland Caron, Co-Chairs, Special Committee on Governmental Restructing Subcommittee on Health, Social Services and Economic Security

FROM: Roger Deshaies, Director, Bureau of Mental Retardation Roger.

RE: Request for Information

The Bureau of Mental Retardation provides through six regional offices the following services to persons with mental retardation and autism:

- Casemanagement
- Resource Development
- Contracting for support services (agencies/individuals)
- Quality Assurance
- Individualized Planning
- Representative Payee Services
- Guardianship Services
- Training

Effective within the next several months additional services will be provided resulting from the consolidation of services previously housed within the Department of Human Services; Bureau of Medical Services. This transfer eliminates much of the duplication . These services follow:

- Policies, rules, regulations related to medicaid services for persons with mental retardation specifically the Intermediate Care Facility for Persons with mental retardation (ICF/MR) program, and the Cost Reimbursement Program for boarding care services for persons with mental retardation.

- Financial management of all Medicaid services for persons with mental retardation.

State House Station 40, Augusta, Maine 04333 - *Offices Located on* 4th Floor, State Office Building
(207) 289-4242

The Bureau of Mental Retardation provides services for 3892 persons residing in a variety of community alternatives. Additionally 262 persons reside at Pineland Center, 12 persons reside at the Aroostook Residential Center, 12 reside at Freeport Towne Square and 16 children reside at the Elizabeth Levenison Center. All are state-operated ICF/MR facilities.

Specific to the questions, the following assessment is provided.

Eligibility criteria and statutory-mandates can result in duplication of certain components of multiple human service agencies. For example, an adolescent with mental retardation under the guardianship of the Department of Human Services could have a caseworker from the Bureau of Mental Retardation, a caseworker from DHS and, potentially, a counselor from the Bureau of Rehabilitation. Additionally, depending on the adolescents living arrangement, agency personnel and school personnel can also be involved in attempts to provide and coordinate services.

It is important to note that the duplication is in component roles not necessarily in the total responsibilities of each staff.

Other areas of overlap include:

. ABUSE/NEGLECT ALLEGATIONS

Investigations are conducted by the Office of Advocacy (DMHMR), and Maine Advocacy Services (federally funded). These are similar functions but different mandates and different responsibilities.

. TRAINING

Provided by both the Bureau and by provider agencies.

. INDIVIDUAL PLANNING

Provided by both the Bureau and by provider agencies.

. RESOURCE DEVELOPMENT

Interviewing potential providers is done by both DHS and BMR. Development activities are also done by both non-profit agencies and by BMR. As with Advocacy, there are many similarities but also differences in mandate.

As mentioned, the transfer of the Medicaid responsibilities will significantly eliminate or at least minimize duplication.

2. The service system for persons with disabilities (both public and private) often fosters dependent rather than independent through overly protective practicies that underestimate the abilities and capabilities of persons with disabilities. The most significant issue revolving around the need for significant revisions in this system is in enabling persons with developmental disabilities to become truly intergrated members of our society. Supported living and supported employment are examples of the emerging models that need to replace the sheltered settings currently in place.

3. The implementation of a system of individualized funding rather than the capacity funding.

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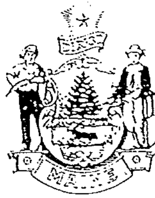

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

August 20, 1991

To: Special Commission on Governmental Restructuring Subcommittee on Health, Social Services and Economic Security

From: Elaine Fuller, Director, Bureau of Medical Services Elaine

Subject: Others Needing Health Care: Answers to Questions

1. One of the major problems concerning governmental structures for funding and organization for the delivery of health care is sorting out what services should be part of the long term care system versus the acute care system. In fact, they cannot be separated because there is constant movement of clients between the two systems. The Medicaid program and the other health insurance programs operated by DHS/BMS in fact serve all these populations. There are also other agencies serving these groups, and one area where there may be overlap is in paying claims, with other Departments having some system in place. It is unlikely these other systems are as efficient as the Medicaid Management Information System, which processes over five million claims a year through a highly automated system. To the extent that payment to providers impacts negatively on provider participation in programs, this presents a problem to clients.

2. The biggest challenge and emerging issue for the year 2000 will continue to be the problem of access to health care for the uninsured and the underinsured. Major structural change is needed to develop a public/private partnership that will reduce overall costs in our health care system and provide universal access to basic health care services. Changes are needed in the private insurance industry, in the public funding of health care, in the delivery systems, in the control of the health care system, the funding of these services and in the incentives for consumers to share in the responsibility for a cost-efficient system. Although it is argued that the states can provide the models for change, it is unlikely major reform will occur without support and funding from the Federal level of government.

3. The Departments of State government must be working together, not at cross-purposes, if these changes are to occur. The agencies serving the same constituencies and funding health care need to be working closer together, sharing the same goals and

constraints. Although many of these functions could be structured in one Department, the scope of funding of health care in fact spreads out to many departments, including corrections, education, insurance, as well as Human Services and MH/MR. I would create one agency as the primary agency for the planning, funding and oversight of health care services throughout the state, and require that other Departments relate to that one agency in some formal way.

Topic	Sub-Category	Criteria	Service	Clients Served	Costs State	Costs Federal	Costs Total
Others Needing Health Care	Medicaid Services	Financially eligible, categorical or medically needy	In-patient & Outpatient Hosp.	96,007	33,716,223	59,732,290	127,260,626
			Physician	96,643	8,828,941	15,641,516	24,470,457
			Pharmacy	117,864	13,658,317	24,197,329	37,855,646
			Psych.Hosp.	557	3,151,874	5,583,920	8,735,794
			Rehab. Services	55	68,543	121,431	189,974
		Services must be medically necessary	Dental	42,511	2,037,076	3,608,923	5,645,999
			Medical equip. & supplies	8,683	1,406,280	2,491,392	3,897,672
			Ambulance	4,381	401,552	711,398	1,112,950
			Transportation	12,141	2,245,536	3,978,233	6,223,769
			Podiatry	2,371	81,707	144,755	226,462
			Optical	6,581	54,663	96,841	151,504
			Chiropractic	2,884	110,952	916,566	307.518
			Home Health	4,578	2,702,034	4,786,974	7,489,008
			Mental Health Clinics	8,284	2,227,676	3,946,592	6,174,268
			Rural Health Cnts	8,684	545,993	967,291	1,513,284
			Audiology	511	5,201	9,213	14,414
			Psychological	5,195			2,097,080
			Other	113,839	14,141,205	25,052,821	39,194,026
			TOTAL	147,000*	86,140,399	152,607,939	238,748,338
	Claims Processing	Specific forms & data required	Processing claims for medical/health services for Medicaid, MHP, other DHS Bureaus	5M+ claims processed	1,510,713	3,051,061	4,561,773
	Medicaid Administration		Residential Care		560,458	29,570	590,029
			Licensing & Cert.		684,601	1,138,402	1,823,003
			SURS		121,833	183,966	305,799
			TPL		218,323	425,263	643,586
			All Other BMS **		2,392,130	9,318,784	15,237,807

* Estimated unduplicated recipients including page 2

** Total includes $430,965 for Special Revenue

Dist 8/23 HHS

For Subcommittee on Health, Social Services and Economic Security
- Special Commission on Governmental Restructuring

"Chronically Ill" - Answers to three Questions.

AIDS/HIV - Medical Eye Care - Special Services for Children
Diabetes

Issue: Duplication of services - problems posed to clients

1. All of these programs have in common that special medical care services are being made available to qualifying clients, because arguments can be made that professional providers (physicians, nurses, other medical personnel) or usual payors (medicaid, medicare, Maine Health Care Program, other insurance) are not adequately meeting the needs. This means that clients must establish qualifying credentials for a variety of programs, and need assistance to identify everything for which they qualify. The DHS specifically provides case management in AIDS and Special Services for Children. With all of these programs, the Bureau of Health has gotten involved because adequate medical expertise was not available in other government agencies for certain aspects of the complex care these persons receive. In the case of AIDS care, Bureau of Health professionals have provided case management consultation, and manage entirely the prevention piece. The other programs are administratively located in the Bureau of Health. On-going medical care of the chronically ill has not been a traditional public health service. This would be considered tertiary prevention, or maximum health maintenance where disease or disability has already occurred. Yet, the expertise afforded by health professionals is clearly needed. Overlap occurs with services provided by the Bureau of Medical Services (a primary payor), Bureau of Child and Family Services (case management), Bureau of Rehabilitation, Office of Health Planning, Research and Development (surveillance and Certificate of Need issues). There is also overlap with Departments of Education, Corrections, and Mental Health and Mental Retardation, for these programs.

Issue: Emerging needs of these clients by Year 2000 - Structural Changes to Government needed.

2. As the population is aging, and simultaneously there has been emphasis on care of the ill as opposed to disease prevention, we will see this population (chronically ill or disabled) grow at a fast rate. More and more clients will need more and more services. Structurally, it would be better to have a Department of Health separate from social services.

Issue: The number one thing I would change.

3. The number one thing I would care is to shift emphasis and resources toward prevention and primary care. We should establish health goals based on health maintenance and allocate resources in accordance with those goals.

TOPIC	SUB-CATEGORY	CRITERIA	SERVICE	CLIENTS SERVED	STATE	COSTS FEDERAL	TOTAL
Chronically Ill	Diabetes	At risk for Diabetes or complications	Patient Ed. Screening for eye disease prenatal ed. for diabetic women to prevent birth defects	People with Diabetes 66,000	$62,000	$202,000	FY'89 $262,000
	Special services for children	Maine residents under 18 yrs Household income (less than 185% national poverty) Medical eligibility: children with a congential or acquired chronic disease or condition All services are pre-authorized	Diagnostic & Treatment services by a medical subspecialist, Physical, occupational and/or speech language therapy, hospital services, prescribed medications, Orthotics and prosthetic services Care coordination Specialized multi-disciplinary clinics	1,913	860,430	536,020	1,296,450
	Medical Eye Care *1% under age of 5	Maine resident suffering from significant disorder which if untreated, may progress to blindness or be suffering from significant vision impairment after correction financially eligible	Preauthorization: Diagnostic and treatment services Corrective glasses Transportation to a needed service Medication	2,267*	360,584		360,584

Topic	Sub-Category	Criteria	Service	Clients Served	State	Costs Federal	Total
Chronically Ill Long Term Care	AIDS Case Management	HIV infected individuals and their families.	Service needs assessment, case planning, coordination of an advocacy for multi-disciplinary services.	600	136,602		136,602
	Drug Reimbursement Program	Low income HIV infected individuals with no third party payor.	Payment for FDA approved prescription medications.	110	25,355	37,342	62,697
	Pediatric AIDS Program	HIV infected children and their families.	Respite care Transportation Equipment Support and Advocacy	32		25,000	25,000
	Homebased Care	Low income HIV infected individuals.	Homemaker/Home Health Aide Services Personal Care In-home Mental Health Case Management	New program		163,216	163,216

Child + Family Services

Topic	Sub-Category	Criteria	Service	Clients Served	State	Costs Federal	Total
Physically Disabled	Blind Services	Legally blind or visually impaired adults	Skills train. including mobiity, self care, economic self-sufficiency	112	54,885		54,885
	Homemaker	Physically handicapped adults living in the commun.	Grocery shopping Home maintenance training, chore service, limited personal care. Food preparation	235	25,880	140,020	165,900
	Transportation	Physically handicapped	Scheduled routes and demand response transport	108	813	12,724	13,537

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John R. McKernan, Jr.
Governor

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Robert W. Glover, Ph.D.
Commissioner

August 22, 1991

To All Interested Parties:

Attached is the latest draft of the Department's proposal to establish regional boards to plan, coordinate, and oversee mental health services.

This proposal will be discussed at the September 5th meeting of the Visions Group which will be held at the All Souls Church on King Street in Augusta.

Please share this document with others as you wish.

I look forward to discussing ideas you have on regionalization in preparation for the Department's responding to a December 1st deadline from the Legislature's Human Resources Committee for draft legislation to establish regional boards.

Should you have questions prior to the September 5th meeting, please feel free to contact my office.

Sincerely,

Robert W. Glover, Ph.D.
Commissioner

19840

August 1991

A PROPOSAL FOR THE DEVELOPMENT OF REGIONAL BOARDS TO ENHANCE COMMUNITY-BASED MENTAL HEALTH SERVICE PROGRAMS IN MAINE

The purpose of this document is to share background information on the proposed development of regional governing boards to plan, coordinate, and oversee community-based mental health services throughout Maine.

This proposal has evolved over the last several years starting in 1988 with a priority from the statewide planning process calling for coordination of services and efforts among agencies, organizations, and systems. Now that the Systems Assessment Commission has issued its report, the development of regional boards is a specific strategy being considered by the Department of Mental Health (abbreviated as the "Department" in the following pages). In addition, the Department has been requested to submit draft legislation to the Human Resources Committee of the state legislature.

This overview may serve as a common resource to help inform statewide discussion of the issues involved for everyone. In turn, that discussion will inform and guide the Department's understanding and planning for the implementation of the regional board structure. Input into the process of developing regional boards has been encouraged from all sectors of the community -- from those who receive mental health services, their families and friends, from the professional staff and boards of directors of contract agencies funded by the Department, other state agencies, and local government, as well as concerned citizens and the public at large.

COMMUNITY-BASED SERVICES AND COMMUNITY MENTAL HEALTH CENTERS:

The current community-based service system in Maine is loosely organized into three general categories:

1. Two state-operated psychiatric institutes that provide inpatient and other services when appropriate community resources are not available;

2. Eight community mental health centers that provide a range of services to a wide variety of clients; and

3. Other provider agencies which provide specialized services in such areas as crisis/emergency services, community support/intensive case management, vocational programs, residential services, social clubs, deaf/geriatric specialized services, inpatient services, and human resource development/public information.

These elements support the foundations of the mental health system, which by state law are planned and managed by the Department of Mental Health through direct supervision of state-operated facilities and through formal contracts with local provider agencies.

Community mental health centers (CMHCs) are funded under contract in accordance with Department of Mental Health priorities and procedures for the services involved as well as for financial accountability. Although the centers have a long history of developing services in Maine, having earned a reputation for providing professional, compassionate, quality services to persons in need of mental health assistance, the boards of these non-profit corporations are officially responsible only for the corporate entity they direct. In fact, funding for Department sponsored mental health services represents in some cases only 17% of the center's budget.

DEPARTMENT OF MENTAL HEALTH:

The role of the Department, and specifically its Bureau of Mental Health, is to plan and monitor community-based service development, and to insure that legislative and Department priorities are realized through service contracts with the CMHCs and other local providers.

The Department has the statutory responsibility for overseeing the state institutes and maximizing opportunities and strategies to coordinate activities between the institutes and community-based programs.

In the past, the needs of the psychiatric institutes have dominated the Department's agenda. With a burgeoning inpatient population, many requiring skilled care on a constant basis, costs and staff issues have presented formidable problems.

Given this financially restrictive and difficult situation, the Department has tried to develop and apply community services on a consistent basis within the total fiscal resources available each year. However, the demands of centralized, coordinated planning accepted by the state have produced mixed results, the Department has been unable to distribute available funds in an entirely uniform manner across various regions in the state or consistently reflect individual regional strengths in resource development.

REGIONAL BOARD CONCEPT AND OBJECTIVES:

In recent times, the enactment of the federal comprehensive planning legislation (Public Law 99-660) has required the state to develop comprehensive mental health service plans as a prerequisite for securing certain federal funds. As a result, the Department of Mental Health has engaged in statewide planning for Maine, with widespread input from concerned citizens and families residing in various regions throughout the state. This nevertheless resulted in a centralized budget and program initiatives. The Department recognized that more input information -- based on local perceptions, needs, and resources -- would be beneficial both to the Department and, ultimately, to the people of Maine.

The emergence of the regional concept and strategy was dramatically noted in the work of the Systems Assessment Commission, which examined the mental health service systems in 12 states. The Commission concluded its work with the recommendation that Maine consider the use of regional boards as a means to expedite important objectives:

- To provide a positive influence on the development of a vision for the mental health system;
- To respond to a variety of mental health needs;
- To stimulate the growth of services;
- To clarify the role and tasks of the Department;
- To encourage consumer input in the planning, delivery, and monitoring of services; and
- To increase the level of community input in the overall development of the service system.

ACTIVITIES AND ISSUES, 1988 - 1991:

Several events, activities, and initiatives have combined to suggest the need for a regional board structure. These include:

- The recent Consent Decree requiring that needs be met in local/regional settings;
- Departmental initiatives to receive feedback on Department policy from a variety of constituencies (through the Visions Group, Portland Planning Group, and Northern Tier Planning Group);
- A new Commissioner of Mental Health;
- The Systems Assessment Commission's activities and report;
- The state's current fiscal crisis requiring more focused application of limited tax dollars;
- The dramatic increase in the number of contracts between the Department and local provider agencies (300% in 3 years);
- Increased demands for accountability;
- Overall trends and policies in Maine state government toward more regional and local control and less state government;
- Deliberations of the legislature's Human Resources Committee; and
- Legislative task force activities examining reorganization of state agencies.

CONSENT DECREE:

Signed in mid-1990, the Consent Decree addresses the need for a comprehensive mental health services system.

Of utmost concern is the necessity to develop and provide programs for individuals who have a serious mental illness and who require access to inpatient, outpatient, and supportive services and structures to meet individualized needs.

The Consent Decree requirements for Individualized Support Plans prescribe shared planning for these services by communities and the Department. In addition, the Consent Decree mandates the establishment of standards for community-based mental health programs, and for services that may span several categories of human service and education programs. Finally, the Consent Decree calls for normal community based settings to be used whenever possible. This necessitates a level of local understanding only accessible by regionally based decision making.

NEW DIRECTIONS:

The Visions Group, which began to meet in September 1990, was established by the Department as a vehicle for various representatives of family and consumer groups, provider agencies, the Department, and commission/committee members to discuss new initiatives and Department strategies, and to engage in collaboration and planning with the Department and among group members. The establishment of the Visions Group followed successful local planning efforts among similar representatives in the Portland area.

Since the inception of the Visions Group, members have joined together in formulating principles and values for governing the mental health service system. The Visions Group has explored several options, including regional boards, to address mental health service system needs.

The Commissioner of Mental Health, Dr. Robert Glover, is building consensus for advancing community-based strategies. His perspective includes experience in several states and at the national level through research, consulting, and committee activities for the National Institute of Mental Health and the National Association of State Mental Health Program Directors. Since his arrival, the Department has also utilized nationally recognized consultants to help gather and develop ideas for improvements in the mental health service system throughout Maine.

SYSTEMS ASSESSMENT COMMISSION REPORT:

One of the Systems Assessment Commission's tasks, assigned by the legislature, was to "formulate specific proposals for alternative systems of care." In its report, the Commission stressed the need for making progress in such areas as:

- Allowing for regional diversity;
- Enabling ongoing flexibility, so that the mental health system can be adaptable to both individual and community needs;
- Accounting for, and responding to, variations in demography; and
- Stimulating improvements in the treatment of mental illness.

The report of the Systems Assessment Commission discusses the practical mechanics of implementing regional strategies. Topics include: the nature of planning regional and community services; structure for regional planning and program direction; and three options for regional programs as the means to realize values identified by the Commission, and to encourage new directions for the mental health service system.

FINANCIAL CONTRACTION, CONTRACT EXPANSION:

The current financial status of Maine state government -- and its effect on the potential for securing additional financial resources for the mental health system -- may serve as a further stimulus to explore options for planning and providing mental health services in a climate of diminishing funds.

Maine's financial crisis imposes a harsh challenge to provide services throughout the state while taking into consideration such issues as: service efficiency and effectiveness; equitable distribution of resources across various regions; enlightened investment of funds according to identified community needs; and the question of who should make such decisions in each community.

As financial resources are currently shrinking, the past several years have also witnessed the extension of numerous individual contracts between the Department and provider agencies. For the current fiscal year, the Department has more than 100 contracts -- each of which must be developed, implemented, and monitored from a central bureaucracy, without the advantages enjoyed by most government bureaus in having a formal regional presence.

While expanding available services, the growth of contracting has imposed an increasingly heavier administrative burden on the Bureau of Mental Health. The overload has demanded recognition of the need for a more manageable structure and process to identify potential service providers and maintain relationships with these organizations.

Adding to the administrative responsibility for developing and maintaining these contractual relationships, consumers of mental health services and their families have claimed a major role in assessing local mental health service needs and selecting providers to meet those needs.

MORE ACCOUNTABILITY AND LOCAL CONTROL:

Maine citizens rightfully expect government agencies to have built-in mechanisms for insuring the best services possible through a structure to monitor and evaluate existing programs. Especially concerned with these issues in recent years have been the consumers of mental health services and their families. Presently, consumers are offered a mixed opportunity for participating in the planning and evaluation process of community-based services.

Meanwhile, there is also a growing trend toward regionalization in other facets of Maine state government. There has been a proliferation of local and regional committees, boards, commissions, and advisory groups for many programs managed by other agencies of state government and the Governor's Office. Some of these structures are traditional, such as local school boards, planning commissions, and administrative districts. Others, such as private industry councils, for instance, are less visible and only now emerging into public view and local influence. The legislature is currently examining these structures and will recommend future regionalization for specific agencies of state government.

VALUES AND PRINCIPLES:

In September of last year, the Department established a set of values and principles that would serve as a guide to the development of mental health services throughout the communities of Maine.

This set of guiding principles, reviewed and unanimously endorsed by the Visions Group, specifically related to client-based and family-based values. A summary of these values and principles is attached as an addendum to this report.

Other system values are reflected in the following sources:

- The Department's 99-660 state planning document;
- Reports from the Systems Assessment Commission;
- Deliberations of the Maine Commission on Mental Health;
- The Consent Decree; and
- Statements by boards of directors and staff of provider agencies, and by consumer organizations, family groups, and citizens at large.

The processes that were used to deliver these values clearly demonstrate the willingness of these constituencies to engage in dialogue, under the assumption that positive action will result. The match between inherent values and a management system that can maximize such values is crucial.

Changes in the management of the total service system through regional boards is consistent with the values and principles agreed to by these constituencies.

To insure these values, current and emerging management systems must be: sensitive to local needs; responsive to consumers and families at the local level; capable of planning, implementing, monitoring, and evaluating local services; and located near the site of service delivery.

WHY REGIONALIZATION:

A number of reasons for regionalization have been offered by various observers favoring the development of citizen-controlled mental health services boards in defined regions throughout the state. The reasons for developing regional governing boards to plan, coordinate, and oversee community-based mental health services include:

- To engage in outcome oriented planning based upon establishing achievable goals and measurable time-limited objectives;

- To respond to the state's diverse demographic characteristics;

- To serve as a quasi-governmental organization at a manageable, regional level (since Maine is not governed through county structures reflecting local preferences, such as in other states);

- To improve the coordination of mental health service system development for Maine's 493 separate towns and additional smaller residential areas;
- To differentiate between urban and rural needs (with 85% of Maine's population living within 15 miles of the Interstate);

- To foster the development of a minimum level of service that could be planned and available to meet the unique needs of diverse regions;

- To enhance consumer and family involvement in decisions that affect their lives with regard to service type, client group served, the provider organization, financial support, staffing, and other characteristics of the provider agency;

- To expand a community's capacity to secure funds beyond those provided by the Department through the initiation of pilot programs, local fundraising, and other vehicles;

- To encourage the expansion of consumer-operated services that can be implemented in response to individual consumers whose needs are better understood at the local level;

- To reduce the number and type of rules, regulations, and other controls exercised by the state; and

- To develop policies and programs that may be consistent with local circumstances.

POTENTIAL OUTCOMES:

As projected by various individuals in Maine who have examined the potential for such a system -- and based on experience in other states -- regionalization is expected to have several outcomes that will alter the current nature of the mental health system. Some expected outcomes are:

- Empowerment of the consumers and families in an ongoing role to plan, direct, and evaluate the services that they determine should be available;

- Integration of the community mental health provider system at the local level through an organization having no inherent conflict of interest, since regional boards would not provide direct services;

- Cost-effective stewardship of public funds by eliminating waste and duplication now being perpetuated through a Department-directed labyrinth of contracts with separate agencies;

- Building on the unique characteristics and strengths of each region by board involvement with local schools, housing authorities, correctional facilities, supported employment services, special populations, other human service and health provider agencies, and other persons and organizations that should be involved in the mental health care system; and

- Immediate access to local decision-makers who are directly responsible for oversight of the community mental health care system.

The latter outcome would also substantially lessen the current necessity of contacting Augusta in order to resolve provider and service organization issues.

ROLE OF THE DEPARTMENT OF MENTAL HEALTH:

Broadly conceived, under a regional system the Department of Mental Health would assume responsibility for four basic functions, serving to assure oversight of public funds while placing decision-making responsibility closer to Maine citizens at the community level.

These basic functions of the Department of Mental Health would be:

1. To provide leadership and a vision of the future.

2. To develop and make available a comprehensive information base and to provide leadership and support in mental health planning.

3. To develop state resources and an equitable allocation plan, including financial, technical, human, institutional, and other resources.

4. To develop and implement an comprehensive quality assurance program to set rules and minimum standards of performance including:

   a. quality of service standards
   b. program guidelines and regulations
   c. financial and accounting standards
   d. requirements for monitoring compliance
   e. standards for a minimum data set
   f. criteria for assessing program outcome

ROLE OF REGIONAL BOARDS:

The roles and functions of the regional boards may include:

1. To assess local needs;
2. To develop a strategic plan having measurable goals for services to meet identified consumers' needs;
3. To develop financial and other resources;
4. To implement the service plan through contracts;
5. To provide evaluation and quality assurance;
6. To protect consumer and family rights;
7. To provide technical assistance and consultation;
8. To distribute financial resources;
9. To manage short-range and long-range planning for the region;
10. To implement the Consent Decree and other mandates.

GUIDELINES FOR DETERMINING REGIONS:

1. Natural boundaries that are sensitive to systems that people utilize for their daily activities including services, shopping, commerce, and social supports.
2. Differences among lifestyles and access issues related to urban, rural, and suburban settings.
3. To the extent possible, mental health regions should be contiguous with other regions for the Department of Human Services, education, public safety, labor, Department of Transportation (which has 9 regional transportation entities) and other state-operated and state funded services.
4. Conducive to placing staff, fiscal resources, and human resources near sites where people need and seek services.
5. Regions should each have their own capacities to deal with persons who may require involuntary hospitalization.
6. Utilizing population scales appropriate to providing a full array of mental health services, within appropriate travel time, and in relation to the mode of service delivery (e.g. mobile rural outreach, etc.).

TYPE OF LEGAL ENTITY:

The regional board would each be an independent 501 (c) (3) corporation. Roles and functions would be established through state legislation that would identify the authority of the regional board to delegate responsibilities, fund provider agencies, engage in contractual relationships with agencies and individuals, and have formal relationships with other types of entities and organizations (including consumer and family groups).

Responsibilities and the nature of formal relationships between the Department of Human Services, Department of Mental Health and Mental Retardation, and the Bureau of Mental Health would also be detailed in state legislation.

COMPOSITION OF THE REGIONAL BOARD:

It is proposed that each board have a maximum of 15 members. At least 60% (nine members) must be representatives of consumers' and families' interests. Of these nine, four members must be primary consumers.

"Primary Consumers" are persons who have been, or are currently, recipients of publically operated or funded mental health services.

No members of a regional board shall be a state government employee or an employee of an agency that receives funds from a regional board. All members of the regional board shall abstain from any activities that would create any real or apparent conflict of interest.

NOMINATION AND APPOINTMENT:

All appointments shall be for three years with staggered terms. A board member may serve a maximum of two consecutive terms. The county commissioners (or some other vehicle) in a region will on a proportional basis, collectively appoint eight members to the regional board. At least 4 of these members shall represent consumers and families. No more than four of the commissioners' appointees shall be "members at large". This is only one approach. Other approaches may be based on a system of local elections or other nominating processes.

The Commissioner of Mental Health shall appoint seven members to each regional board. The Commissioner may appoint any proportion of members to represent consumers, families, and members at large.

OPERATIONAL COSTS:

The Department of Mental Health will financially support the costs for each regional board during the initial and future years of their operation. These expenses would include staff, facility costs, equipment, supplies, direct operating expenses, and other support expenses to be determined. The Department may use its discretion in securing these funds from a variety of sources.

BOARD RELATIONSHIP TO THE DEPARTMENT:

1. The Department will hold each board accountable for assuming the responsibility for implementation of all services in the region that are supported with funds from the Department.

2. The Board shall develop a strategic plan with attainable goals and a service plan based on regional needs and a plan to allocate fiscal and other resources based on strategies to meet these needs. The Department of Mental Health and Mental Retardation may review, comment, and approve the regional plan.

3. Each regional board shall be accountable for implementation of any provisions of the current or future consent decree that relate to community-based services.

4. The regional boards and the Department shall develop criteria that describes the process and content of the regional planning activities. Such criteria shall include specification of the relationship between the regional board (and its funded agencies) and the state hospital that serves the region.

5. The Department may place any board in receivership for health, safety, criminal, and other activities that are in violation of state statute and regulation.

LIABILITY:

Each board shall have tort claims liability as determined by state statute.

RELATIONSHIP OF BOARD TO OTHER COMMUNITY ENTITIES:

1. The relationship between the board and provider agencies shall be limited to the terms of the contract and/or memoranda of agreement which shall be independently negotiated with each provider.

2. Nothing shall limit the board to contracting with any existing provider agencies or for providing funds to or developing other mechanisms for providing fiscal resources to, or on the behalf of, any individual requiring mental health services.

3. In developing relationships with other community entities, the regional board will consider its own role and the role of such entities in:

   a. development of the regional plan for services;
   b. identification of priority clientele to be served;
   c. participation in needs assessment activities;
   d. development of outcome criteria for assessing the effectiveness of services to individuals and groups;
   e. determining the means by which the regional board and other community based entities will pursue the outcomes identified in the regional plan.

IMPACT OF REGIONALIZATION ON LEADERSHIP:

It is anticipated that the current efforts of the Governor's Office and state legislature to examine the structure and function of state government agencies will have a significant impact on the management of public services, and the extent to which these services can meet identified needs at the community level. The current legislative task forces examining agencies will recommend new regions that can be used by the majority of state agencies. The Department of Mental Health will await the recommendations from these task forces before recommending any specific regional configuration.

Both advocates and critics of regionalization have raised issues regarding the extent to which regions represent a duplication of effort and/or an unnecessary structural layer between the Department and community-based provider agencies. Other issues that focus on regional effectiveness should also be discussed and independent group of persons to establish a procedure for documenting these issues and developing a strategy to evaluate the effectiveness of regionalization on management, services, clientele, and other criteria to be developed.

One specific area of impact will be on the role of the Department and the Bureau of Mental Health under a regional system. The leadership role of the Department under the regional system shall include the provision of: (a) technical assistance; (b) training; (c) fiscal resources; (d) problem solving and dispute resolution; (e) fiscal and program audits; (f) public education; (g) institutional backing for involuntary and other inpatient hospitalization at state facilities if required; (h) standards for a minimum date set; and (i) identification of issues that cross all regions which require decisions, development of policies, resource development, and other supports.

It is the goal of the Department to develop regional resources and refocus leadership of the mental health system to local choice and opportunities at the regional/community level to develop conditions under which persons who have a mental illness experience opportunities to make choices in pursuit of a personal future; have respect and dignity; fully participate in aspects of community living; and have opportunities to develop and exercise competencies.

It is anticipated that regions will maximize local power and leadership for service systems change.

RELATION TO MAINE COMMISSION AND THE PLANNING COUNCIL:

There will be no contractual or administrative relationship between any board and the Commission or Council.

Regions will submit their plans to be used as part of the P.L. 99-660 statewide plan.

PLAN FOR PHASING-IN OF REGIONAL AUTHROITIES:

Year I (FY 92):

- Establish Boards and Initial Functions

1. Develop mission and by-laws consistent with enabling statue
2. Assess local needs (local system assessment planning teams)
3. Develop plan of services for short and long-term (coordinated with the state Mental Health Planning Council)
4. Coordinate Individual Support Planning and development with area providers
5. Review and advise Department regarding contracts with area providers
6. Identify local resources (financial, in-kind)

- Staffing:

1. Up to 2 FTE professional staff and 1 clerical. For initial year staff may be from existing Department positions.

- Department Functions (First Year Only):

1. Provide technical assistance and consultation to boards and staff (Current Department policies, Consent Decree compliance, mandated services and priority populations, etc.)
2. Distribute financial resources (contracting)
3. Evaluation and quality assurance of services
4. Develop and implement Individual Support Plans (ISP)
5. Protect consumer and family rights

Year II (FY 93):

- Expand Regional Authority, (add following functions to those identified in YR I).

1. Development of individual based MIS capacity
2. Coordinate ISP training, monitor implementation with area providers
3. Assume role in protection of consumer rights (grievances, coordinate with Office of Consumer Affairs)
4. Participate in quality assurance activities with Department staff
5. Sign-off authority on Department contracts, according to identified needs in the area

- Staffing:

  1. All staff (3 FTEs) employed directly by Board

- Department functions (second year only):

  1. Technical assistance and consultation to Boards
  2. Contracting (with Board sign-offs)
  3. Some evaluation and quality assurance activities
  4. ISP implementation
  5. Ultimate level for protection of consumer and family rights

Year III (FY 94):

- Full Authority Implementation (adding following to those identified in YR I and II):

  1. Implement plan of services to meet identified needs
  2. Direct evaluation and quality assurance
  3. Distribution of financial resources
  4. Technical assistance to provider agencies
  5. Consent Decree implementation
  6. Development of regional budgets based on MIS data for DMH&MR consideration

- Exploration of Medicaid reimbursement for administrative functions to complement funding for regional staff. Staffing increased according to workload and available resources.

DMHMR Values and Guiding Principles

Client-Based

Individuals and their families will be given the highest consideration in the development of services and Department policy.

Department services should be consumer-driven, meaning that: clients should be empowered through making their own decisions about their lives and the care that they receive; providers should be trained and sensitive to issues of client autonomy and empowerment; services should be "client-friendly," that is, easily understandable, accessible, and useable by clients themselves: and peer support networks should be available wherever need and desired by clients.

Those affected by mental illness or mental retardation and those who are part of natural support systems for them should participate in care planning and delivery, wherever and as much as possible and appropriate.

People receiving Departmental services are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs, and aspirations are not determinable on the basis of a psychiatric label.

People receiving Departmental services have the same rights as do all other citizens of Maine, including the right to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.

People should receive Departmental services without regard to race, religion, national origin, sex, physical disability, or other charactreristics, and services should be sensitive and responsive to cultural differences and special needs.

People should live, learn, and work in their communities.

Special efforts should be made to enhance access to care and overcome existing barriers to services, especially for groups such as children and homeless street people.

All advisory, planning, and governance bodies associated with Department programs should include consumer and natural support system members.

Family-Based

Individuals and their families will be given the highest consideration in the development of services and Department policy. *[duplicates statement under Client-Based category above]*

Those affected by mental illness or mental retardation and those who are part of natural support systems for them should participate in care planning and delivery, wherever and as much as possible and appropriate. *[duplicates statement under Client-Based category above]*

Policies and services for families which include individuals with mental retardation, emotional problems, or mental illness should focus on family unity and family empowerment. These policies must encourage direct involvement in selecting and arranging services, and maintaining community ties.

Assistance, including respite arrangements, should be available to those providing support for those affected by mental retardation, emotional problems, or mental illness.

All advisory, planning, and governance bodies associated with Department programs should include consumer and natural support system members. [duplicates statement under Client-Based category above]

Services-Based

Services provided for by the Department should foster dignity and self-worth. These services must assist each individual to achieve maximum independence.

Departmental services should address a broad spectrum of needs, from promotion of health, to support for those in difficulty, to intervention, diagnosis, treatment, rehabilitation, care and support for those affected by mental illness, emotional problems, and mental retardation.

Services provided by the Department should be individualized, guided by an individualized service plan, and in accordance with the unique needs and potentials of each person.

The Department should provide for services within the least restrictive, most normative environment that is clinically appropriate, with emphasis on home, school, primary health care, worksite, and other natural settings.

Quality should be built into the system of services and monitored regularly. Care givien at all points in the mental health system should represent state-of-the-art practice.

Protection of life and health should be paramount in the provision of services. In crisis situations, the mental health system should protect client safety and provide support while respecting client autonomy.

Diagnosis, evaluation, treatment, rehabilitation, care and support should be provided as near as possible to the place the client regards as home base.

There should be continuing public education on mental illness, emotional problems, and mental retardation that is aimed at fostering supportive community attitudes and eliminating stigma so that those affected will have greater opportunities to achieve interdependence and their potential as productive members of society.

Diagnosis, treatment, and support for the unique needs of those affected by multiple diagnoses (for example: substance abuse, head injuries, the aftermath of psychological trauma, with mental illness, emotional problems, or mental retardation) should be provided within the context of the service system, but not necessarily in institutions.

Early identification and intervention should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

Services should be provided in a fiscally responsible manner, emphasizing efficient and effective care for those in need.

Services should be based, when feasible, on research findings and recognized models of success.

Services and supports should be administered and provided in a manner which avoids unnecessary bureaucracy and indirect costs, and maximizes direct services.

Services and supports should be provided and organized in a way which is responsive to communities served, and, therefore, may represent differing models.

The delivery of services should be provided by individuals who are qualified by training and/or experience, as determined by appropriate credentialing authorities.

System-Based

At all levels of policy and provision of care, there should be a focus on continuous improvement in the system of services.

The system of services should be integrated, that is, there should be coordination between providers of different levels of community and inpatient services. Coordination should be promoted through effective resolution of issues of control and responsibility between services providers.

There should be a clear assignment of responsiblity and accountablity for oversight and service deliver in the service system.

The system's structure should be flexible in responding to problems of service delivery.

The system of services should allow clients to move easily from one part of the system to another, according to their needs, without undue barriers.

People served by the Department should be ensured continuity of care and consistent, nurturing environment.

Resources in the system should be balanced so as to provide for the entire range of client needs, without undue emphasis on inpatient care at the expense of community services.

The system of services should be understood and accepted by average Maine citizens.

Those having needs should be able to obtain services across professional lines in an integrated system that fosters continuity of care and overcomes gaps in services and barriers to care and support. Collegiality and team approaches should be the dominant characteristics of service delivery.

Case management should be a strong decision-making element in coordinating services and service providers.

Sources: The preceding draft DMHMR values and principles were adapted from a number of different sources, including the following documents:

A Plan for People. Long Range Planning Task Force to Meet the Long Range Needs and Interests of Maine Citizens with Mental Retardation or Autism (supported by the Maine Bureau of Mental Retardation) December, 1988.

Maine Comprehensive Mental Health Services Plan, Maine Mental Health Planning Council and Maine Department of Mental Health and Mental Retardation, September, 1989.

Bureau of Children with Special Needs Biennial Plan 1989-1990, January 1989.

Commission Preliminary Report, State of Maine Systems Assessment Commission, September 10, 1990.

Settlement agreement to consent decree in class action suit, AMHI clients v. Maine Department of Mental Health and Mental Retardation and Maine Department of Human Services, August 1, 1990.

"Community Mental Health Service Agency Values and Guiding Principles, Draft #3," Maine Council of Community Mental Health Services, 10/29/90.

Draft Final Report: Summary Findings and Recommendations, State of Maine Systems Assessment Commission, November 14, 1990.

Dept 8/23 HHS

ABUSED/NEGLECTED ADULTS

1. DUPLICATION/OVERLAP

There is no duplication and/or no overlap for these two groups of consumers.

2. EMERGING ISSUES

Family Crisis:

* Expanded public awareness of problem.
* Expanded education especially media education and prevention efforts (community based).
* Expanded shelter services particularly halfway house/transition housing with education, job, support components..

Rape Crisis:

* National and state issues: date rape.
* Expanded education and prevention efforts.
* Limited safe home network.
* System education: hospitals, law enforcement and judiciary - also media.

3. NUMBER 1 CHANGE

Family Crisis and Rape Crisis:

* Would have a much more aggressive broader based, community-supported education and prevention effort.

if needed.

Topic	Sub-Category	Criteria	Service	Clients Served	State	Costs Federal	Total
Abused and Neglected Adults	Family Crisis (Battered women and their child-ren) Services	Women who have been physically or psychologi-cally abused. (Children may accompany mothers).	Emergency Shelter Individual Advocacy Children's Programs Employment Counseling Housing Assist. Assistance with legal and law enforcement. Transportation	1,620	1,123,630	126,510	1,250,140
	Rape Crisis Svs.	Victims Potential victims of rape or sexual assault	24 hour crisis hotline Crisis support Advocacy with law enforcement Legal Support groups Transportation	1,960	317,985	48,355	366,340
	Homemaker	Adults under protection or guardianship of DHS	Protective case monitoring, personal care, food shopping, preparation, chore service.	76	6,561	35,494	42,055
	Transportation	Adults under protection or guardianship of DHS	Public and demand response transport	49	376	6,017	6,393

Dist 8/23 HHS

August 23, 1991

TO: Rosalyne S. Bernstein and Roland Caron, Co-Chairs, Special Committee on Governmental Restructing Subcommittee on Health, Social Services and Economic Security

FROM: Robert W. Glover, Ph.D., Commissioner

RE: Answer to Three Questions - Geriatric Services

---

1. There is no duplication or overlap as there are minimal services available for the elderly mentally ill person.

   Home health agencies do provide some mental health services but the recipients are physically ill homebased with primary need for health services.

2. As the population ages the needs for mental health services increases. In addition to the chronically mentally ill population, many people develop both short and long term mental illness in their 60's - 70's and 80's.

   Increased need for specialized mental health services.

3. Focus resources away from institutional services toward community programs.

   Insure that the entire population of Maine's elderly has equal access to whatever services are available. Fill in the existing gaps in services.

RWG/g

Dist 8/23 HHS

AUG 22 1991

ELDERS

1. **Identify duplication and/or overlap of services for this group of consumers. What problems do they present to the client?**

Older people in Maine are eligible for many state and federally funded services. Eligibility is based on age, income, functional impairment or some combination of the three. Most services are provided directly by DHS or through DHS contract agencies.

Principal areas of duplication are: 1. Determining eligibility for benefits; and 2. Providing in-home, supportive services. Services are categorically funded and eligibility criteria differ just enough from program to program that the older consumer may have to tell her "story" several times in order to obtain all the necessary benefits. Someone needing services to remain at home may talk first with a hospital social worker; next with a home health agency; then the Area Agency on Aging, a homemaker agency, or both; and finally, DHS for Medicaid and Food Stamp eligibility. There are no fewer than seven state/federal funding sources for in-home services. Many older people simply won't put up with the process. In a 1989 survey, 25% of Maine's elders said they wouldn't accept services even if they were eligible; for those 75+ the figure was 33%.

2. **What do you see as the emerging issues/needs of your clients by the year 2000? And what structural changes are needed to meet those needs?**

According to the 1990 census, 18% of Maine's population is 60+ years old. It will increase to 21% by 2010. Already there are five rural counties where the elderly are more than 20% of the population. Maine's elderly are not affluent -- one in five have incomes below poverty and one in three are considered "near poor." The poverty rate for older women is twice that for men.

In the year 2000 older people will need what they need today -- affordable housing, health care, and transportation. If Maine continues to rely on the property tax to fund education, many elderly will no longer be able to maintain homes in rural areas. If they stay, it may be because they are successful in limiting spending on schools, which then may drive younger families away.

More divorce, fewer children and more employed caregivers are likely to mean changes in the family support that is the backbone of our current long term care system. We will rely more on paid caregivers who must be trained and compensated as professionals. The distinction between health and social services will blur, so it will be important to design an integrated delivery system that maximizes consumer choice.

Maine's infrastructure is designed for a younger, able-bodied population. Both public and private sector will have to adapt jobs, products and services to an aging population.

3. **What is the number one thing you would change?**

Reduce the reliance on institutions, both hospitals and nursing home, as settings for delivering health care and supportive services to older people.

TOPIC	SUBCATEGORY	CRITERIA	SERVICE	CLIENTS SERVED	FY 90 STATE	FY 90 FEDERAL	TOTAL
Elders	Nutrition Meals on Wheels Community Meal Sites	60+ yrs Functional Impairment 60+ yrs.	Meals, social-ization & public education	5,414 12,192		$2,476,287	$2,476,287
	Home Based Care	60+ yrs. Functional Imp. 18+ yrs. Functional Imp.	Home health, PCA, case mgmt. day care, mental health	1,552 140	$ 3,620,147		3,620,147
	Congregate Housing Services	60+ yrs. Functional Imp. Tenant of subsi-dized housing	PCA, case mgmt. meals, home health transpor-tation	175	439,916		439,916
	Social Services	60+ yrs.	Outreach, info. & assistance, legal, transportation, housing benefits applications,	29,577	381,337	1,223,334	1,604,671
	Employment	60+ yrs. Low income	Job training, subsidized employ-ment, placement	87		363,847	363,847
	Foster Grandparent	60+ yrs. Low income	Volunteer placement with special needs children	72	23,667	195,009	218,676
	Ombudsman	Consumer of home health or institutional care	advocacy, complaint investigation	638	68,682	57,315	125,997

Dist 8/23 HHS

Demographics Of Maine's Elderly

Income Levels, Age, Gender, Marital Status, Household Size, and Living Arrangements

Bureau of Elder and Adult Services
Christine Gianopoulos, Director

Maine Department of Human Services
Rollin Ives, Commissioner

June 1991

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Introduction

The Bureau of Elder and Adult Services plans, develops and coordinates services for people living in Maine who are sixty years of age and older.

In 1989, the number of people age 60 and older in Maine was estimated to be 219,000. By the year 2010 it will be 273,000. This represents a twenty-five percent increase in twenty years. Mainers are living longer than ever before. In 1987, a man 60 years old was likely to live to age 78; at 60 a woman was likely to live to age 82. Our communities, our families and public service agencies will be profoundly affected by the growth in this population.

For many, a longer life means more years beyond retirement, which they enjoy in good health, with adequate income and with leisure time to enjoy interests they have not been able to pursue during their working years. For others, it can mean years of poverty, poor health and limited mobility. Almost 10,000 Mainers 60 years of age or older live in institutions such as nursing and boarding homes. To assess the needs of the remaining 209,000 elderly people living in the community, the Bureau commissioned a statewide telephone interview survey of a random sample of this group. This report describes that diverse population in terms of income levels, age, gender, marital status, household size and living arrangements.

Services are provided to older Mainers through five regional Area Agencies on Aging (AAAs). Where significant variations in the characteristics of the older population exist among regions, the data is reported by region. For purposes of this report, counties included in each region and the AAA which serves those counties are identified in Table 1.

Table 1: Counties Included in Each Region

Region	Counties
Northern Region (Aroostook AAA)	Aroostook
Eastern Region (Eastern AAA)	Hancock Penobscot Piscataquis Washington
Central Region (Senior Spectrum)	Kennebec Knox Lincoln Sagadahoc Somerset Waldo
Western Region (Western AAA)	Androscoggin Franklin Oxford
Southern Region (Southern AAA)	Cumberland York

Income

The Bureau of the Census estimates that nationwide in 1987, 11.8% of people 60 and older lived in households with incomes below poverty. Among the 209,000 non-institutionalized older Mainers, 22% or 46,000 are poor (living at or below poverty). An additional 13% or 28,000 older Mainers, are "near poor" (living between poverty and 125% of poverty).

TABLE 2: Federal Poverty Levels for 1989

Size of Household	100% of Poverty	125% of Poverty
One	$5,980	$7,475
Two	8,020	10,025
Three	10,060	12,575
Four	12,100	15,125

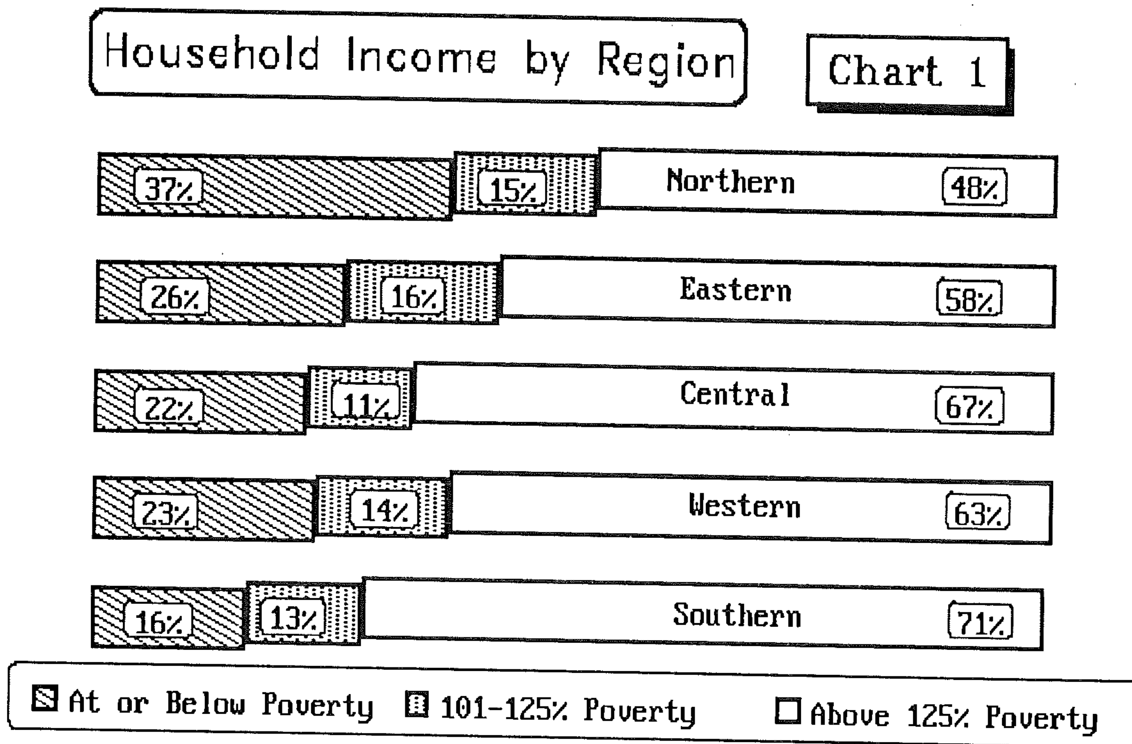
The percentage of poor older people, 22%, is markedly higher than the 13% poor in Maine's total population. The percentage of poor in the older population increases with age. (Table 3)

TABLE 3: Income Levels

	60 - 69	70 - 79	80+
At or Below Poverty	18%	21%	39%
101% and 125% of Poverty	11%	14%	18%
Above 125% of Poverty	71%	65%	43%
	100%	100%	100%

Poverty among people 60 and older also varies

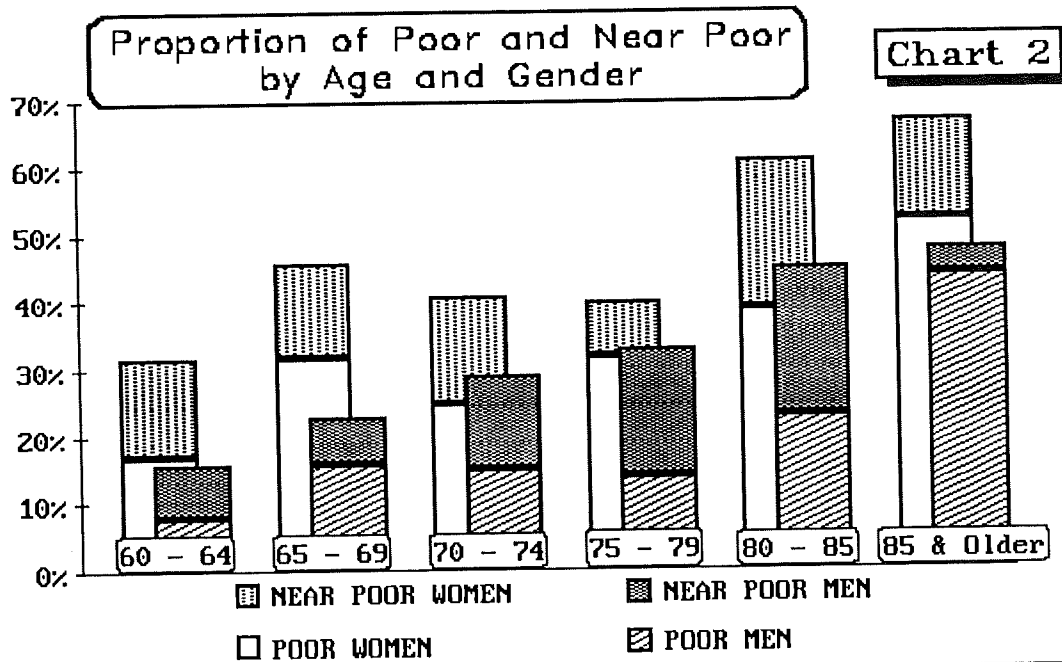
significantly by region. In the Northern region, the proportion of older Mainers with household incomes at or below poverty is higher than any other region of the state. Thirty-seven percent of the elderly in this region have incomes at or below poverty.



Poverty levels also vary considerably by gender. Of the 46,000 elderly poor 31,000 are women and 15,000 are men. Forty-four percent of women 60 and older in Maine are living at or below 125% of poverty. (Chart 2)

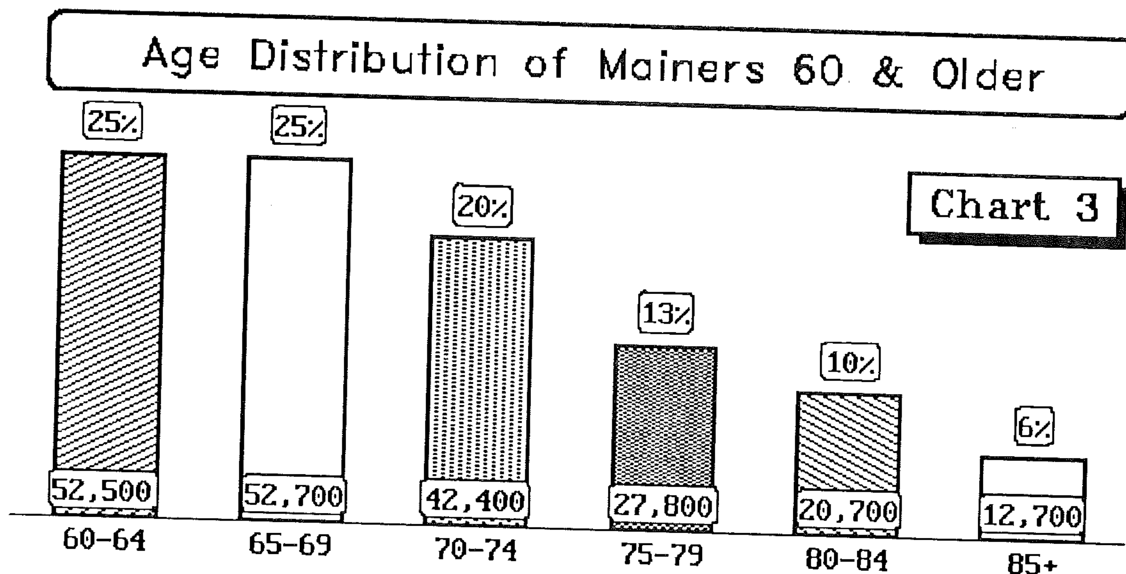
Many characteristics of the poor and near poor distinguish them from the rest of the older population. Poor elderly are less likely to drive a car. They are more likely to live in apartments. They are more likely to be widowed.

They are more likely to be women.



Age and Gender of Population

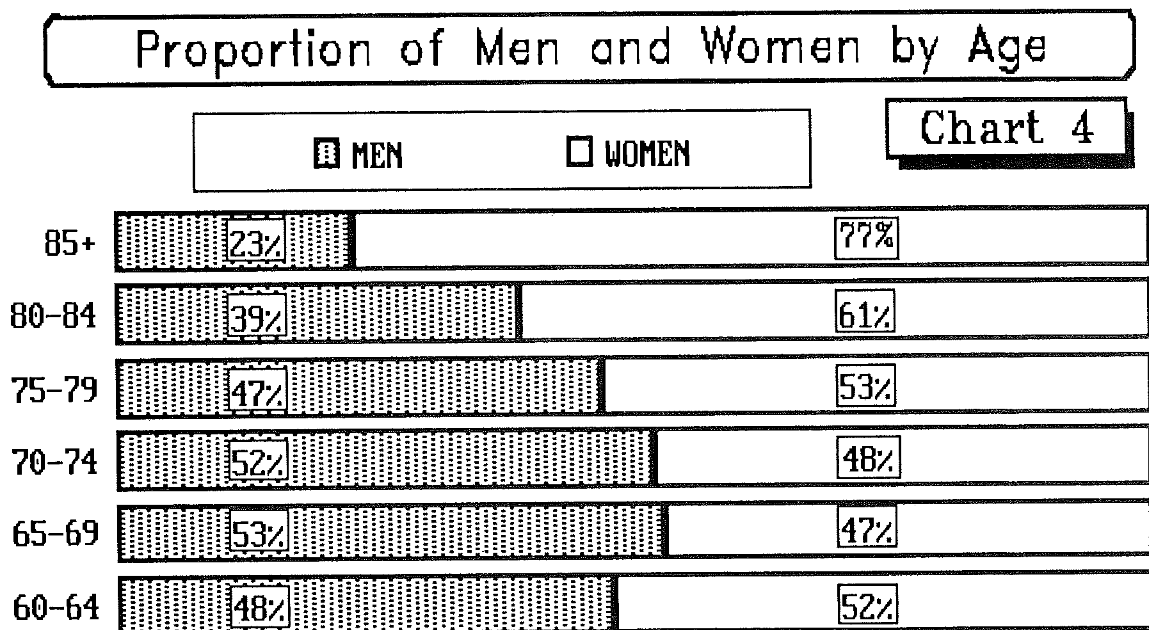
One-fourth of Maine's older population is between the ages of 60 and 64, and another one-fourth is between the ages of 65 and 69. (Chart 3) The average age of women 60 and older is 72. The average age of men 60 and older is 70. Average age does not vary by region.



The ratio of women to men in the population age 60 and older increases with age. In the age group 60 to 64, 52% are women. Among those 85 and older, 77% are women. (Chart 4)

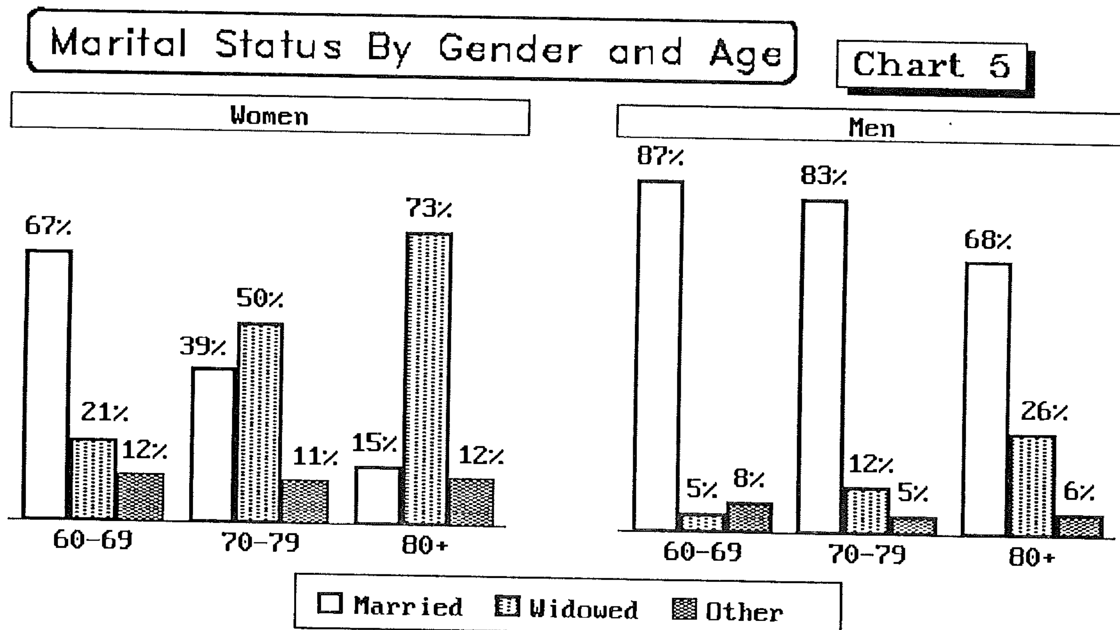
There is considerable migration of younger retired persons into Maine. Between 1970 and 1990, approximately 32,000 persons 65 and older moved into Maine. Over the same period over 100,000 people age 45 - 64 moved to

Maine who were either retired when they moved or retired shortly after moving. As this population ages, Maine will gain a large group of people 60 and older that includes a relatively higher proportion of men and has incomes above 125% of poverty as well as experience and skills which will support an independent lifestyle.



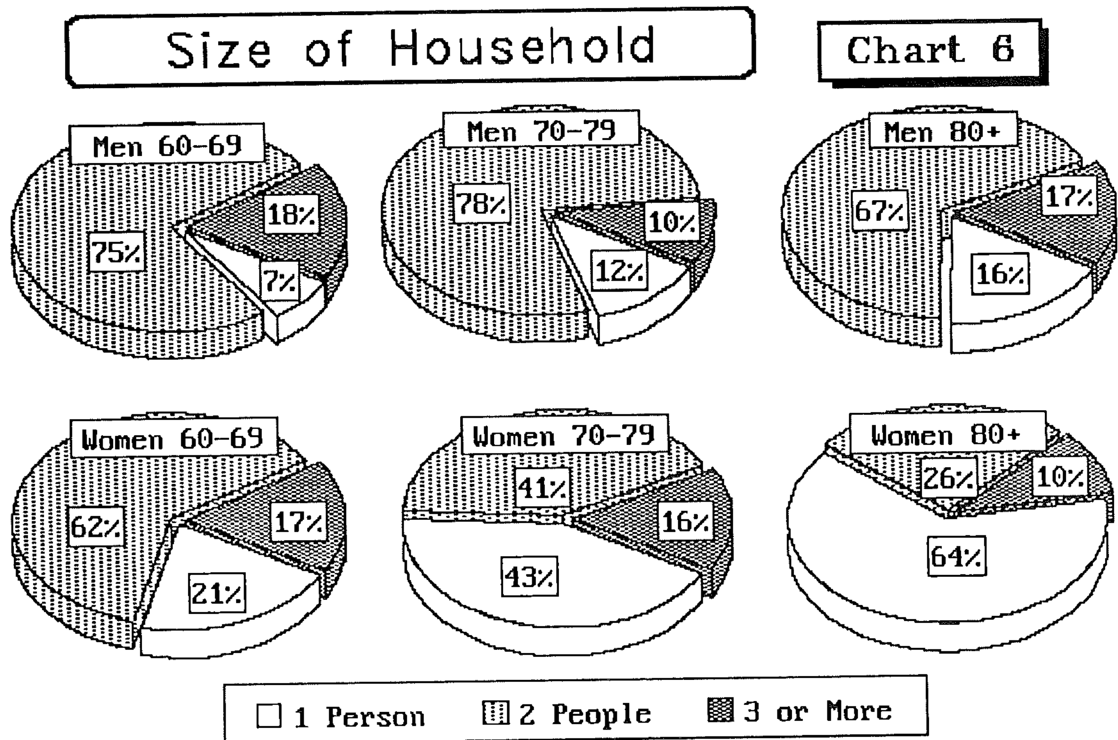
Marital Status

Nearly two-thirds, 64%, of all Mainers 60 and older are married. Over a quarter of them, 26%, are widowed. The remaining 9.5% are either divorced or separated or have never been married. Marital status changes significantly, however, as people age. (Chart 5) One reason for this is the marriage rate among men and women who have been widowed. Nationally 28 out of every 1,000 widowed men remarried in 1985, only 6 out of every 1,000 widowed women remarried that year. Of every 1,000 divorced men, 122 remarried in 1985. Only 82 out of every 1,000 divorced women remarried that year. The trend among both men and women since 1970 has been consistently toward fewer remarriages among both divorced and widowed people.

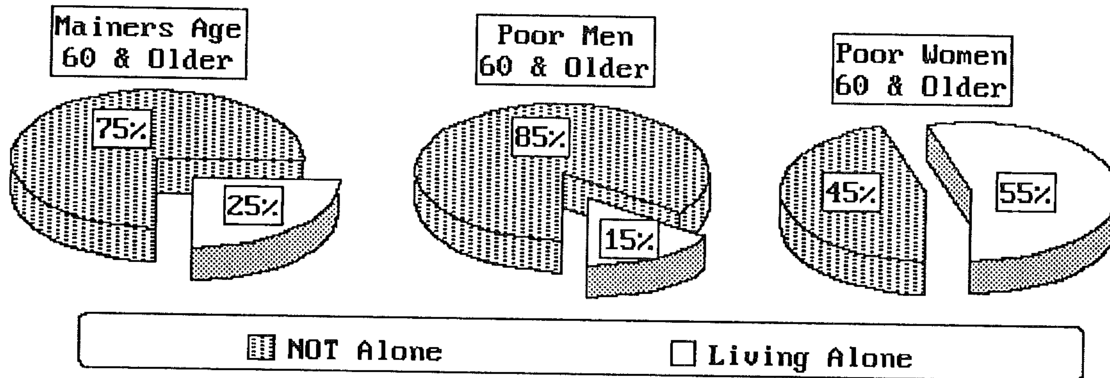


Household Size and Living Arrangements

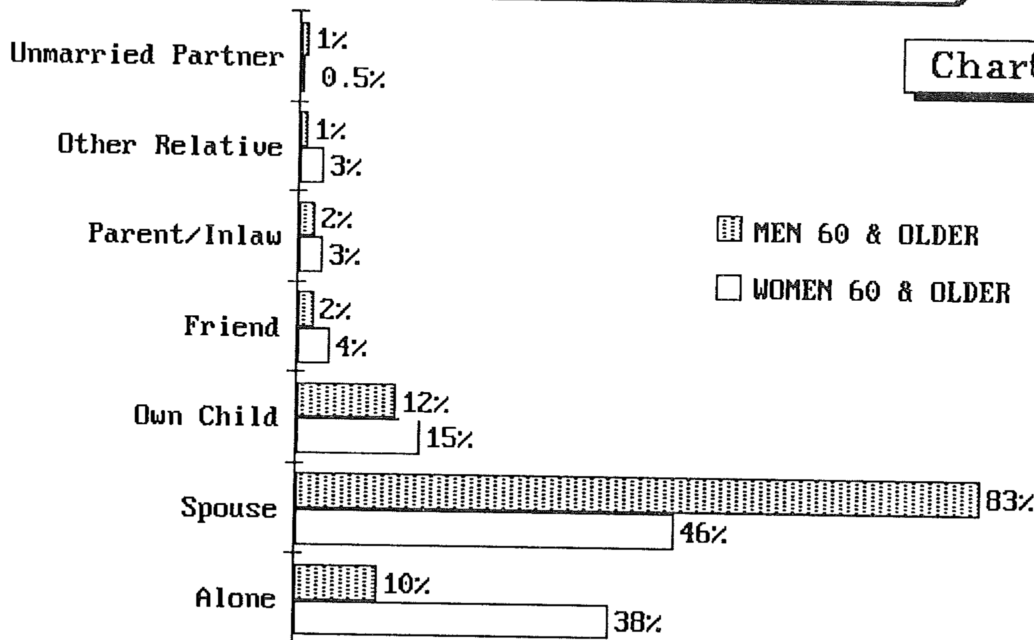
Household size varies significantly with age and gender. Among all older Mainers, 61% live with one other person (usually a spouse), 25% live alone, and the remaining 14% live in households of three or more people. (Chart 6)



The data corroborate the large number of women who lose a spouse after age 70 and are likely to live alone. (Chart 7) Since a spouse is the most frequent caregiver, people living alone are more likely to require services and are at greater risk of institutionalization.



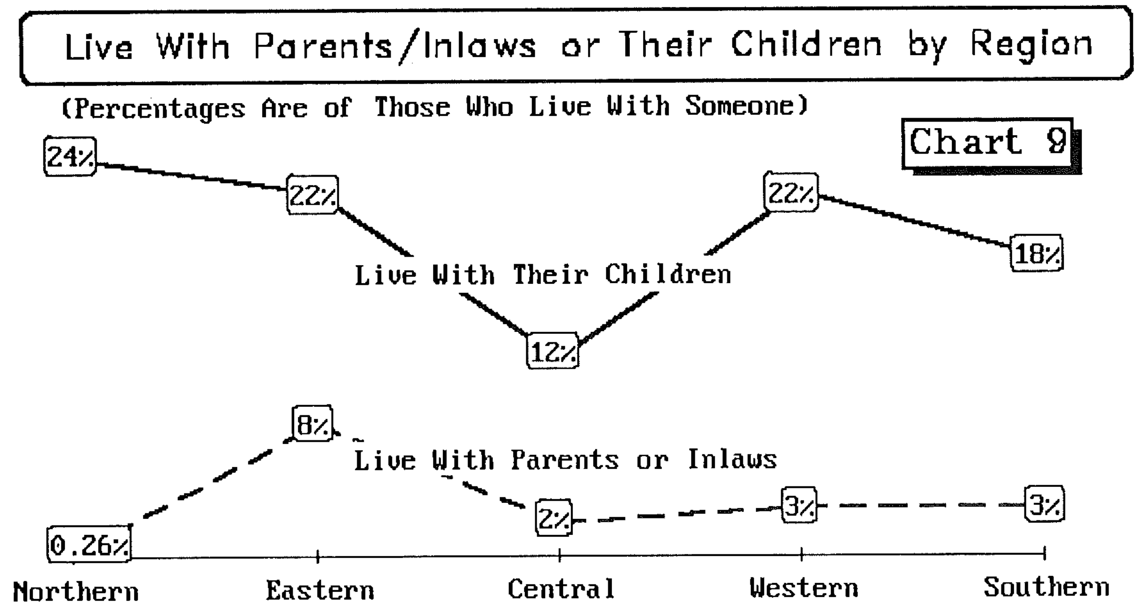
Men age 60 and older are far more likely to live with a spouse than women. Women age 60 and older are more likely than men to live alone.



Older women are also more likely than older men to live

with one or more of their own children, a friend, a parent or inlaw, or other relative. (Chart 8)

There is a regional variation in the proportion of elderly who live with their parents or inlaws and in the proportion of elderly who live with their children. The lowest proportion of elderly who live with their parents or inlaws occurs in Northern Maine. (Chart 9)



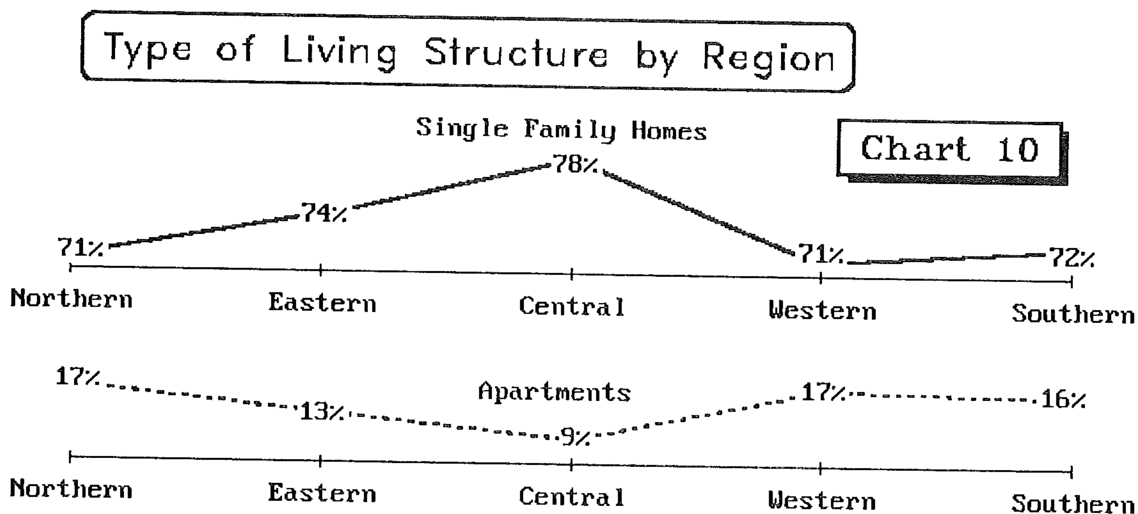
Type of Residence

Almost three-quarters of those 60 and older live in single family houses. (Table 4)

TABLE 4: Type of Residence by Gender/Age

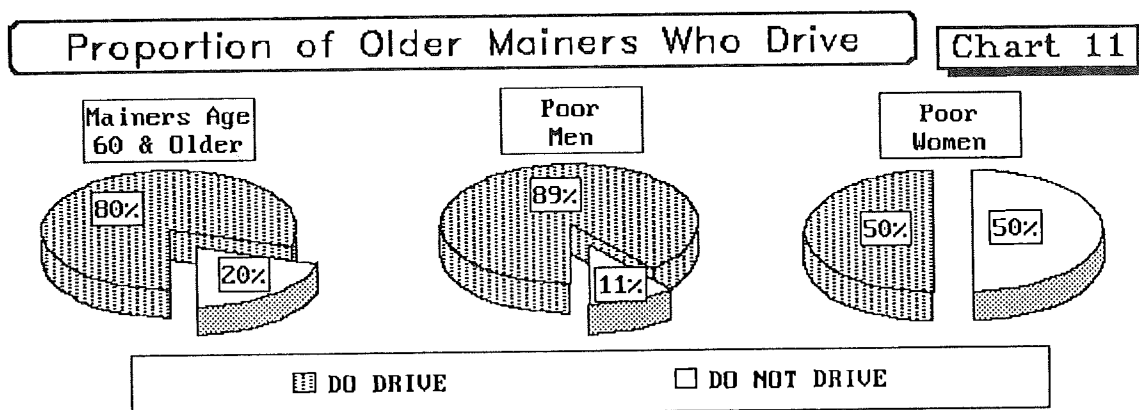
Gender/Age	Single Family Homes	Mobile Homes	Apartments	Duplexes
Men 60+	80%	10%	7%	3%
Women 60+	69%	19%	9%	3%
Women 60 - 69	73%	13%	12%	2%
Women 70 - 79	71%	19%	7%	3%
Women 80 +	56%	34%	3%	7%

Among men and women, income is a factor in whether they live in a single family home. Among older Mainers with household incomes at or below poverty, both men and women are less likely to live in single family homes and more likely to live in apartments than those with higher incomes.



Transportation

The ability to travel within one's community, particularly for shopping and medical appointments, is a critical factor in maintaining personal independence. An automobile is a necessity in Maine and can be crucial to people living in isolated rural areas. Among all Mainers 60 and older, 80% drive. The proportion who drive varies significantly by gender and age, and, for women, by income. Ninety-two percent of men and 69% of women 60 and older drive a car.

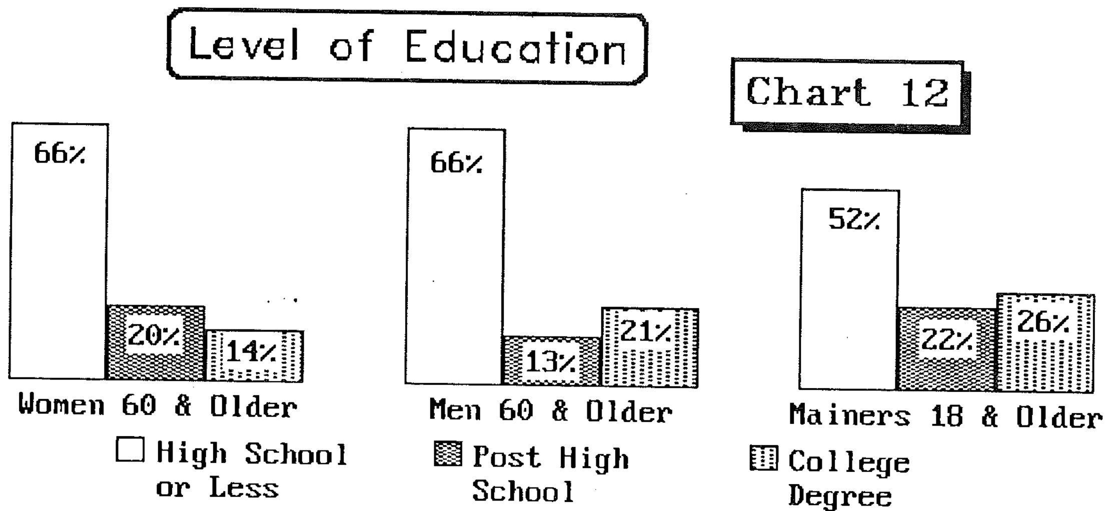


The proportion of men who drive decreases from 96% (age 60 to 69) to 88% (age 80 and older). The proportion of women who drive decreases from 80% (60 to 69) to 34% (80 and older). Among the near poor, 25% do not drive. Among the poor, 37% do not drive. Transportation is a much greater problem for poor older women than for any other segment of our population. Among poor women 50% do not drive while, among poor men 11% do not drive. (Chart 11)

Education

Among those 60 and older, 12,950 or 6% did not finish eighth grade, and an additional 54,550 people 60 and older did not finish high school. Roughly one-third received a high school diploma. One-sixth completed some post high school education, and another one-sixth graduated from college.

A study conducted by the Commission on Maine's Future in 1989 shows the level of education achieved by Mainers age 60 and older is lower than for the general population 18 and older. (Chart 12)



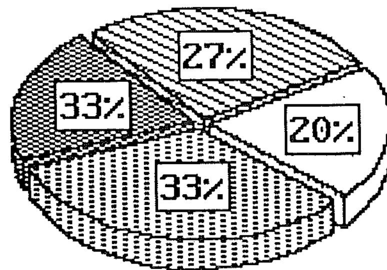
Among Mainers age 60 and older, level of education does not vary significantly with age. It does, however, vary significantly with gender. While older women are slightly more likely to have completed a high school diploma, they are much less likely to have completed a college degree. Twenty-two percent of older men and 14 percent of older

women completed college degrees.

Income and Education

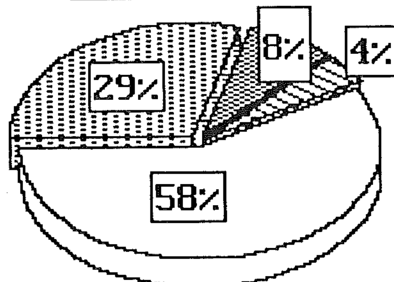
Chart 13

Above 125% of Poverty

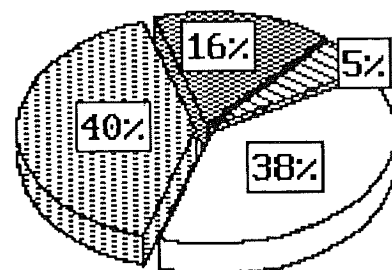


☐ Less Than H.S.
▥ H.S. Diploma
▩ Post H.S.
▧ College

At or Below Poverty



101-125% of Poverty

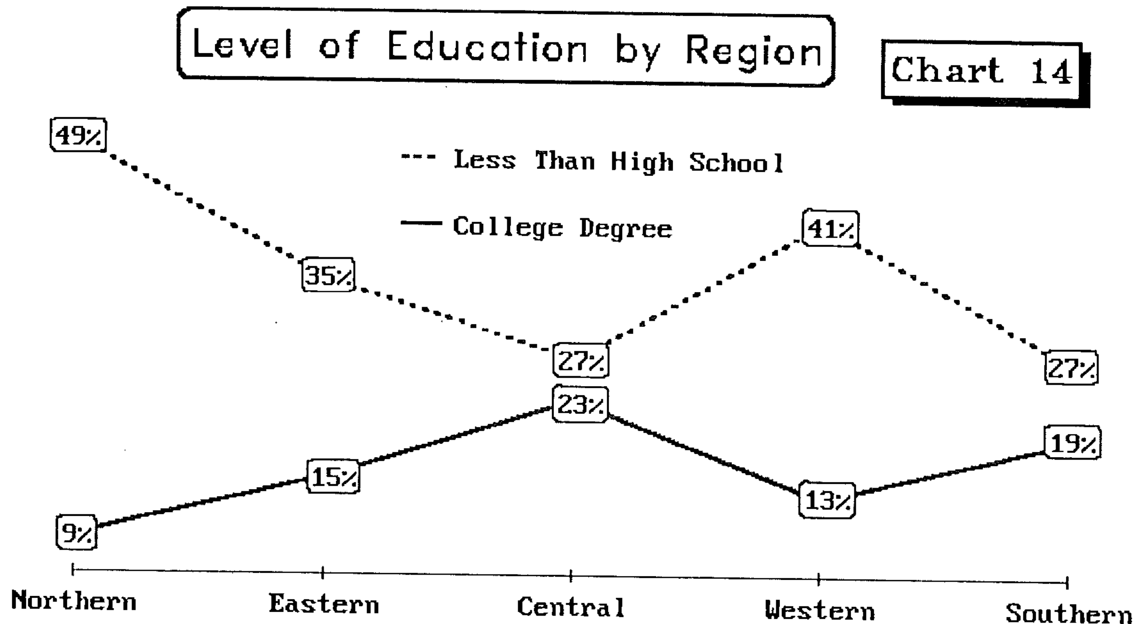


Income level varies significantly with level of education. Among poor older people in Maine, 58% have less than a high school education and only 4% graduated from college. Among near poor elderly, 38% failed to graduate from high school and only 5% completed a college degree. Of the remaining elderly, 80% graduated from high school and 27% graduated from college. (Chart 13)

Perhaps the most striking variation in level of education occurs regionally. Northern Maine has the highest

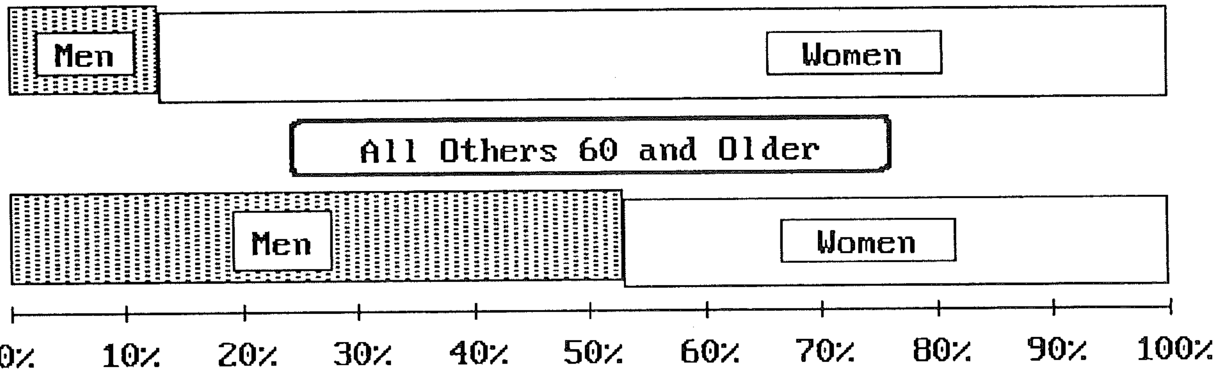
proportion of elderly who have not completed high school, 49%, and the lowest proportion who have completed college, 9%. Forty-one percent of the older population in Western Maine have not completed high school and only 13% have a college degree.

Central Maine has the lowest proportion of older Mainers who have not completed high school, 27%, and the highest proportion of college graduates, 23%. (Chart 14)



Old, Poor and Living Alone

Living alone is not, in and of itself, an indicator of need. Some older people can afford to live alone and do so by choice. Older people with lower incomes who live alone are, however, more likely to need services. There are at least 20,000 Mainers who are 70 years of age or older, have incomes at or below 125% of poverty ($7,475 per year for a household of one in 1989) and who live alone. This group of older people differs significantly from the rest of Maine's population age 60 and older in several ways.

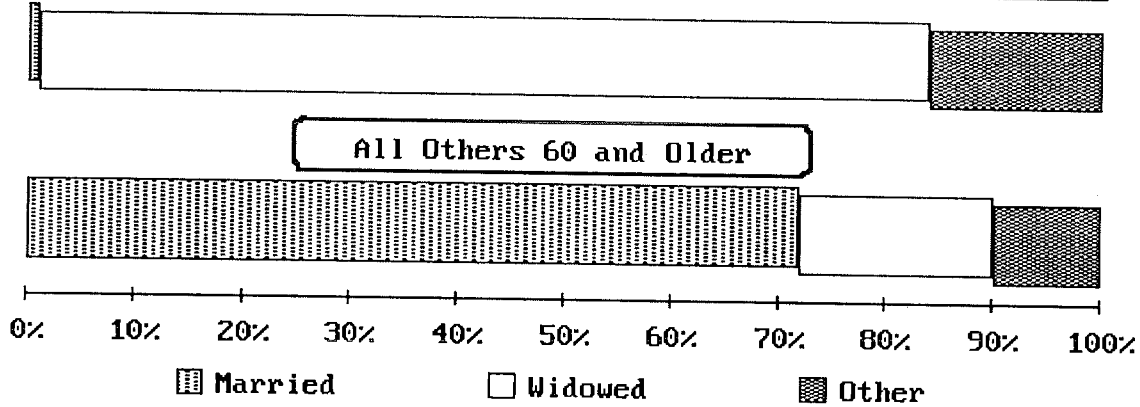


Eighty-seven percent (87%) of this population are women, compared to 47% women in the remaining elderly population. Of these women, 95% are widowed while 18% of the remaining elderly are widowed.

Marital Status

Chart 16

70 & Older, Income at or Below 125% Poverty, Living Alone



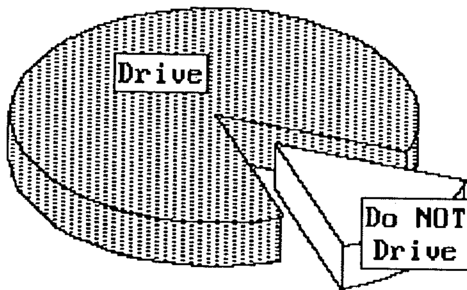
Among the population over 70, poor or near poor and living alone, only 1% are married and 72% are widowed. Among all other people 60 and older, 72% are married and 18% are widowed.

This group is much less likely to drive an automobile and five times as likely to use public or senior citizens' transportation as other older Mainers.

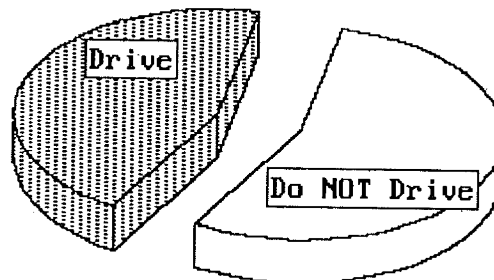
Drive An Automobile

Chart 17

All Others 60 and Older

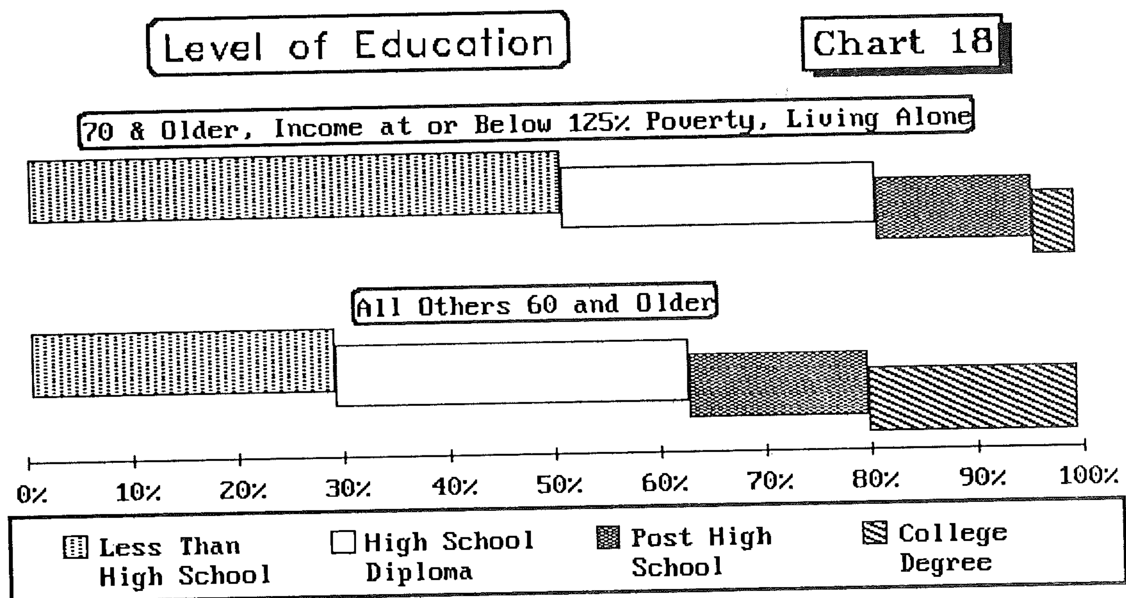


70 & Older, Income at or Below 125% Poverty, Living Alone



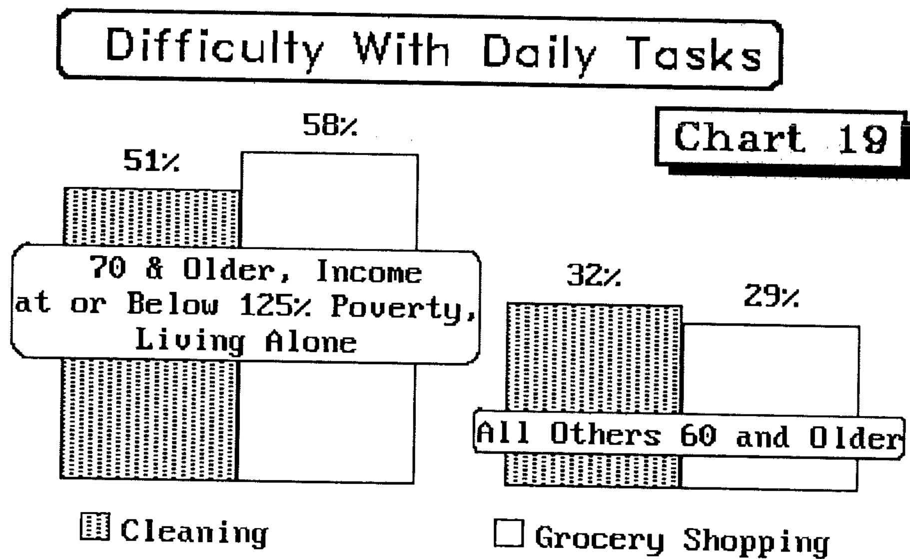
Nearly half, 45%, of this population live in apartments while only 9% of the rest of the elderly population live in apartments. Forty percent (40%) live in single family homes, while 78% of the rest of the elderly population live in single family homes.

Fewer than half of this group graduated from high school and only 4% graduated from college. Among the remainder of the population age 60 and older, 71% received a high school diploma and 20% have a college degree.



Close to a third of this population have difficulty with daily tasks. They are more likely to have difficulty with housecleaning and grocery shopping than the remainder of the elderly population. Their need for assistance with other types of daily tasks does not vary significantly from the remainder of the population age 60 and older. However, half

of all older people who have difficulty with daily tasks receive help from a spouse. Since few in this group live with a spouse, this source of help is not available. Their needs will continue to command the attention of our communities and public service agencies.



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Introduction

The Bureau of Elder and Adult Services plans, develops and coordinates services for people living in Maine who are sixty years of age and older.

In 1989, the number of people age 60 and older in Maine was estimated to be 219,000. By the year 2010 it will be 273,000. This represents a twenty-five percent increase in twenty years. Mainers are living longer than ever before. In 1987, a man 60 years old was likely to live to age 78; at 60 a woman was likely to live to age 82. Our communities, our families and public service agencies will be profoundly affected by the growth in this population.

For many, a longer life means more years beyond retirement, which they enjoy in good health, with adequate income and with leisure time to enjoy interests they have not been able to pursue during their working years. For others, it can mean years of poverty, poor health and limited mobility. Almost 10,000 Mainers 60 years of age or older live in institutions such as nursing and boarding homes. To assess the needs of the remaining 209,000 elderly people living in the community, the Bureau commissioned a statewide telephone interview survey of a random sample of this group. This report describes that diverse population in terms of income levels, age, gender, marital status, household size and living arrangements.

Services are provided to older Mainers through five regional Area Agencies on Aging (AAAs). Where significant variations in the characteristics of the older population exist among regions, the data is reported by region. For purposes of this report, counties included in each region and the AAA which serves those counties are identified in Table 1.

Table 1: Counties Included in Each Region	
Northern Region (Aroostook AAA)	Aroostook
Eastern Region (Eastern AAA)	Hancock Penobscot Piscataquis Washington
Central Region (Senior Spectrum)	Kennebec Knox Lincoln Sagadahoc Somerset Waldo
Western Region (Western AAA)	Androscoggin Franklin Oxford
Southern Region (Southern AAA)	Cumberland York

Income

The Bureau of the Census estimates that nationwide in 1987, 11.8% of people 60 and older lived in households with incomes below poverty. Among the 209,000 non-institutionalized older Mainers, 22% or 46,000 are poor (living at or below poverty). An additional 13% or 28,000 older Mainers, are "near poor" (living between poverty and 125% of poverty).

TABLE 2: Federal Poverty Levels for 1989

Size of Household	100% of Poverty	125% of Poverty
One	$5,980	$7,475
Two	8,020	10,025
Three	10,060	12,575
Four	12,100	15,125

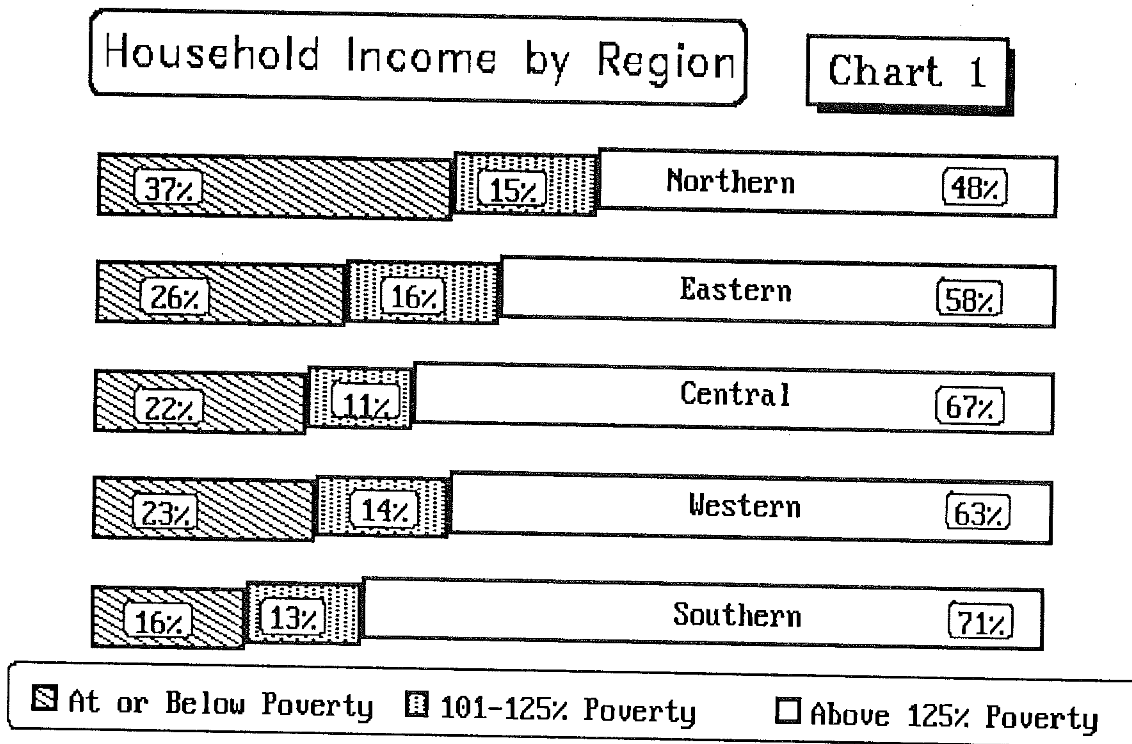
The percentage of poor older people, 22%, is markedly higher than the 13% poor in Maine's total population. The percentage of poor in the older population increases with age. (Table 3)

TABLE 3: Income Levels

	60 - 69	70 - 79	80+
At or Below Poverty	18%	21%	39%
101% and 125% of Poverty	11%	14%	18%
Above 125% of Poverty	71%	65%	43%
	100%	100%	100%

Poverty among people 60 and older also varies

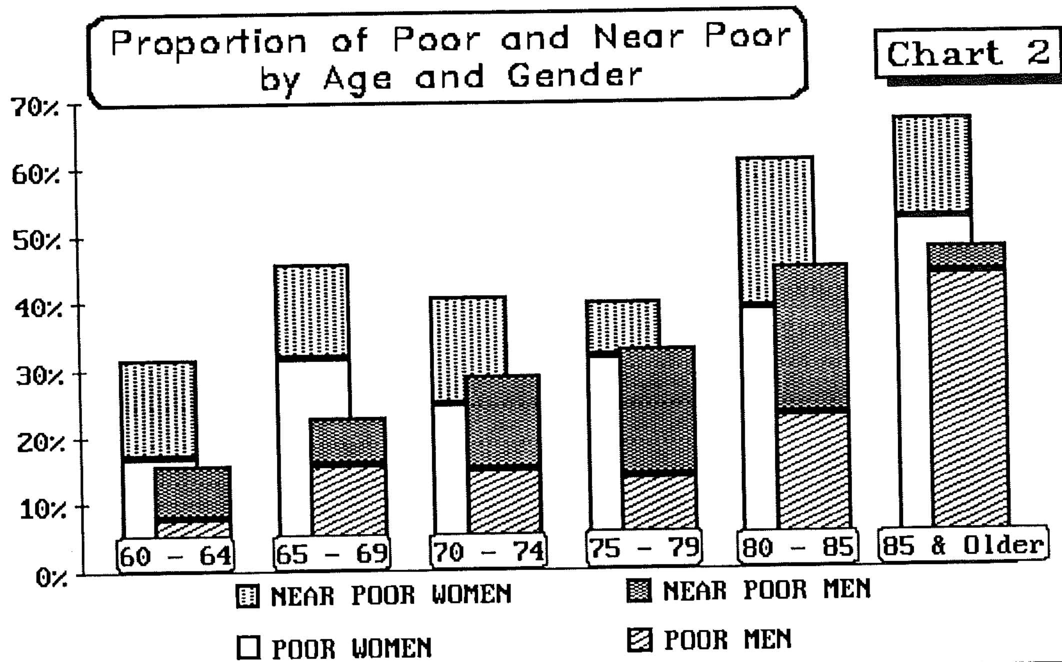
significantly by region. In the Northern region, the proportion of older Mainers with household incomes at or below poverty is higher than any other region of the state. Thirty-seven percent of the elderly in this region have incomes at or below poverty.



Poverty levels also vary considerably by gender. Of the 46,000 elderly poor 31,000 are women and 15,000 are men. Forty-four percent of women 60 and older in Maine are living at or below 125% of poverty. (Chart 2)

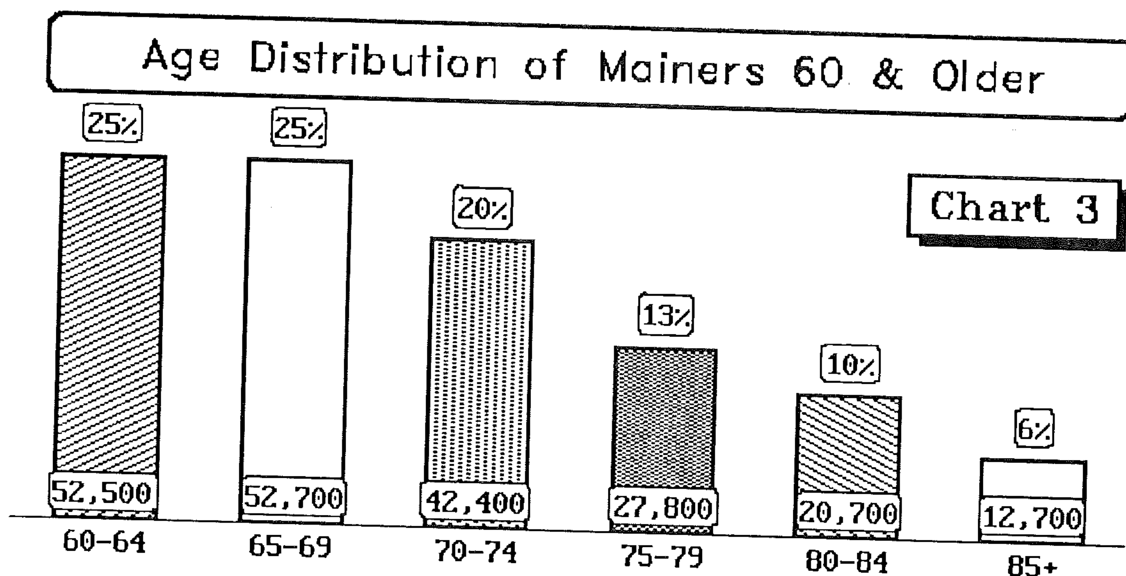
Many characteristics of the poor and near poor distinguish them from the rest of the older population. Poor elderly are less likely to drive a car. They are more likely to live in apartments. They are more likely to be widowed.

They are more likely to be women.



Age and Gender of Population

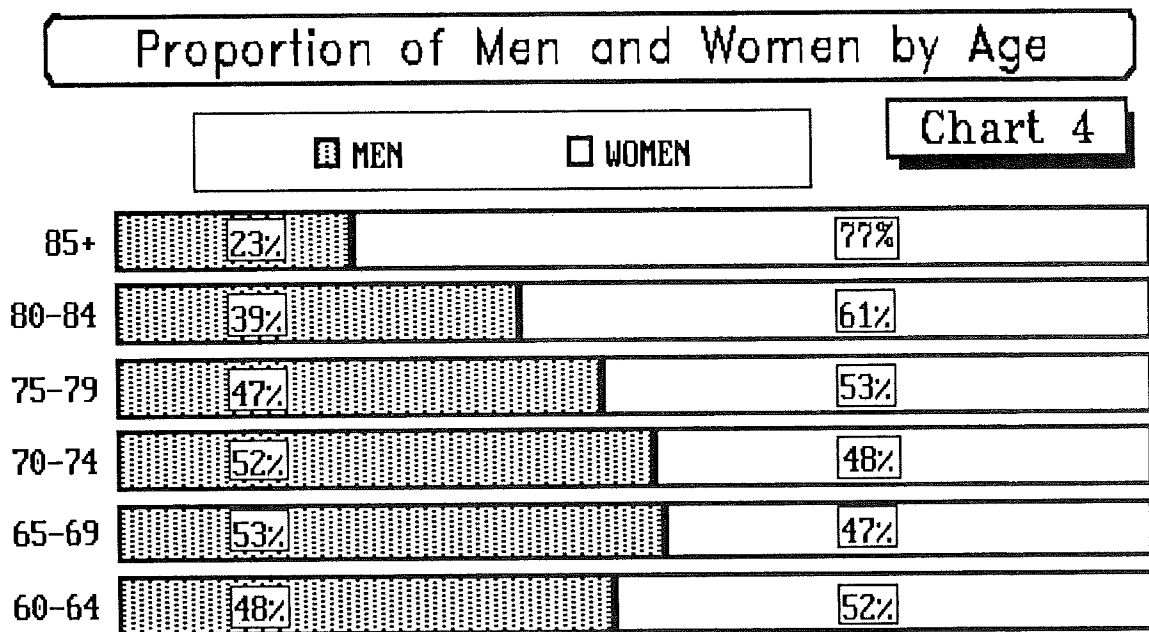
One-fourth of Maine's older population is between the ages of 60 and 64, and another one-fourth is between the ages of 65 and 69. (Chart 3) The average age of women 60 and older is 72. The average age of men 60 and older is 70. Average age does not vary by region.



The ratio of women to men in the population age 60 and older increases with age. In the age group 60 to 64, 52% are women. Among those 85 and older, 77% are women. (Chart 4)

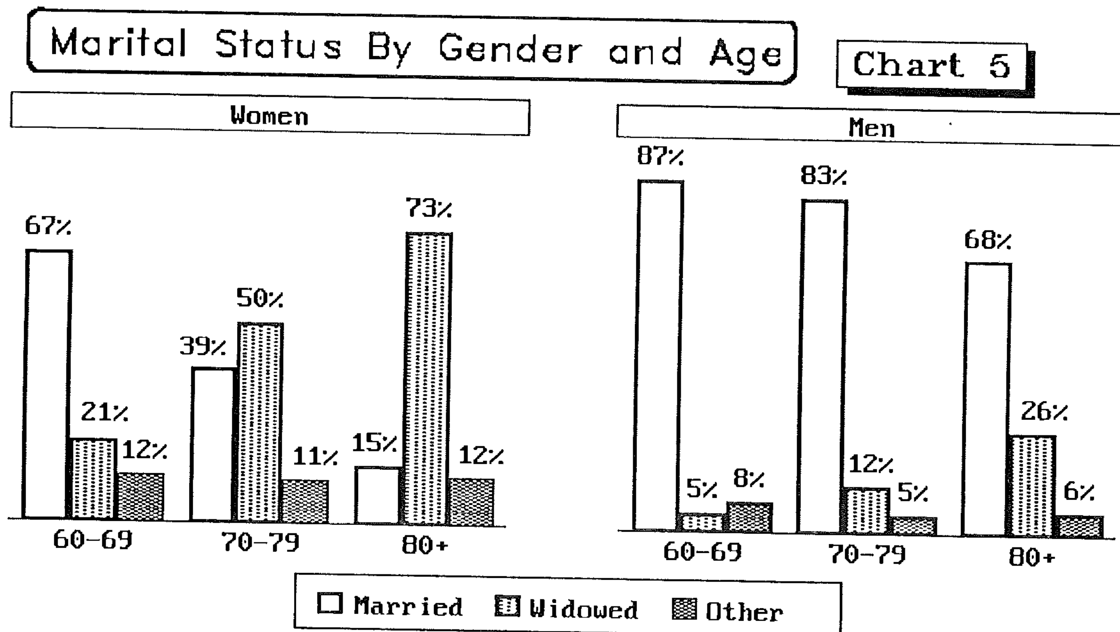
There is considerable migration of younger retired persons into Maine. Between 1970 and 1990, approximately 32,000 persons 65 and older moved into Maine. Over the same period over 100,000 people age 45 - 64 moved to

Maine who were either retired when they moved or retired shortly after moving. As this population ages, Maine will gain a large group of people 60 and older that includes a relatively higher proportion of men and has incomes above 125% of poverty as well as experience and skills which will support an independent lifestyle.



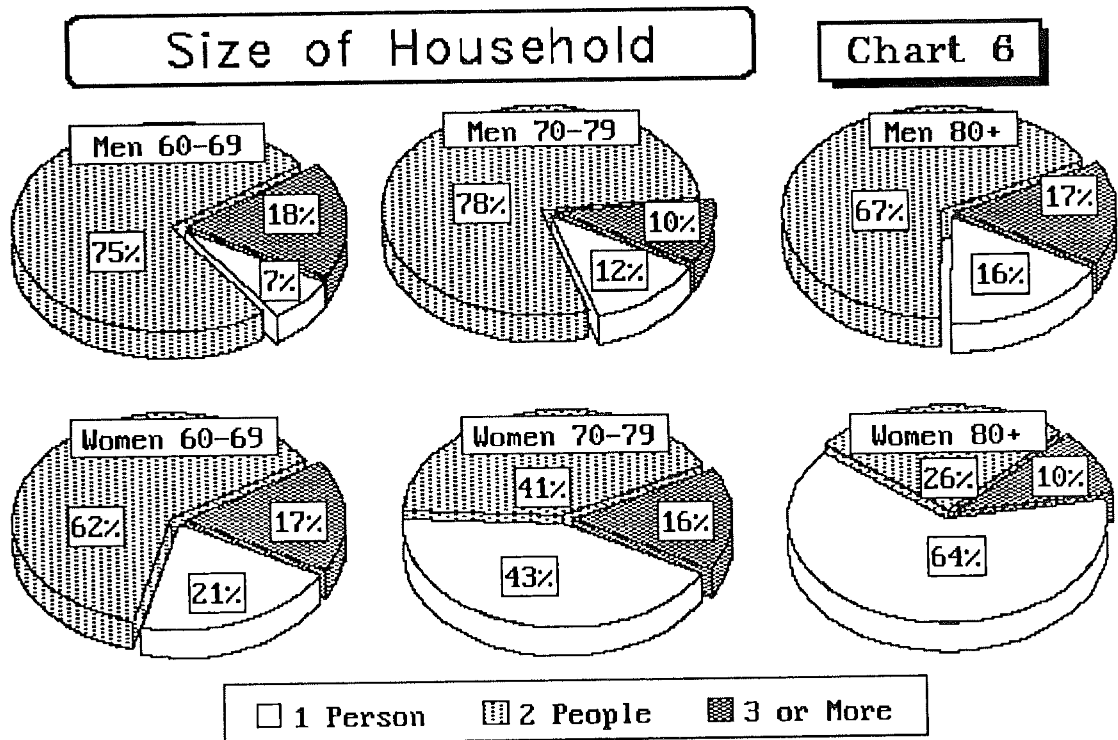
Marital Status

Nearly two-thirds, 64%, of all Mainers 60 and older are married. Over a quarter of them, 26%, are widowed. The remaining 9.5% are either divorced or separated or have never been married. Marital status changes significantly, however, as people age. (Chart 5) One reason for this is the marriage rate among men and women who have been widowed. Nationally 28 out of every 1,000 widowed men remarried in 1985, only 6 out of every 1,000 widowed women remarried that year. Of every 1,000 divorced men, 122 remarried in 1985. Only 82 out of every 1,000 divorced women remarried that year. The trend among both men and women since 1970 has been consistently toward fewer remarriages among both divorced and widowed people.

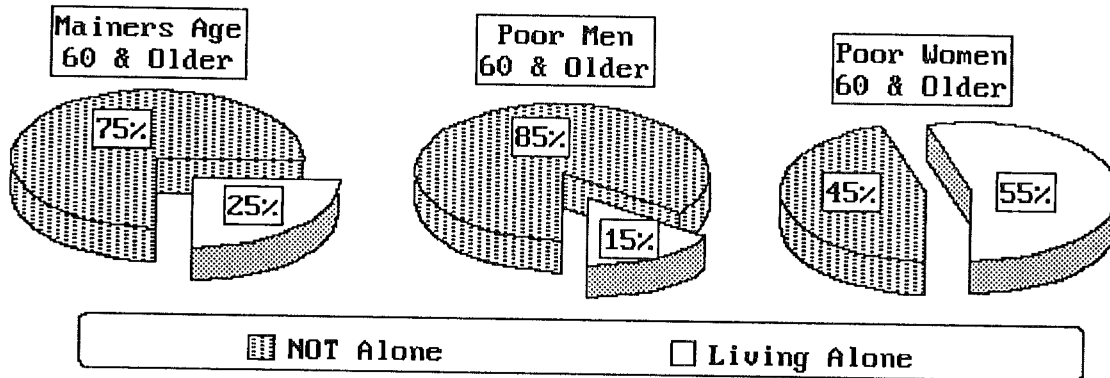


Household Size and Living Arrangements

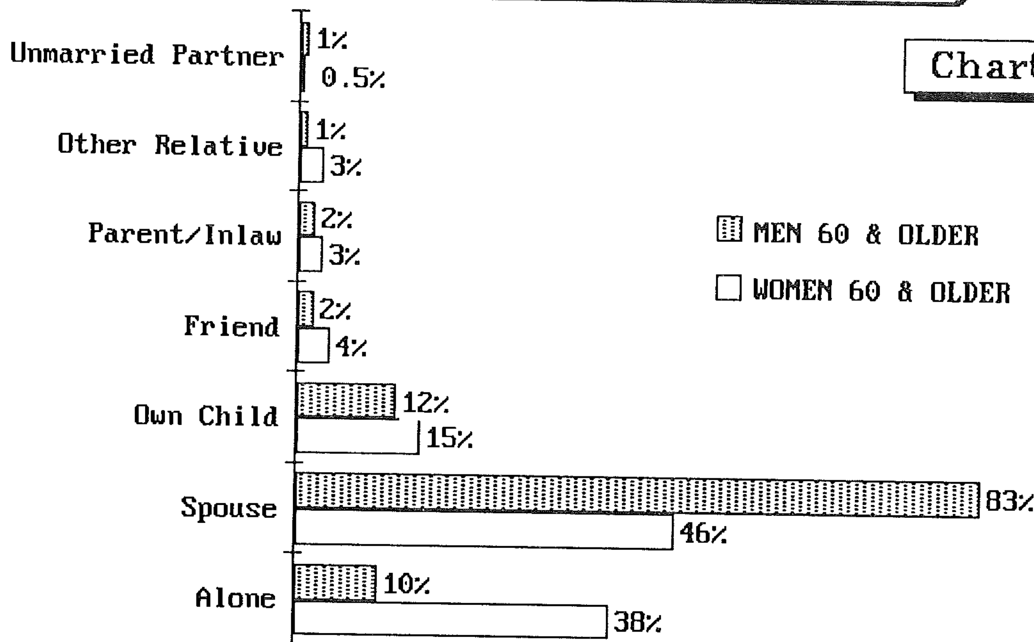
Household size varies significantly with age and gender. Among all older Mainers, 61% live with one other person (usually a spouse), 25% live alone, and the remaining 14% live in households of three or more people. (Chart 6)



The data corroborate the large number of women who lose a spouse after age 70 and are likely to live alone. (Chart 7) Since a spouse is the most frequent caregiver, people living alone are more likely to require services and are at greater risk of institutionalization.



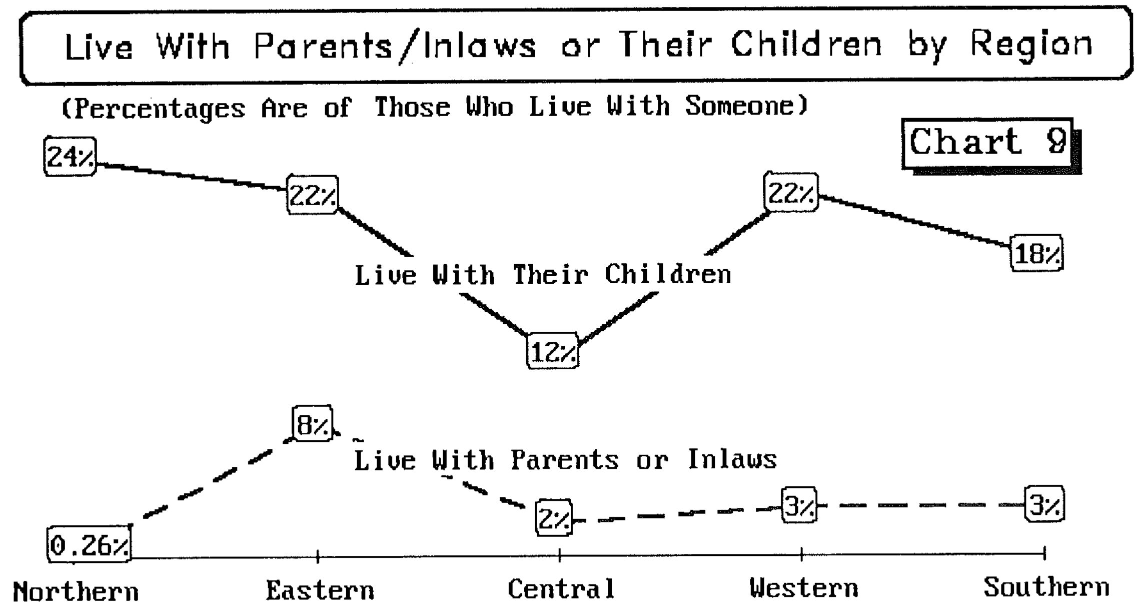
Men age 60 and older are far more likely to live with a spouse than women. Women age 60 and older are more likely than men to live alone.



Older women are also more likely than older men to live

with one or more of their own children, a friend, a parent or inlaw, or other relative. (Chart 8)

There is a regional variation in the proportion of elderly who live with their parents or inlaws and in the proportion of elderly who live with their children. The lowest proportion of elderly who live with their parents or inlaws occurs in Northern Maine. (Chart 9)



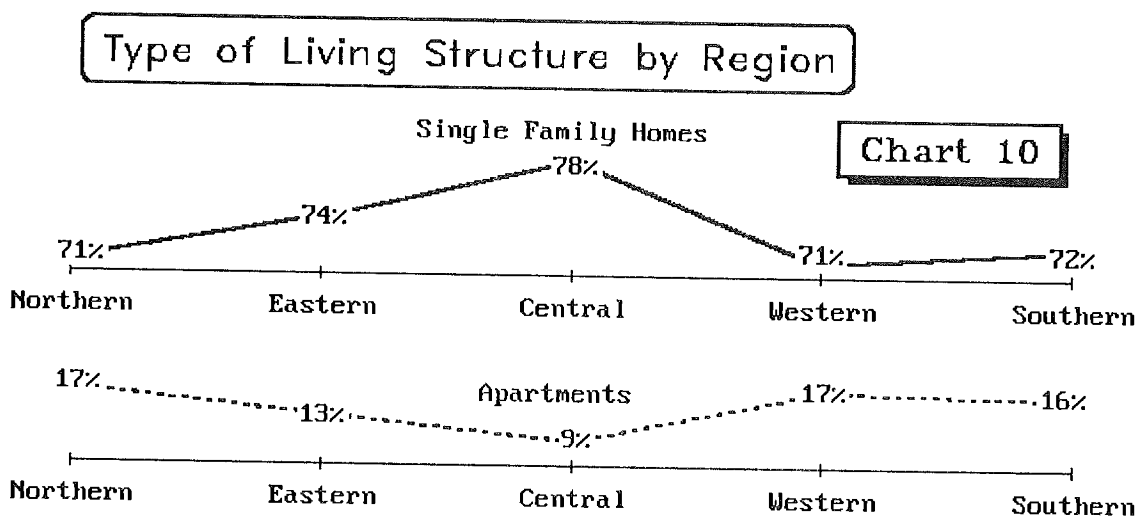
Type of Residence

Almost three-quarters of those 60 and older live in single family houses. (Table 4)

TABLE 4: Type of Residence by Gender/Age

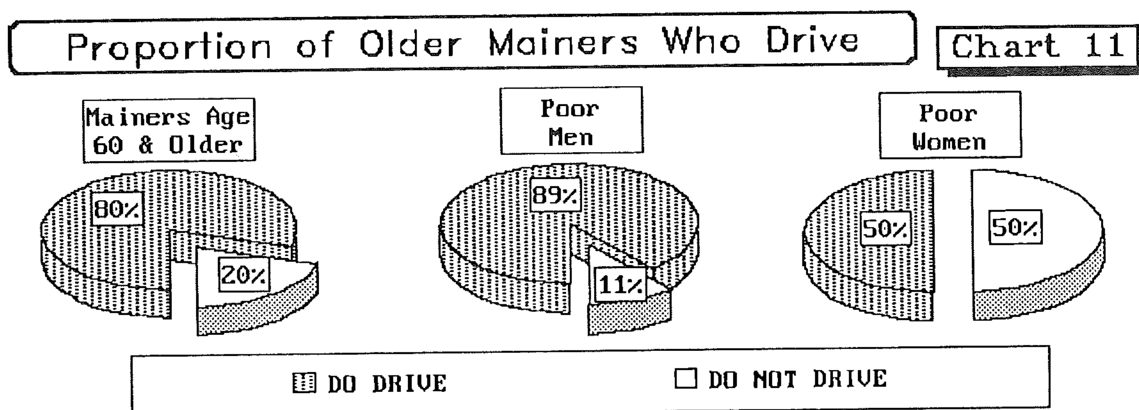
Gender/Age	Single Family Homes	Mobile Homes	Apartments	Duplexes
Men 60+	80%	10%	7%	3%
Women 60+	69%	19%	9%	3%
Women 60 - 69	73%	13%	12%	2%
Women 70 - 79	71%	19%	7%	3%
Women 80 +	56%	34%	3%	7%

Among men and women, income is a factor in whether they live in a single family home. Among older Mainers with household incomes at or below poverty, both men and women are less likely to live in single family homes and more likely to live in apartments than those with higher incomes.



Transportation

The ability to travel within one's community, particularly for shopping and medical appointments, is a critical factor in maintaining personal independence. An automobile is a necessity in Maine and can be crucial to people living in isolated rural areas. Among all Mainers 60 and older, 80% drive. The proportion who drive varies significantly by gender and age, and, for women, by income. Ninety-two percent of men and 69% of women 60 and older drive a car.

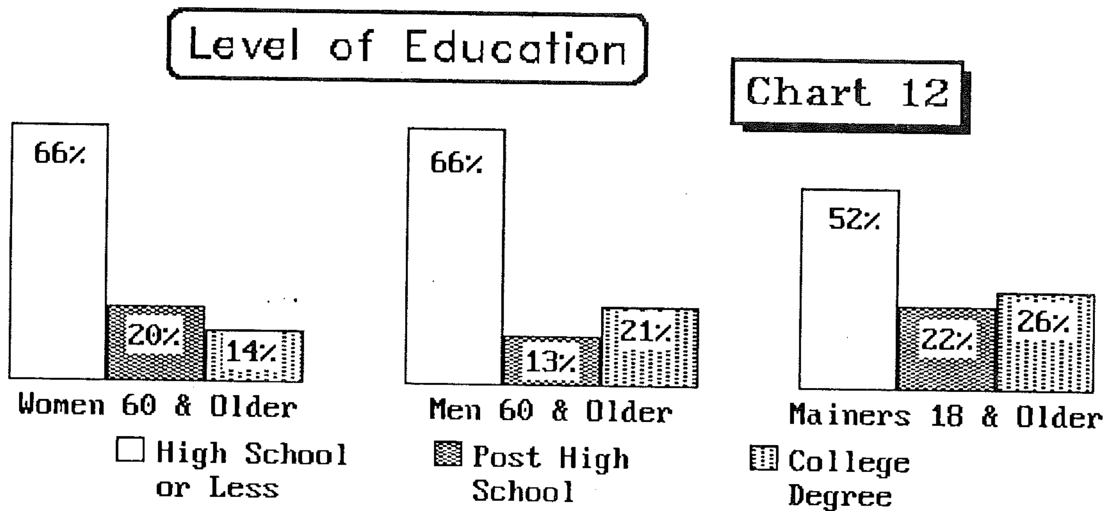


The proportion of men who drive decreases from 96% (age 60 to 69) to 88% (age 80 and older). The proportion of women who drive decreases from 80% (60 to 69) to 34% (80 and older). Among the near poor, 25% do not drive. Among the poor, 37% do not drive. Transportation is a much greater problem for poor older women than for any other segment of our population. Among poor women 50% do not drive while, among poor men 11% do not drive. (Chart 11)

Education

Among those 60 and older, 12,950 or 6% did not finish eighth grade, and an additional 54,550 people 60 and older did not finish high school. Roughly one-third received a high school diploma. One-sixth completed some post high school education, and another one-sixth graduated from college.

A study conducted by the Commission on Maine's Future in 1989 shows the level of education achieved by Mainers age 60 and older is lower than for the general population 18 and older. (Chart 12)



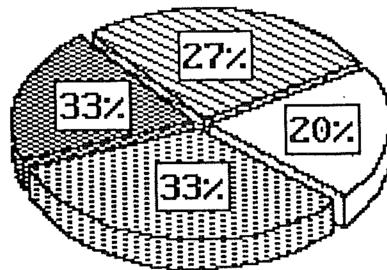
Among Mainers age 60 and older, level of education does not vary significantly with age. It does, however, vary significantly with gender. While older women are slightly more likely to have completed a high school diploma, they are much less likely to have completed a college degree. Twenty-two percent of older men and 14 percent of older

women completed college degrees.

Income and Education

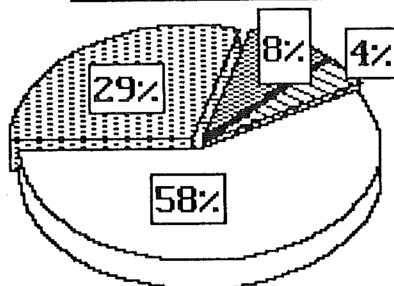
Chart 13

Above 125% of Poverty

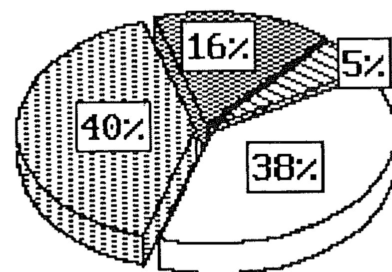


Less Than H.S.
H.S. Diploma
Post H.S.
College

At or Below Poverty



101-125% of Poverty

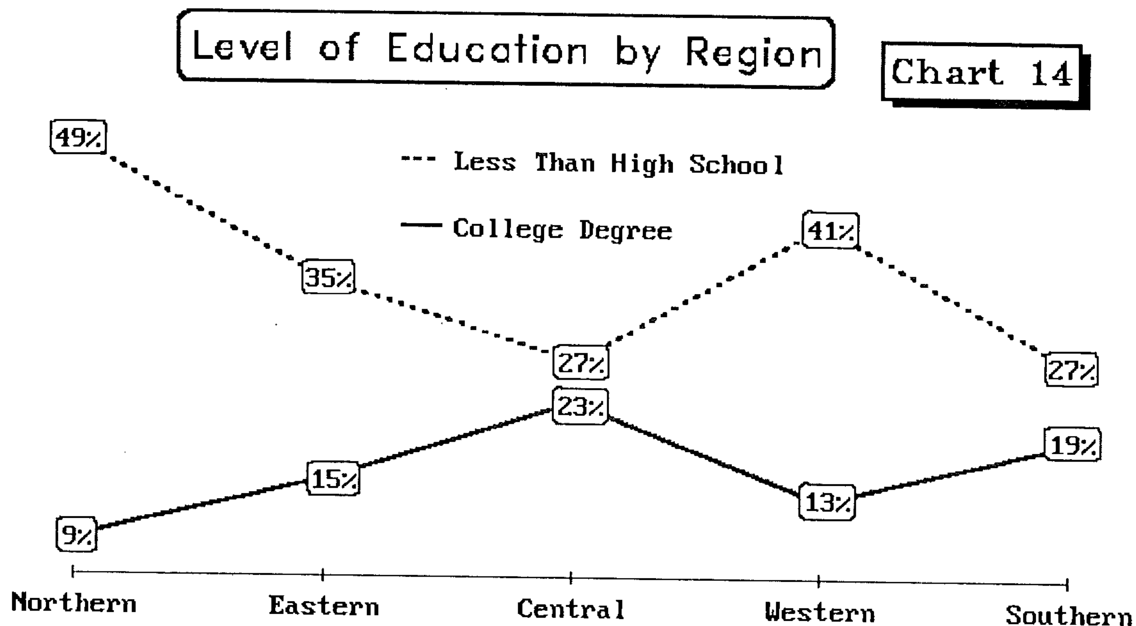


Income level varies significantly with level of education. Among poor older people in Maine, 58% have less than a high school education and only 4% graduated from college. Among near poor elderly, 38% failed to graduate from high school and only 5% completed a college degree. Of the remaining elderly, 80% graduated from high school and 27% graduated from college. (Chart 13)

Perhaps the most striking variation in level of education occurs regionally. Northern Maine has the highest

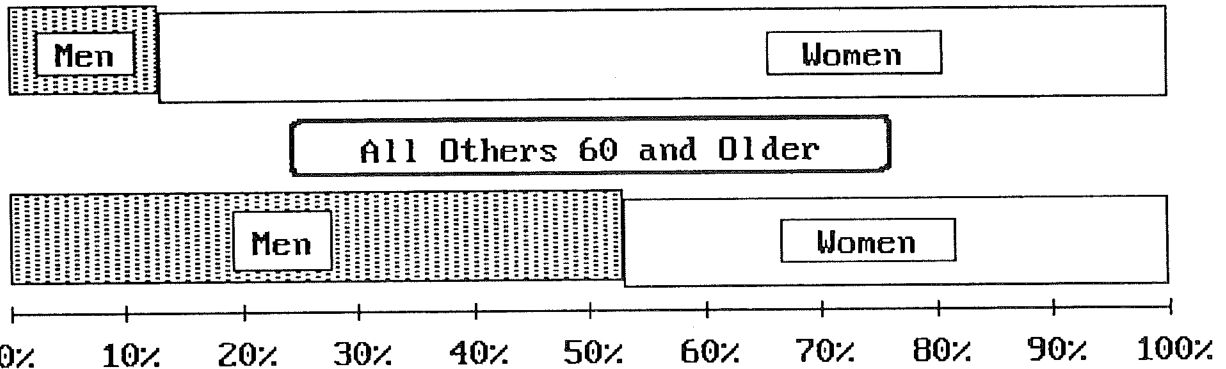
proportion of elderly who have not completed high school, 49%, and the lowest proportion who have completed college, 9%. Forty-one percent of the older population in Western Maine have not completed high school and only 13% have a college degree.

Central Maine has the lowest proportion of older Mainers who have not completed high school, 27%, and the highest proportion of college graduates, 23%. (Chart 14)



Old, Poor and Living Alone

Living alone is not, in and of itself, an indicator of need. Some older people can afford to live alone and do so by choice. Older people with lower incomes who live alone are, however, more likely to need services. There are at least 20,000 Mainers who are 70 years of age or older, have incomes at or below 125% of poverty ($7,475 per year for a household of one in 1989) and who live alone. This group of older people differs significantly from the rest of Maine's population age 60 and older in several ways.

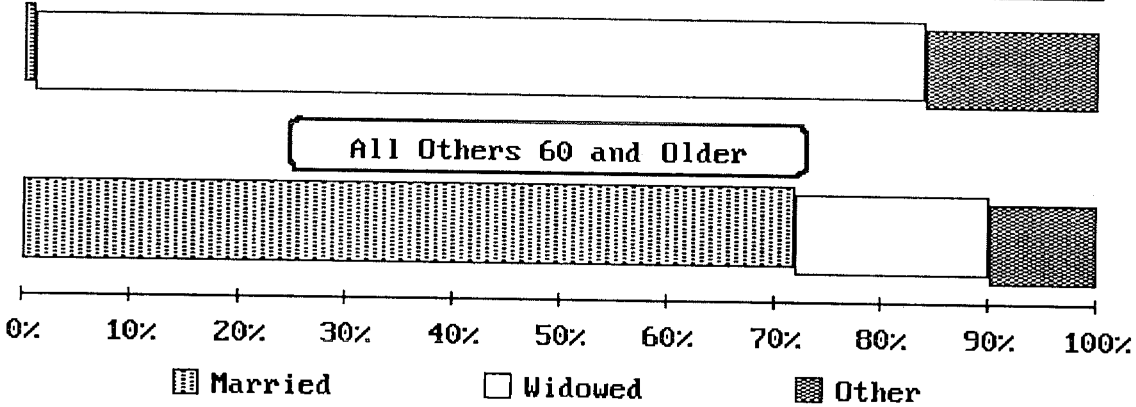


Eighty-seven percent (87%) of this population are women, compared to 47% women in the remaining elderly population. Of these women, 95% are widowed while 18% of the remaining elderly are widowed.

Marital Status

Chart 16

70 & Older, Income at or Below 125% Poverty, Living Alone



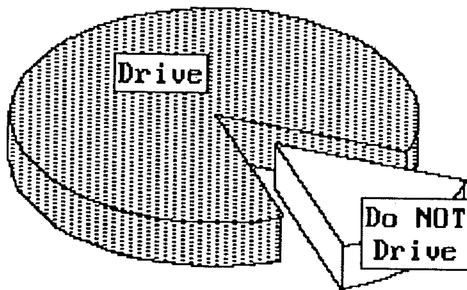
Among the population over 70, poor or near poor and living alone, only 1% are married and 72% are widowed. Among all other people 60 and older, 72% are married and 18% are widowed.

This group is much less likely to drive an automobile and five times as likely to use public or senior citizens' transportation as other older Mainers.

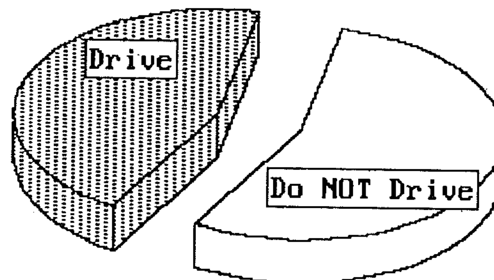
Drive An Automobile

Chart 17

All Others 60 and Older

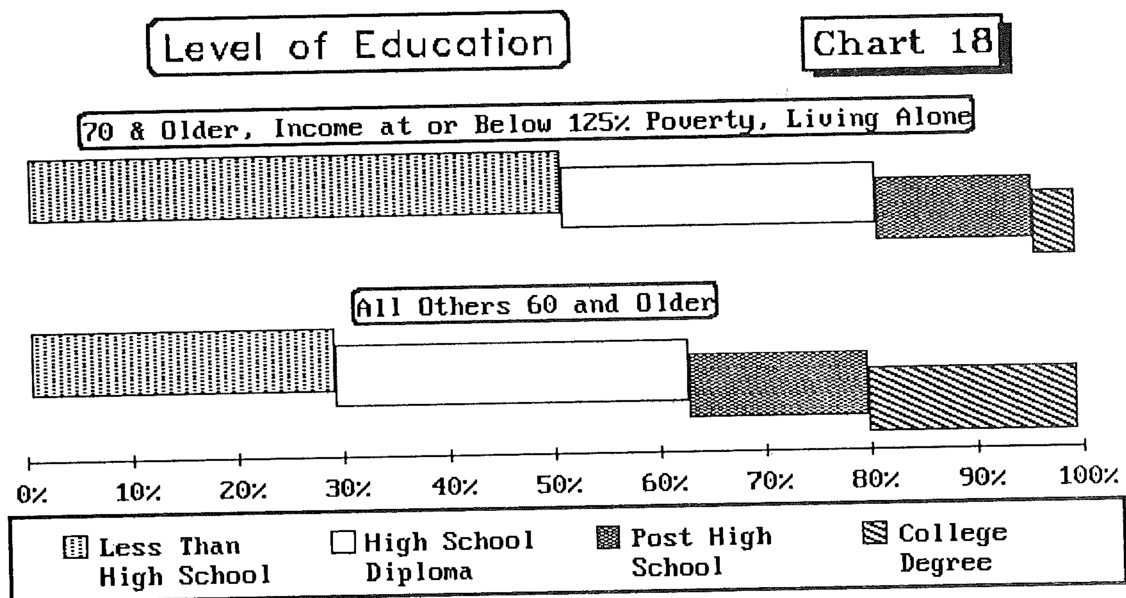


70 & Older, Income at or Below 125% Poverty, Living Alone



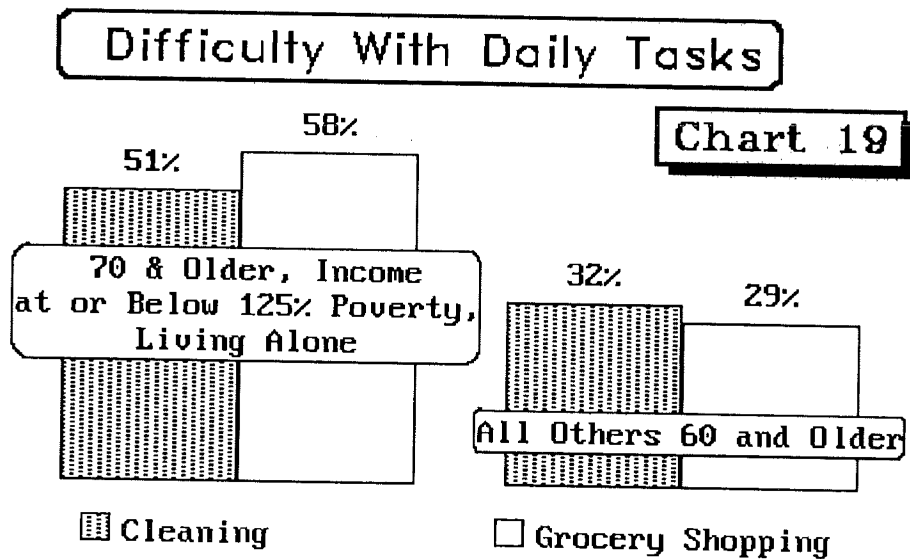
Nearly half, 45%, of this population live in apartments while only 9% of the rest of the elderly population live in apartments. Forty percent (40%) live in single family homes, while 78% of the rest of the elderly population live in single family homes.

Fewer than half of this group graduated from high school and only 4% graduated from college. Among the remainder of the population age 60 and older, 71% received a high school diploma and 20% have a college degree.



Close to a third of this population have difficulty with daily tasks. They are more likely to have difficulty with housecleaning and grocery shopping than the remainder of the elderly population. Their need for assistance with other types of daily tasks does not vary significantly from the remainder of the population age 60 and older. However, half

of all older people who have difficulty with daily tasks receive help from a spouse. Since few in this group live with a spouse, this source of help is not available. Their needs will continue to command the attention of our communities and public service agencies.



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MAINE COMMITTEE ON AGING
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September 20, 1991

LOCAL 289-3658
TOLL FREE 1-800-452-1912
(for Ombudsman Program)

TO: Special Commission on Governmental Restructuring Committee on Health, Social Services and Economic Security.

FROM: Sheila Comerford, Director, Maine Committee on Aging on behalf of James Normington, Ph.D., Chair.

RE: Comments on Interim Report.

The Maine Committee on Aging (MCoA) is a 15-member citizens advisory board to the Governor and the Legislature who advocate on behalf of Maine's 219,000 older people. The MCoA generally supports the direction of this subcommittee's work thus far, believing that

* creating central intake
* expanding early intervention
* restructuring programs and the system

can improve the way human services are delivered to Maine's citizens.

We confine our comments today to two areas - the consolidation of advisory groups (option #19) and the creation of a new Department of Children and Family Services (Option #1).

(Option #19)

1. Various proposals have been brought forward during the past several years to combine state advocacy and advisory organizations under one umbrella agency. We believe that such an office of advocacy would require another layer of management, add another layer of cost and would lead to a diffusion of resources and focus.

   In order for groups such as the MCoA to be effective advocates they must be small, lean, and most importantly, independent. Whenever you tie an advocacy organization to either a Department or an administration's budgets and policies, advocacy is compromised. In the past the Appropriations Committee has researched the possibility of establishing such an

umbrella agency and rejected the idea. The MCoA believes strongly that in good times funding spent on advocacy and advisory groups, if they are active, is a good idea. It is critical in bad times.

During the 115th 1st session several advisory and advocacy organizations proposed to the Appropriations Committee a reduction in their operating costs by sharing space, equipment and support staff. We believe this is the direction the state should be proceeding in for all groups. This model encourages efficiency yet does not compromise advocacy.

In addition to informal consolidation other ways to reduce costs without compromising advocacy include:

* Reduce the number of board or commission members.

* Amend statutes to allow groups more flexibility with meeting schedules thereby saving money.

(Option #1)

II. There has been much discussion surrounding a reorganization of DHS to provide better services. One proposal places the Bureau of Elder and Adult Services under a Department of Youth and Family, another proposal under a Department of Health. The MCoA is concerned that if elderly services are placed in the Department of Youth and Families that an unintended result will be increasing ageism-with children and elderly competing for scarce dollars. We are less opposed to BEAS under a Department of Health although elderly services must and do encompass more than health related issues.

One alternative to either of those proposals would be what several other states have done in acknowledgement of society's changing demographics and that is to establish a Department level Office on Aging. Funding for all services must be included in a department such as this in order for it to be effective including the Low Cost Drug Program, Medicaid, Tax and Rent Refund, etc.

Thank you for accepting our comments. The MCoA is happy to assist this Committee in any way during your deliberations.

jg
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MAINE STATE LEGISLATIVE COMMITTEE

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COORDINATOR
Capital City Task Force
Ms. Janet Hawes Jones
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(207) 622-0211

DATE: September 23, 1991

TO: Ms. Bernstein
Mr. Caron

FROM: Hilton Power HP

As Vice Chair of the Maine State Legislative Committee, I want to thank you for this opportunity to present testimony to your Committee.

The Commissions charge is to:

1. Maximize citizen participation in public policy making
2. Use public resources to consolidate and restructure State Government to assure efficiency and cost savings.

These may be contradictory aims. Which aim is paramount?

A general comment first. This Commission, nor any other, is likely to be able to fulfill its mission in the time available. Nevertheless, such a distinguished body is going to be able to point to potential changes which might accomplish its goals. But, because of the complexity of the structures and functions, the Commission's recommendations should be the subject of further in depth study, before such recommendations are enacted or adopted for implementation. This is especially important in view of your goal to maximize citizen participation in public policy making.

With respect to the work of this Committee on Health, Social Services and Economic Security, AARP will wish to examine, in detail and with care, any proposal that would limit access to the Commissioner by the Bureau of Maine's Elderly and Adult Services. Indeed, given the growing number of elderly in the State of Maine for the next two decades, the Committee should consider giving Elderly Services its own Commissioner.

A Second matter on the Commission's agenda deserving careful thought is the charge to consolidate, restructure and streamline advisory groups. Advocacy plays a central role in maintaining citizen participation in public policy making. Consolidation, or elimination of advocacy groups, would reflect adversely upon both legislative and executive branches and create a cacophony

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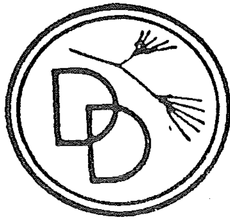
of discordant voices that could bring some aspects of the legislative functions to a halt.

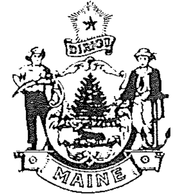
Outside of these two general points there is a need to improve and make accessible information and referral services for all elderly consumers, whether for health, social, supportive income housing or transportation services.

Thank you.



MAINE PLANNING AND ADVISORY COUNCIL ON DEVELOPMENTAL DISABILITIES

State House Station 139, Augusta, Maine 04333
For Persons w/ Disabilities & Families 1-800-244-3990
All others (207) 289-4213



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Governor

Peter R. Stowell
Executive Director

ADVOCACY FOR CHANGE:

FAMILY SUPPORT BELIEF STATEMENTS

In America, over 90% of all children with disabilities live with their families. Children belong with and do best in families. Families are the primary care-takers for children with disabilities. As such, they want to be valued and supported. They are the experts about the needs of their children and their families. They want to be recognized as the primary decision-makers in determining what supports and services that children and families need.

Families have unique and differing needs which change over time. Supports and services available to families need to be flexible and responsive to these differing needs and be available to the total family, not just the family member with the disability. Families need this support from the birth of their children and throughout the life cycle.

Early identification and coordination of services is crucial. Families need one place where they can learn what services are available and receive the help to obtain those services. Families need services and supports that are as close to home and as much a part of the community as possible. In addition, families need opportunities to connect with other families for the purpose of sharing information, support and ideas.

Finally, families, professionals and communities want to be partners in helping families provide the best possible care for the children.

NATIONAL ASSOCIATION OF DEVELOPMENTAL DISABILITIES COUNCILS
1234 Massachusetts Avenue, NW • Suite 103
Washington, DC 20005

SYNOPSIS

Department of Mental Health and Mental Retardation
Family Support Task Force

I. Introduction

The Family Support Task Force was created to educate policymakers on the need for family support services.

II. Family Support

Family supports allow families to support all their members and to participate in everyday activities of community living.

III. Implementing Recommendations

The Family Support Task Force offers its assistance to the Commissioner of the Department of Mental Health and Mental Retardation in addressing the recommendations of this report.

The Department of Mental Health and Mental Retardation should create family support councils consisting of family members of people with disabilities.

The Department of Mental Health and Mental Retardation should develop principles of service delivery allowing the independence, productivity, and integration into the community of people with disabilities and their families.

The Department should develop comprehensive family support service delivery systems crossing age groups, disability groups, geography and develop consistent policies to support it.

The Commissioner should immediately identify a strategy to implement the Task Force's recommendations.

IV. Priority Recommendations

Information Services-- The Task Force recommends that every family in Maine have access to up-to-date, responsive information services, including specific information about disabilities, programs, entitlements and eligibility requirements.

Respite Care-- The Department of Mental Health and Mental Retardation should offer respite care to every family based on individual family needs.

Family Support Groups-- The Department should encourage the development of family support groups statewide and provide funding assistance for their operation.

V. Additional Priority Recommendations

Health Care-- The Task Force recommends that health insurance coverage be available to people with disabilities and their family members on the same basis as people without disabilities.

VI. Other Recommendations

The Task Force recommends initiatives in the areas of assistive technology, community integration and public awareness, crisis intervention, early intervention/prevention, educational services, family counseling, financial issues, future planning, integrated child care, recreation, self-advocacy, and service coordination.

EXECUTIVE SUMMARY

Department of Mental Health and Mental Retardation
Family Support Task Force

I. Introduction

The Family Support Task Force of the Department of Mental Health and Mental Retardation was formed in November, 1989 to assist the Department to better understand the needs of families who care for their family members with disabilities at home or would provide for their care at home if supports were available. Importantly, the Department viewed families as experts in determining their own needs and wished to hear directly from families regarding these supports that would make a difference in improving the quality of life for all family members. Accordingly, with few exceptions, the membership of the Task Force has consisted almost exclusively of family members. In some cases, even the professionals on the Task Force are parents of children with disabilities. The Task Force has met on a regular basis from its inception to the issuance of this report.

II. Definition: Family Support

Family supports are services which allow families to support all their members and which promote participation in everyday activities of community living. In other words, whatever it takes to enable families with members with disabilities to live full, productive lives just like families without disabilities.

III. What Families Have Said About Themselves

In America, over 90% of all children with disabilities live with their families. Children belong with and do best in families. Families are the primary care-takers for children with disabilities. As such, they want to be valued and supported. They are the experts about the needs of their children and their families. They want to be recognized as the primary decision-makers in determining what supports and services that children and families need.

IV. Comprehensive Family Support System Required

In 1987, by law it became "the policy of the State to provide an efficient, coordinated state-wide system of services to children in need of treatment and their families, including a comprehensive system of family support services, insofar as resources permit." Also in 1987, the Commissioner of Mental Health and Mental Retardation was assigned the duty by law to "provide a comprehensive system of support services for families of children with disabilities." Finally, the 1987 law requires the Department to submit a plan to the legislature every two years in January, including 1991, indicating "the State's progress in assuring the development of an array of family support services to enable families to more adequately maintain their children . . . in their natural homes and communities."

V. Family Support Legislation

L.D. 1481; An Act to Facilitate the Delivery of Family Support Services, was enacted by the 115th Maine Legislature and signed by the Governor. This legislation creates six regional family support councils and a state family support council consisting entirely of people with disabilities and their families to advise the Department of Mental Health and Mental Retardation on family support needs throughout the state. Additionally, this legislation expands the list of family support services which can be provided by the Department assuming it has the funds to provide them. The legislation marks a solid foundation on which to address the recommendations in this report.

VI. Implementing Recommendations

The Family Support Task Force urges the Commissioner of the Department of Mental Health and Mental Retardation to utilize the expertise of the Family Support Task Force and to consider the requirements of L.D. 1481; An Act to Facilitate the Delivery of Family Support Services, as building blocks to address the recommendations in this report. Specifically,

1. The Family Support Task Force recommends that the Department of Mental Health and Mental Retardation create family support councils consisting entirely of family members of people with disabilities to advise the Department on the establishment of a comprehensive family support delivery system and to help plan that system.

2. We recommend that the Department of Mental Health and Mental Retardation develop principles of service delivery which allow the independence, productivity and integration into the community of people with disabilities and their families. Family support services must be community based, family centered, and determined by the family.

3. The Task Force recommends that the Department of Mental Health and Mental Retardation develop comprehensive family support services delivery system which crosses age groups, disability groups, geography, and develops policies which hold together consistently from one bureau of the Department to another and from one location of the State to another.

4. We recommend that the Commissioner of the Department of Mental Health and Mental Retardation, in conjunction with the Task Force, identify an implementation group to strategize responding to the Task Force's recommendations. We recommend the development of this implementation response at once. Families cannot afford to wait any longer.

VII. Priority Recommendations

The following recommendations relating to family support groups, respite care, and information services are offered by the Task Force as priority recommendations for immediate attention by the Department of Mental Health and Mental Retardation. These priority recommendations are consistently identified by family members of people with disabilities as being of great importance to them. Furthermore, they can be immediately addressed by the Department.

INFORMATION SERVICES

Access to appropriate, accurate, timely information is vital for the well-being of people with disabilities and their families. On the other hand, not having access to the information is costly, not only in terms of time lost or money spent on wasted phone calls, but also because often the window of opportunity to remediate the effects of a specific disability is lost. Family morale suffers, as well, when appropriate services cannot be located because families don't know where to turn to find it. The Task Force recognizes the complexity of this topic and proposes no global solutions. However, we are aware of information service models which families have reported as helpful to them. One type is the statewide information service operated by the Maine Parent Federation which responds to more than 3,200 contacts from families annually. This program, called SPIN, is designed to focus on the informational needs of families of people with disabilities. The second widely endorsed model is represented by York County Parent Awareness, a program in southern Maine, managed by family members of people with disabilities, designed to provide basic information services to parents as well as connecting them with each other for further informational, emotional or resource support.

RECOMMENDATION:

The Task Force recommends that every family in Maine have access to up-to-date, responsive information services, including specific information about disabilities, programs, entitlements and eligibility requirements.

The Task Force concurs with the finding of the Developmental Disabilities Council's Family Contribution Study which identified information services as families top-rated need. This conclusion has been confirmed as well by the Council's Consumer Satisfaction Survey and an information survey conducted by the Department of Education. It is imperative that the Department address this need constructively.

ADDITIONAL RECOMMENDATIONS:

1. The Department of Mental Health and Mental Retardation should install a toll-free number to guide families to appropriate information sources.

2. The Department should use electronic and print media to inform families of the availability of a central information and referral source.

3. Parents and people with disabilities should help develop and manage any new information and referral systems.

4. The Task Force advises that any information service system needs to assure appropriate responses to families through caring followup inquiries to them to ascertain that they have received appropriate and useful information.

RESPITE CARE

Respite care is an essential element in family life, preventing needless family trauma, helping to avoid family crisis, and providing renewed care-giving energy. Families of people with disabilities are strong and

dedicate themselves to meeting the needs of all their family members, including the person with disabilities. Like all of us, however, families need to get away to refresh themselves. Without respite care, this is often not possible for families of people with disabilities since trained care-givers familiar with the needs of the family are often not available. The Department's Respite Care Program has made a difference in the lives of hundreds of Maine families by providing them with breaks from family care. Funds are limited, however, and many other families go without and rely upon the kindnesses of friends, neighbors, and relatives for such services when they're available at all. To maintain family health, respite care must be available to all families of people with disabilities in such amounts as allow the family to maintain the health, safety, and well-being of all its members.

RECOMMENDATION:

The Department of Mental Health and Mental Retardation should offer respite care to every family based on individual family needs.

ADDITIONAL RECOMMENDATIONS:

1. To promote the well-being of all family members, respite care should be available without cost to families regardless of income.

2. The amount, type and frequency of respite care provided to families must be flexible enough to meet their ever-changing family needs.

3. Respite care should be offered to families on a planned, scheduled, predictable or even emergency basis, but not used as crisis intervention. Similarly, crisis intervention should not be offered to families as respite care.

4. The Family Support Task Force recommends that all the Department's respite care programs be administered by the Bureau of Children with Special Needs' respite unit.

5. The Task Force recommends the continued development of the respitality program on a statewide basis to be available to families regardless of residence.

FAMILY SUPPORT GROUPS

Families learn from each other. Families want to talk to other families who are dealing with similar kinds of family situations as they are. Exchanging ideas, lending emotional support, or guiding other families to useful resources are all important functions of family groups. Many families have reported that their primary source of emotional support comes from these groups. The Task Force has observed a dramatic increase in the number of family groups in the past two years. Many of these are informal groups, meeting regularly to conduct their business. Many have developed programs to bring information to the group through speakers, videos, print material, etc. However, most groups have little opportunity to access funds to actualize these programs.

RECOMMENDATION:

The Department of Mental Health and Mental Retardation should encourage

the development of family support groups statewide and provide a small amount of funding for their operation.

ADDITIONAL RECOMMENDATIONS:

1. Training and technical assistance funding should be available through the Department of Mental Health and Mental Retardation for the development of local family support groups and the enhancement of existing groups statewide.

2. The Department should develop a capacity to organize groups for siblings, fathers, grandparents, adoptive families and other family members of people with disabilities.

VIII. Additional Priority Recommendation-- Health Care

Families of people with disabilities have consistently identified health care coverage as important to them. The Task Force recognizes that health care coverage is the emerging social issue for the 1990's. We recognize that the Department of Mental Health and Mental Retardation does not carry primary responsibility for shaping public policy regarding health care. However, we believe that the Department should begin to equip itself with the requisite knowledge and skills to participate as an active partner concerning health care coverage for its constituencies, including people with mental illness, mental retardation, autism, special needs and their families.

HEALTH CARE

The Task Force believes that quality health care is the right of all people, including people with disabilities and their families. Unfortunately, our experience has been that people with disabilities are often denied health insurance completely, assigned to high risk pools with higher co-payments, deductibles and higher premiums, and as a result are often dependent upon public health insurance such as Medicaid. Such dependency guarantees that families must remain poor to maintain this coverage since Medicaid is an income eligible program. Our belief is that families of people with disabilities often find any health insurance vehicle they can and hang on to it as long as possible, always in fear that a change in their income, marital status, or health of family members could jeopardize their coverage.

RECOMMENDATION:

The Task Force recommends that health insurance coverage should be available to people with disabilities and their family members on the same basis as people without disabilities. We recommend further that the Department of Mental Health and Mental Retardation become knowledgeable about barriers affecting families inabilities to obtain or maintain health insurance and of alternatives to the present health care coverage system.

ADDITIONAL RECOMMENDATIONS:

1. Continue to implement the Maine Health Plan with inclusion of people with disabilities and their families.

2. The Department of Mental Health and Mental Retardation should advocate with the federal government to remove deeming from Medicaid policy for families with children with disabilities under the age of twenty-one.

3. The Department of Mental Health and Mental Retardation in conjunction with advocacy groups should monitor recent legislation requiring health insurance companies to provide coverage to people with disabilities after a one-time exclusion for pre-existing conditions.

IX. Other Recommendations

ASSISTIVE TECHNOLOGY

The Department must develop the capacity and resources to make assistive technology available to families to assist in the activities of daily living in order to promote greater independence, productivity, integration into the community and increased contributions to society.

COMMUNITY INTEGRATION & PUBLIC AWARENESS

The Department of Mental Health and Mental Retardation should undertake state-wide public awareness efforts to increase community support of people with disabilities and their families.

CRISIS INTERVENTION

The Department of Mental Health and Mental Retardation should offer crisis intervention services to people with disabilities and their families throughout the life-cycle of the family member until the family support system has been fully developed.

EARLY INTERVENTION/PREVENTION

The Task Force recommends that the Department of Mental Health and Mental Retardation, in conjunction with Child Development Services and the Department of Human Services, define its role in early intervention/ prevention services in such a way that children with disabilities and their families receive needed early intervention services. Early intervention can also mean provision of needed services to a person with disabilities at the earliest possible moment. Such intervention can reduce the effects of a disability, prevent further deterioration, and lead to a more favorable prognosis.

EDUCATIONAL SERVICES

In conjunction with the Department of Education, the Department of Mental Health and Mental Retardation should assure that families with disabilities have access to advocacy and educational services throughout the child's school years.

FAMILY COUNSELING

The Task Force recommends that the Department of Mental Health and Mental Retardation develop the capacity to offer families a full range of counseling services.

FINANCIAL ISSUES

Families should be offered additional financial supports to obtain services and purchase items important to them in raising a family member with a disability at home.

FUTURE PLANNING

The Task Force recommends that the Department of Mental Health and Mental Retardation establish the capacity to provide families with planning for people with disabilities. Planning should address services addressed in this report and should be available to families at all times but especially during significant transition points: birth, entrance into preschool services, entrance into the school system, change of schools, graduation and community living.

Future planning should address residential services, vocational services, transportation, personal care assistance, financial planning, recreation and leisure services, family planning, genetic counseling, continuing education, respite care, self-advocacy, service coordination, legal planning, and wills, trusts and guardianship.

INTEGRATED CHILD CARE

The Task Force recommends that integrated child care opportunities for children with disabilities be available at no increased cost or inconvenience for families.

RECREATION

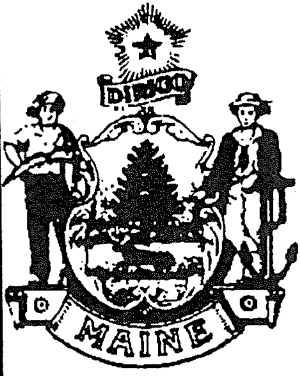
The Department of Mental Health and Mental Retardation should assure that people with disabilities and their families receive opportunities for recreational and leisure activities at the local level in programs which are also available to people without disabilities.

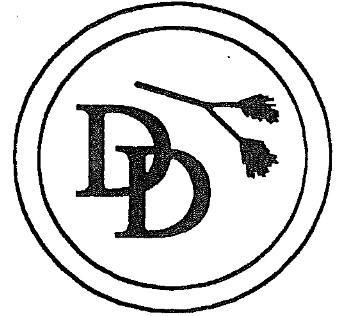
SELF-ADVOCACY

The FSTF recommends that the Department of Mental Health and Mental Retardation, in conjunction with advocacy and self-advocacy groups, make available self-advocacy training opportunities throughout the life span of the individual with disabilities.

SERVICE COORDINATION

The Department of Mental Health and Mental Retardation should offer quality, family-focused service coordination services to people with disabilities and their families to address both the present needs and the future of the person with a disability and other family members.





1992 - 1994

THREE YEAR STATE PLAN

Maine Planning & Advisory Council on Developmental Disabilities
State House Station #139
Augusta, Maine 04333
(207) 289-4213 or
1-800-244-3990

FAMILY BELIEF STATEMENTS

What is family support?

Families with members with disabilities contribute much to the economic health and social fabric of the state, improving the quality of life for all Maine families. Family support recognizes and respects the primary role of the family in the lives of family members. It strives to support families in their natural roles by building upon their unique strengths as individuals and families. It promotes normal patterns of living at home and in the community, maintains family unity, and reunites families with members who have been placed out of the home.

Family supports are needed throughout the lifespan of the individual with the disability. Family needs change over time, thus family support must be flexible and responsive to the uniqueness of individual families.

Family members with disabilities have preferences and personal aspirations to live and work, to learn and grow, and have relationships just as others in the community.

Family support embraces the right of families to make choices based upon individual family preferences. Families must be viewed as making significant public policy contributions to the choices offered by the family support system.

Family supports should maximize the family's control over the services and support they receive.

Families need opportunities to connect with similar families for the purpose of sharing information, support, and ideas.

Family support will help friends, neighbors, and citizens to better understand, accept and include people with disabilities and their families in community activities.

Family support recognizes that families are the experts and primary decision makers about their children with disabilities. They are the constant in their child's life while the service system and personnel within those systems change.

All children, regardless of disability, belong with families and need enduring relationships with adults.

Families must receive the supports necessary to care for their children with disabilities at home.

Family support embraces the right of adults to define their own family.

COMMUNITY INCLUSION BELIEF STATEMENTS

What is community inclusion?

Community inclusion is a basic human right, reflecting our society's long-standing belief in democratic ideals. Community inclusion recognizes and respects the rights of all people to be included in all aspects of community life. It recognizes that people with disabilities, like all citizens, need the same access to community resources because the community greatly influences a person's development, learning, and contributions to society. Community inclusion recognizes that all people need to be involved in activities which confirm their sense of worth as full and complete members of society.

Our focus should shift from people being in the community to being part of the community.

The unity and well-being of the community requires its attending the needs of all its members. Community inclusion means celebrating the gifts and capacities of all people as community members.

People are more satisfied when they have choices and can act on their wishes and needs according to their own values and preferences.

People need and seek the acceptance, recognition, and respect that come from satisfying relationships. For children, friendships need to be promoted. For adults, relationships must be freely entered into.

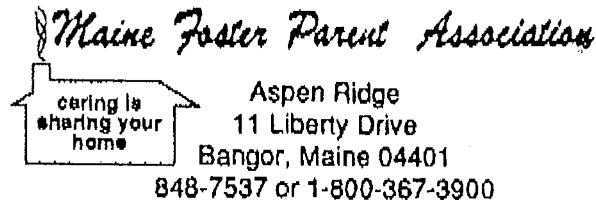
People should be informed of and have the opportunity to act on all the rights and duties of citizenship.

With the experience of being part of the regular classroom, students can learn the academic and social skills needed to succeed in the real world after they leave school.

People should have choices about where in the community they prefer to live and have the right to decide which housing most closely matches their preferences.

Work is a life activity through which an adult person's life experiences, satisfactions and self-esteem are significantly defined. People with disabilities should fully and equally participate in the work force.

Physical accessibility, technology, and transportation are inseparably linked to community inclusion. They must be available to people with disabilities and their families.



Aspen Ridge
11 Liberty Drive
Bangor, Maine 04401
848-7537 or 1-800-367-3900

September 19, 1991

To Members of the Committee on Health, Social Services and Economic Security:

The Maine Foster Parent Association feels strongly that the formation of a Department of Child and Family Services is in the best interest of children, families and the State of Maine. We urge that prevention and early intervention be the goal and that this be reflected in the mission of this new Department by the directive to screen families into the system upon referral rather than out as is presently the case.

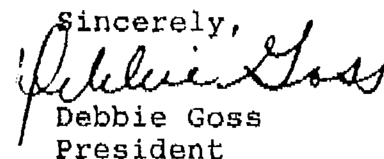
Regarding items seven and eight from "options under discussion", it seems ideal to us that a family be assigned one worker, responsible for assessment of that family's needs who would also continue to function as broker and advocate for that family. This family caseworker would design, coordinate and oversee an individualized plan which would neither neglect nor overlap services essential to that family's well being. This would be of benefit, not only to the family which would have an ongoing relationship with one person but for social workers whose present compartmentalized view of his or her client limits intervention options.

Given the large percentage of state wards who are adjudicated we would also urge that existing information from the Department of Corrections be incorporated into a central information and intake system and the formation of a family court be considered.

As the largest single provider group to state wards, Maine Foster Parent Association expects to work closely with the committee charged with the development of regional boards which would plan and implement appropriate services for Maine's children.

We thank you for this opportunity to express our opinions and concerns and look forward to an interactive relationship with this and future committees.

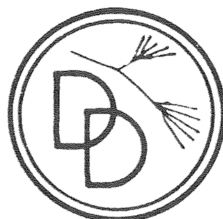
Sincerely,



Debbie Goss
President

Caring For Families Who Care

The Report of the Family Contribution Study Advisory Committee
(Executive Summary)



The Maine Planning and Advisory Council on Developmental Disabilities
State House Station 139
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Authors:
Peter R. Stowell, Executive Director, Developmental Disabilities Council
L. Jean Price, Study Consultant

Family Contribution Study Advisory Committee

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Caroline Hyde, Parent, Pownal
Zilpha Booth, Parent, Bar Harbor
Carol Boston, Parent, Augusta
Ralph Cordes, Associate Executive Director, Sweetser Children's Home, Saco
Davene Fahy, Preschool Coordinator, Mid-Coast Children's Services, Rockland
Brian Foster, Director, Regional Special Education, Waldo
Barbara A. Gill, State Senator, South Portland
Phil Guiles, Parent, New Gloucester
Jean Manning, Parent, Augusta
Lee Parker, Director, Bath-Brunswick Child Care Services, Inc.
Susan B. Parker, Commissioner, Department of Mental Health and Mental Retardation, Augusta
Charlene B. Rydell, State Representative, Brunswick
David Stockford, Director, Division of Special Education, Augusta

Support Resources:
Betsy J. Davenport, Director, Bureau of Mental Retardation, Augusta
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Peter R. Stowell, Executive Director, Developmental Disabilities Council, Augusta

Illustrations:
Karen Gilg

Dedication

The Maine Planning and Advisory Council on Developmental Disabilities would like to dedicate this report to the One Hundred Seventy One Maine families interviewed for the Family Contribution Study—your stories of trial and triumph touched all of us.

CARING FOR FAMILIES WHO CARE

The Report of the Family Contribution Study Advisory Committee
(Executive Summary)

Peter R. Stowell, Executive Director
Maine Planning and Advisory Council on Developmental Disabilities
and
L. Jean Price, Study Consultant

"We have been able to maintain our son at home at times, but not without constant cost to my family in emotional pain, strained relationships and financial drain. When things are working, I am always aware that if suddenly they don't work, I am on my own to invent again."
Parent of adolescent with emotional disturbance, Central Maine

It is generally accepted with little or no debate that all children are best off being raised within a family and the needs of severely handicapped children are best met in a family (natural, adoptive or foster) home...One of the great ironies — and tragedies — of traditional service systems is that they have undermined families. It has often been easier for parents to have their children institutionalized or placed in other out-of-home settings than to receive in-home supports. (The Center on Human Policy, Syracuse University, 1987)

The last two decades have witnessed a change from institutionalizing family members with disabilities to understanding that families provide the belonging and nurturing that make for a richer quality of life.

It is time to shift attention from separating families to supporting them. Family supports are services which allow families to support all their members and promote participation in everyday activities of community living. A family support system enhances the capacity of families to provide care at home for their family members with disabilities.

Families are strong. Family support services build stronger, healthier families by protecting its members from dissolution and by reducing the need to place them outside the home for daily care.

The Developmental Disabilities Act of 1987 reinforces the values that individuals with disabilities should live at home in their own communities, should work in integrated settings and should be supported in reaching their fullest potential as people and as citizens. The law also calls for State Planning Councils to analyze "the extent, scope and effectiveness of services provided and functions performed by all state agencies which impact or potentially impact on the ability of persons with developmental disabilities to achieve the goals of independence, productivity, and integration into the community."

The Maine Developmental Disabilities Council has addressed the needs of families in part by conducting the Family Contribution Study, the objectives of which were to:

- recognize the economic and social contributions of Maine families who care for their family members with disabilities at home.
- identify and quantify family support needs to assist families in maintaining their sons and daughters and family members.
- identify both tangible and intangible contributions of Maine families: educational levels of parents, employment levels, community involvement and geographic distribution.
- identify the impact of maintaining a child with developmental disabilities at home—economic, marital, familial, emotional, social and recreational.
- formulate new policies which facilitate the provision of family support services.
- identify existing policies which impede the provision of family support services.

A STATEMENT IN SUPPORT OF FAMILIES AND THEIR CHILDREN

(These principles should guide public policy toward families of children with disabilities...and the action of states and agencies when they become involved with families.)

• All children, regardless of disability, belong with families and need enduring relationships with adults.

• Families should receive the supports necessary to maintain their children at home.

• Family supports should build on existing social networks and natural sources of support.

• Family supports should maximize the family's control over the services and supports they receive.

• Family supports should support the entire family.

• Family support services should encourage the integration of children with disabilities into the community.

—Center on Human Policy Syracuse University

—Maine Developmental Disabilities Council

FAMILY SUPPORT SERVICES FACT SHEET

FACT: A foster home placement costs a minimum of about $4,000 annually. For the same $4,000, 5 families could receive respite care for a year helping them better care for their child with a disability at home.

FACT: A typical boarding care placement costs about $6,000 annually. For the same $6,000, 5 families could receive respite care with 16 more provided with "respitality" - an innovative program matching families of children with disabilities with participating hotels and restaurants for a much needed break.

FACT: A specialized boarding care placement costs around $10,000 annually. The same $10,000 could buy respite for 5 families, "respitality" for 20 and information and referral services for 100 more.

FACT: An intermediate care facility placement for persons with mental retardation costs about $42,000 annually. For $42,000, respite care could be provided for about 60 families, helping them stay together. Or family therapy for a whole year for about 20 families, helping them support each other together with more understanding.

FACT: A placement for a year at Pineland Center costs about $65,000. With the same $65,000, we could choose to:

• Provide respiite care to more than 90 families, giving all family members a break, or

• Provide case management services to about 65 families who maintain their children with disabilities at home, sorting out difficult life choices, or

• Establish more than 60 local family support groups, helping families learn from each other and receive emotional support, or

• Provide information and referral services to 2,000 Maine families, fulfilling their top-rated service request, or

• Provide family therapy to more than 25 families, promoting family health, maintaining family unity.

FACT: For each year services supporting a family to care for a child with disabilities at home is provided, taxpayers can save most of the $65,000 the same child would cost for care at Pineland.

—Maine Developmental Disabilities Council

FAMILY CONTRIBUTION STUDY RECOMMENDATIONS

COMMUNITY INTEGRATION

The Maine Developmental Disabilities Council recommends that persons with disabilities and their families be provided access to employment, educational, social and recreational opportunities in the community on the same basis as persons without disabilities.

RESPITE CARE

The Maine Developmental Disabilities Council recommends that quality, affordable respite care services in a variety of settings be available for every family in Maine with a family member with disabilities.

Delivery of respite care services should be centered around family needs as determined by the family and acceptability of respite services should be determined by the family as well.

CHILD CARE

The Maine Developmental Disabilities Council recommends that affordable, quality child care services be available to every Maine family with a child with disabilities. The Council recognizes that the availability of child care services is an issue for many Maine families and recognizes additionally the added difficulty of obtaining quality child care for children with special needs in settings with their non-disabled peers.

INFORMATION AND REFERRAL

The Maine Developmental Disabilities Council recommends that every family with a member who has disabilities have access to up-to-date, responsive information services including information about specific disabilities and information about service programs and eligibility requirements.

CASE MANAGEMENT

The Maine Developmental Disabilities Council recommends that case management services be available for all families with a member with disabilities. Case management services should consider the strengths and needs of the entire family unit and be sufficiently flexible to provide the informational and decision-making supports as determined by the family.

FAMILY SUPPORT GROUPS

The Maine Developmental Disabilities Council recommends that every family with a family member with disabilities have the opportunity to be linked with other families and family support groups.

The Council recommends that peer support programs be available to any Maine family with a family member with disabilities.

FAMILY COUNSELING AND THERAPY

The Maine Developmental Disabilities Council recommends that family counseling and family therapy services be available to families to promote family health and help preserve family unity.

FUTURE PLANNING

The Maine Developmental Disabilities Council recommends that future planning services or permanency planning be available to all persons with disabilities and their families over the life cycle.

FAMILY EDUCATION AND TRAINING

The Maine Developmental Disabilities Council recommends that quality family education and training support resources be available to support families in meeting their needs for on-going education.

ADAPTIVE EQUIPMENT

The Maine Developmental Disabilities Council recommends that adaptive equipment be available for all persons with disabilities and/or their families to assist with activities of daily living such as self-care, receptive and expressive language, learning, mobility, self-direction, independent living and economic self-sufficiency.

FINANCIAL ISSUES AND HEALTH COVERAGE

The Maine Developmental Disabilities Council recommends a comprehensive study of financial support programs such as cash subsidies, tax credits or service vouchers be undertaken to develop recommendations to assist Maine families with a family member with a disability.

The Council also recommends that all families in Maine with a family member with a disability have access to adequate, affordable, comprehensive health coverage.

WHAT WE FOUND OUT ABOUT FAMILY SUPPORTS

FAMILY CONTRIBUTION STUDY — 171 FAMILIES INTERVIEWED

COMMUNITY INTEGRATION

• Less than half of Maine families expressing a need for social or recreational services were successful in meeting that need.

• The Maine Respite Care Survey (1984) identified the greatest social problem of families to be the isolation they feel from the community.

RESPITE CARE

• Approximately two-thirds of families have not received in-home respite services.

• The Bureau of Mental Retardation reported that 180 people did not get requested respite over a three-month period, October through December, 1988; lack of sufficient funding was a significant reason the service was not available.

CHILD CARE

• Families identified child care as high on their list of service needs.

• Three out of five families needing child care don't get it.

• Families reported high costs, lack of care-provider knowledge and training and increased care-giving demands of children with disabilities as contributing to the shortage of available child care.

INFORMATION AND REFERRAL

• Families identified information and referral services as their top-rated service need.

• Nine out of ten Maine families considered availability of reliable, responsive information and referral servivces to be their greatest concern for the future.

CASE MANAGEMENT

• Only 60% of Maine families identifying case management as a service need actually received it. Four out of ten families go without.

• Nearly eight out of ten families say they will need case management services in the future.

SUPPORT GROUPS

• One out of three Maine families citing the need for support group involvement didn't receive the opportunity to participate.

• Nearly two of three Maine parents wanted access to a state-wide network of parent groups.

FAMILY COUNSELING AND THERAPY

• More than half of families interviewed identified family counseling as a service need; only about half of them received services.

• Families very often cannot afford the cost of counseling; some are excluded from health insurance coverage and third party reimbursements; others cannot afford insurance at all.

FUTURE PLANNING

• Maine families reported no available goal-setting and planning system for their child once secondary school ended.

• Over one-half of the families realize the need for future planning now; nearly three out of four families see the need in the years ahead.

FAMILY EDUCATION AND TRAINING

• Forty-five percent of families reported family education is needed.

• Behavior management training was a frequently-mentioned need cited by many families.

ADAPTIVE EQUIPMENT

• Adaptive equipment was reported to be needed by 32% of families.

• Families reported doing without adaptive equipment because it was not affordable.

• Remodeling or building a home to fit the needs of the family member places an overwhelming financial burden on the family.

FINANCIAL ISSUES AND HEALTH COVERAGE

• Financial assistance was identified as a major need. Of those expressing the need, 35% received no assistance.

• Median income for families citing the need for financial assistance was 21,000; $33,500 for those families expressing no need and $25,000 for the survey sample as a whole.

—*Maine Developmental Disabilities Council*

WHAT FAMILIES SAID ABOUT FAMILY SUPPORTS

FAMILY CONTRIBUTION STUDY — 171 FAMILIES INTERVIEWED

COMMUNITY INTEGRATION

"I feel peer pressure has a lot to do with how my child develops in the next six to ten years. If the children in his school were educated to the fact that my son is really no different than themselves, my child would have a better chance of social integration."

"I do not tell any employer that I have epilepsy. I fear discrimination! There should be more education about epilepsy!!"

RESPITE CARE

"Sometimes we feel we are blindly caring for our children. Sometimes we feel very alone. A night out is rare and a weekend away is unheard of. Respite would be nice...."

"I had a woman come in for a half hour two days a week so I could go for a walk...over four years ago. I have had nothing since."

"I have been a single parent for twelve years with no respite."

CHILD CARE

"People are scared to take our daughter. Most of the family has cared for her."

"There is a problem receiving care due to costs."

"I taught a local mother how to perform personal care duties for my child during after-school care. She no longer provides day care. I can't get help now."

INFORMATION AND REFERRAL

"People have to work hard to find services. They don't come knocking at the door..."

"I've been here for fifteen years and still don't know where to go for help."

"I got services quickly when I knew they were available and where to ask for them."

CASE MANAGEMENT

"We would really like a caseworker and one that would come to the home."

"Mom has been case manager."

"We've had to be the case management team. It has been twenty-four months and we're still waiting."

SUPPORT GROUPS

"My support group is fantastic. I meet other people and it's nice just to talk and know someone knows where I'm coming from."

"You start to feel like you're crazy. As much as I talk, I can't get people to understand. I get so angry."

FAMILY COUNSELING AND THERAPY

"All the services in the world can't touch the emotional pain."

"I needed counseling and services were too expensive."

"Family therapy was very helpful but very expensive for the family."

FUTURE PLANNING

"I feel as though we had our heads in the sand because there has been no preparation for what happens to our son now that he's no longer in school."

"Now that she's out of school, she has been thrown to the wolves."

"There doesn't seem to be anybody who can look at long-term plans for children."

FAMILY EDUCATION AND TRAINING

"The State of Maine needs more readily available means for training parents with special needs children."

"We got family education on our own by using literature. Nurses and hospitals told us who to write to. Professionals knew national information sources but did not know what existed in Maine."

ADAPTIVE EQUIPMENT

"Adaptive equipment is very expensive. Therefore, you try to find someone who can make it for you to get by."

"We need other special equipment and clothing but we do not have it because it's not affordable."

"We had to build a new home to fit the needs of our children. We had to put in an elevator, ramps, wider doors, bath, etc. It was a tremendous financial burden."

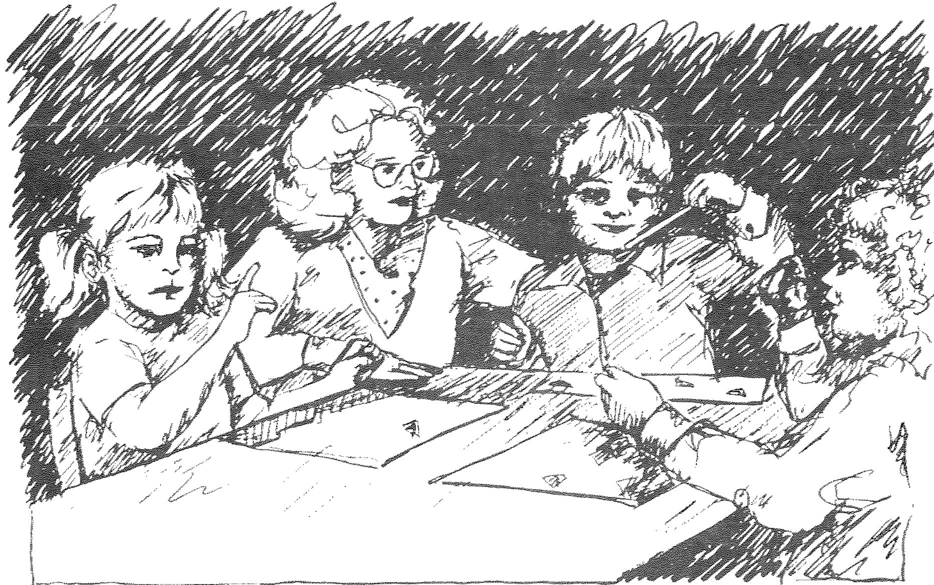
FINANCIAL ISSUES AND HEALTH COVERAGE

"My husband left the family to enable our handicapped child to have Medicaid and SSI."

"I don't believe that three shifts of different personnel in an institution can give my son the loving care that he gets at home. Instead of paying strangers to take care of special people, why doesn't the government pay parents?"

"We have all these other financial obligations that they don't take into consideration. They see our income and that's the end of it...Trying to get your basic needs met is like asking for the world!"

—*Maine Developmental Disabilities Council*



This report was printed under Appropriation Number 3360.2902.

MAINE COMMITTEE ON AGING
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Augusta, Maine 04333

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September 20, 1991

LOCAL 289-3658
TOLL FREE 1-800-452-1912
(for Ombudsman Program)

TO: Special Commission on Governmental Restructuring Committee on Health, Social Services and Economic Security.

FROM: Sheila Comerford, Director, Maine Committee on Aging on behalf of James Normington, Ph.D., Chair.

RE: Comments on Interim Report.

The Maine Committee on Aging (MCoA) is a 15-member citizens advisory board to the Governor and the Legislature who advocate on behalf of Maine's 219,000 older people. The MCoA generally supports the direction of this subcommittee's work thus far, believing that

* creating central intake
* expanding early intervention
* restructuring programs and the system

can improve the way human services are delivered to Maine's citizens.

We confine our comments today to two areas - the consolidation of advisory groups (option #19) and the creation of a new Department of Children and Family Services (Option #1).

(Option #19)

1. Various proposals have been brought forward during the past several years to combine state advocacy and advisory organizations under one umbrella agency. We believe that such an office of advocacy would require another layer of management, add another layer of cost and would lead to a diffusion of resources and focus.

   In order for groups such as the MCoA to be effective advocates they must be small, lean, and most importantly, independent. Whenever you tie an advocacy organization to either a Department or an administration's budgets and policies, advocacy is compromised. In the past the Appropriations Committee has researched the possibility of establishing such an

umbrella agency and rejected the idea. The MCoA believes strongly that in good times funding spent on advocacy and advisory groups, if they are active, is a good idea. It is critical in bad times.

During the 115th 1st session several advisory and advocacy organizations proposed to the Appropriations Committee a reduction in their operating costs by sharing space, equipment and support staff. We believe this is the direction the state should be proceeding in for all groups. This model encourages efficiency yet does not compromise advocacy.

In addition to informal consolidation other ways to reduce costs without compromising advocacy include:

* Reduce the number of board or commission members.

* Amend statutes to allow groups more flexibility with meeting schedules thereby saving money.

(Option #1)

II. There has been much discussion surrounding a reorganization of DHS to provide better services. One proposal places the Bureau of Elder and Adult Services under a Department of Youth and Family, another proposal under a Department of Health. The MCoA is concerned that if elderly services are placed in the Department of Youth and Families that an unintended result will be increasing ageism-with children and elderly competing for scarce dollars. We are less opposed to BEAS under a Department of Health although elderly services must and do encompass more than health related issues.

One alternative to either of those proposals would be what several other states have done in acknowledgement of society's changing demographics and that is to establish a Department level Office on Aging. Funding for all services must be included in a department such as this in order for it to be effective including the Low Cost Drug Program, Medicaid, Tax and Rent Refund, etc.

Thank you for accepting our comments. The MCoA is happy to assist this Committee in any way during your deliberations.

jg
restruc.sc#11

August 8, 1991

Special Commission on Governmental Restructuring
membership & staffing

Co-Chairs: Mr. Henry and Mr. Nicoll

staff: Martha Freeman (OPLA) Richard Silkman (SPO)
Tim Glidden (OPLA) Carol Michel (SPO)

Committees:

I. Committee on Health, Social Services and Economic Security (HSS)

Ms. Bernstein and Mr. Caron, co-chairs
Ms. Levenson
Mr. Rosser

staff: Paul Saucier (OPLA)
Joyce Benson (SPO)

II. Committee on Education and Cultural Services (ECS)

Ms. Amero and Mr. Storer, co-chairs
Mr. Hibyan

staff: Michael Higgins (OPLA)
Richard Sherwood (SPO)

III. Committee on Protection of Public Safety and Health (PSH)

Ms. Kinnelly and Mr. Willey, co-chairs
Mr. Hare

staff: Deborah Friedman (OPLA)
Mike Montagna (SPO)

IV. Committee on Economic and Physical Infrastructure (EPI)

Mr. Flanagan and Ms. Mattimore, co-chairs
Mr. Brace

staff: Karen Hruby (OPLA)
Steve Adams (SPO)

V. Committee on Physical Resources (PYR)

Mr. McGowan and Mr. Cope, co-chairs
Mr. Anderson

staff: Patrick Norton (OPLA)
Mark Dawson (SPO)

VI. Committee on Governmental Relations and Process (GRP)

Mr. Bonney and Ms. Post, co-chairs
Mr. Higgins
Mr. John Lisnik

staff: Jon Clark (OPLA)
Carol Michel (SPO)

Note: OPLA Research Assistants are Mila Dwelley, Roy Lenardson & Bret Preston. Additional SPO and Departmental staff to be assigned.
9102opla

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MAINE STATE LEGISLATIVE COMMITTEE

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COORDINATOR
Capital City Task Force
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63 Waddington Street
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(207) 622-0211

DATE: September 23, 1991

TO: Ms. Bernstein
Mr. Caron

FROM: Hilton Power HP

As Vice Chair of the Maine State Legislative Committee, I want to thank you for this opportunity to present testimony to your Committee.

The Commissions charge is to:

1. Maximize citizen participation in public policy making
2. Use public resources to consolidate and restructure State Government to assure efficiency and cost savings.

These may be contradictory aims. Which aim is paramount?

A general comment first. This Commission, nor any other, is likely to be able to fulfill its mission in the time available. Nevertheless, such a distinguished body is going to be able to point to potential changes which might accomplish its goals. But, because of the complexity of the structures and functions, the Commission's recommendations should be the subject of further in depth study, before such recommendations are enacted or adopted for implementation. This is especially important in view of your goal to maximize citizen participation in public policy making.

With respect to the work of this Committee on Health, Social Services and Economic Security, AARP will wish to examine, in detail and with care, any proposal that would limit access to the Commissioner by the Bureau of Maine's Elderly and Adult Services. Indeed, given the growing number of elderly in the State of Maine for the next two decades, the Committee should consider giving Elderly Services its own Commissioner.

A Second matter on the Commission's agenda deserving careful thought is the charge to consolidate, restructure and streamline advisory groups. Advocacy plays a central role in maintaining citizen participation in public policy making. Consolidation, or elimination of advocacy groups, would reflect adversely upon both legislative and executive branches and create a cacophony

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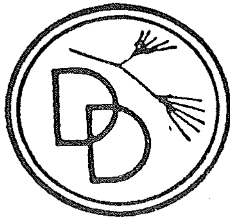
of discordant voices that could bring some aspects of the legislative functions to a halt.

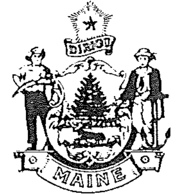
Outside of these two general points there is a need to improve and make accessible information and referral services for all elderly consumers, whether for health, social, supportive income housing or transportation services.

Thank you.



MAINE PLANNING AND ADVISORY COUNCIL ON DEVELOPMENTAL DISABILITIES

State House Station 139, Augusta, Maine 04333
For Persons w/ Disabilities & Families 1-800-244-3990
All others (207) 289-4213



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Vice- Chair

John R. McKernan, Jr.
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Peter R. Stowell
Executive Director

ADVOCACY FOR CHANGE:

FAMILY SUPPORT BELIEF STATEMENTS

In America, over 90% of all children with disabilities live with their families. Children belong with and do best in families. Families are the primary care-takers for children with disabilities. As such, they want to be valued and supported. They are the experts about the needs of their children and their families. They want to be recognized as the primary decision-makers in determining what supports and services that children and families need.

Families have unique and differing needs which change over time. Supports and services available to families need to be flexible and responsive to these differing needs and be available to the total family, not just the family member with the disability. Families need this support from the birth of their children and throughout the life cycle.

Early identification and coordination of services is crucial. Families need one place where they can learn what services are available and receive the help to obtain those services. Families need services and supports that are as close to home and as much a part of the community as possible. In addition, families need opportunities to connect with other families for the purpose of sharing information, support and ideas.

Finally, families, professionals and communities want to be partners in helping families provide the best possible care for the children.

NATIONAL ASSOCIATION OF DEVELOPMENTAL DISABILITIES COUNCILS

1234 Massachusetts Avenue, NW • Suite 103
Washington, DC 20005

SYNOPSIS

Department of Mental Health and Mental Retardation
Family Support Task Force

I. Introduction

The Family Support Task Force was created to educate policymakers on the need for family support services.

II. Family Support

Family supports allow families to support all their members and to participate in everyday activities of community living.

III. Implementing Recommendations

The Family Support Task Force offers its assistance to the Commissioner of the Department of Mental Health and Mental Retardation in addressing the recommendations of this report.

The Department of Mental Health and Mental Retardation should create family support councils consisting of family members of people with disabilities.

The Department of Mental Health and Mental Retardation should develop principles of service delivery allowing the independence, productivity, and integration into the community of people with disabilities and their families.

The Department should develop comprehensive family support service delivery systems crossing age groups, disability groups, geography and develop consistent policies to support it.

The Commissioner should immediately identify a strategy to implement the Task Force's recommendations.

IV. Priority Recommendations

Information Services-- The Task Force recommends that every family in Maine have access to up-to-date, responsive information services, including specific information about disabilities, programs, entitlements and eligibility requirements.

Respite Care-- The Department of Mental Health and Mental Retardation should offer respite care to every family based on individual family needs.

Family Support Groups-- The Department should encourage the development of family support groups statewide and provide funding assistance for their operation.

V. Additional Priority Recommendations

Health Care-- The Task Force recommends that health insurance coverage be available to people with disabilities and their family members on the same basis as people without disabilities.

VI. Other Recommendations

The Task Force recommends initiatives in the areas of assistive technology, community integration and public awareness, crisis intervention, early intervention/prevention, educational services, family counseling, financial issues, future planning, integrated child care, recreation, self-advocacy, and service coordination.

EXECUTIVE SUMMARY

Department of Mental Health and Mental Retardation
Family Support Task Force

I. Introduction

The Family Support Task Force of the Department of Mental Health and Mental Retardation was formed in November, 1989 to assist the Department to better understand the needs of families who care for their family members with disabilities at home or would provide for their care at home if supports were available. Importantly, the Department viewed families as experts in determining their own needs and wished to hear directly from families regarding these supports that would make a difference in improving the quality of life for all family members. Accordingly, with few exceptions, the membership of the Task Force has consisted almost exclusively of family members. In some cases, even the professionals on the Task Force are parents of children with disabilities. The Task Force has met on a regular basis from its inception to the issuance of this report.

II. Definition: Family Support

Family supports are services which allow families to support all their members and which promote participation in everyday activities of community living. In other words, whatever it takes to enable families with members with disabilities to live full, productive lives just like families without disabilities.

III. What Families Have Said About Themselves

In America, over 90% of all children with disabilities live with their families. Children belong with and do best in families. Families are the primary care-takers for children with disabilities. As such, they want to be valued and supported. They are the experts about the needs of their children and their families. They want to be recognized as the primary decision-makers in determining what supports and services that children and families need.

IV. Comprehensive Family Support System Required

In 1987, by law it became "the policy of the State to provide an efficient, coordinated state-wide system of services to children in need of treatment and their families, including a comprehensive system of family support services, insofar as resources permit." Also in 1987, the Commissioner of Mental Health and Mental Retardation was assigned the duty by law to "provide a comprehensive system of support services for families of children with disabilities." Finally, the 1987 law requires the Department to submit a plan to the legislature every two years in January, including 1991, indicating "the State's progress in assuring the development of an array of family support services to enable families to more adequately maintain their children . . . in their natural homes and communities."

V. Family Support Legislation

L.D. 1481; An Act to Facilitate the Delivery of Family Support Services, was enacted by the 115th Maine Legislature and signed by the Governor. This legislation creates six regional family support councils and a state family support council consisting entirely of people with disabilities and their families to advise the Department of Mental Health and Mental Retardation on family support needs throughout the state. Additionally, this legislation expands the list of family support services which can be provided by the Department assuming it has the funds to provide them. The legislation marks a solid foundation on which to address the recommendations in this report.

VI. Implementing Recommendations

The Family Support Task Force urges the Commissioner of the Department of Mental Health and Mental Retardation to utilize the expertise of the Family Support Task Force and to consider the requirements of L.D. 1481; An Act to Facilitate the Delivery of Family Support Services, as building blocks to address the recommendations in this report. Specifically,

1. The Family Support Task Force recommends that the Department of Mental Health and Mental Retardation create family support councils consisting entirely of family members of people with disabilities to advise the Department on the establishment of a comprehensive family support delivery system and to help plan that system.

2. We recommend that the Department of Mental Health and Mental Retardation develop principles of service delivery which allow the independence, productivity and integration into the community of people with disabilities and their families. Family support services must be community based, family centered, and determined by the family.

3. The Task Force recommends that the Department of Mental Health and Mental Retardation develop comprehensive family support services delivery system which crosses age groups, disability groups, geography, and develops policies which hold together consistently from one bureau of the Department to another and from one location of the State to another.

4. We recommend that the Commissioner of the Department of Mental Health and Mental Retardation, in conjunction with the Task Force, identify an implementation group to strategize responding to the Task Force's recommendations. We recommend the development of this implementation response at once. Families cannot afford to wait any longer.

VII. Priority Recommendations

The following recommendations relating to family support groups, respite care, and information services are offered by the Task Force as priority recommendations for immediate attention by the Department of Mental Health and Mental Retardation. These priority recommendations are consistently identified by family members of people with disabilities as being of great importance to them. Furthermore, they can be immediately addressed by the Department.

INFORMATION SERVICES

Access to appropriate, accurate, timely information is vital for the well-being of people with disabilities and their families. On the other hand, not having access to the information is costly, not only in terms of time lost or money spent on wasted phone calls, but also because often the window of opportunity to remediate the effects of a specific disability is lost. Family morale suffers, as well, when appropriate services cannot be located because families don't know where to turn to find it. The Task Force recognizes the complexity of this topic and proposes no global solutions. However, we are aware of information service models which families have reported as helpful to them. One type is the statewide information service operated by the Maine Parent Federation which responds to more than 3,200 contacts from families annually. This program, called SPIN, is designed to focus on the informational needs of families of people with disabilities. The second widely endorsed model is represented by York County Parent Awareness, a program in southern Maine, managed by family members of people with disabilities, designed to provide basic information services to parents as well as connecting them with each other for further informational, emotional or resource support.

RECOMMENDATION:

The Task Force recommends that every family in Maine have access to up-to-date, responsive information services, including specific information about disabilities, programs, entitlements and eligibility requirements.

The Task Force concurs with the finding of the Developmental Disabilities Council's Family Contribution Study which identified information services as families top-rated need. This conclusion has been confirmed as well by the Council's Consumer Satisfaction Survey and an information survey conducted by the Department of Education. It is imperative that the Department address this need constructively.

ADDITIONAL RECOMMENDATIONS:

1. The Department of Mental Health and Mental Retardation should install a toll-free number to guide families to appropriate information sources.

2. The Department should use electronic and print media to inform families of the availability of a central information and referral source.

3. Parents and people with disabilities should help develop and manage any new information and referral systems.

4. The Task Force advises that any information service system needs to assure appropriate responses to families through caring followup inquiries to them to ascertain that they have received appropriate and useful information.

RESPITE CARE

Respite care is an essential element in family life, preventing needless family trauma, helping to avoid family crisis, and providing renewed care-giving energy. Families of people with disabilities are strong and

dedicate themselves to meeting the needs of all their family members, including the person with disabilities. Like all of us, however, families need to get away to refresh themselves. Without respite care, this is often not possible for families of people with disabilities since trained care-givers familiar with the needs of the family are often not available. The Department's Respite Care Program has made a difference in the lives of hundreds of Maine families by providing them with breaks from family care. Funds are limited, however, and many other families go without and rely upon the kindnesses of friends, neighbors, and relatives for such services when they're available at all. To maintain family health, respite care must be available to all families of people with disabilities in such amounts as allow the family to maintain the health, safety, and well-being of all its members.

RECOMMENDATION:

The Department of Mental Health and Mental Retardation should offer respite care to every family based on individual family needs.

ADDITIONAL RECOMMENDATIONS:

1. To promote the well-being of all family members, respite care should be available without cost to families regardless of income.

2. The amount, type and frequency of respite care provided to families must be flexible enough to meet their ever-changing family needs.

3. Respite care should be offered to families on a planned, scheduled, predictable or even emergency basis, but not used as crisis intervention. Similarly, crisis intervention should not be offered to families as respite care.

4. The Family Support Task Force recommends that all the Department's respite care programs be administered by the Bureau of Children with Special Needs' respite unit.

5. The Task Force recommends the continued development of the respitality program on a statewide basis to be available to families regardless of residence.

FAMILY SUPPORT GROUPS

Families learn from each other. Families want to talk to other families who are dealing with similar kinds of family situations as they are. Exchanging ideas, lending emotional support, or guiding other families to useful resources are all important functions of family groups. Many families have reported that their primary source of emotional support comes from these groups. The Task Force has observed a dramatic increase in the number of family groups in the past two years. Many of these are informal groups, meeting regularly to conduct their business. Many have developed programs to bring information to the group through speakers, videos, print material, etc. However, most groups have little opportunity to access funds to actualize these programs.

RECOMMENDATION:

The Department of Mental Health and Mental Retardation should encourage

the development of family support groups statewide and provide a small amount of funding for their operation.

ADDITIONAL RECOMMENDATIONS:

1. Training and technical assistance funding should be available through the Department of Mental Health and Mental Retardation for the development of local family support groups and the enhancement of existing groups statewide.

2. The Department should develop a capacity to organize groups for siblings, fathers, grandparents, adoptive families and other family members of people with disabilities.

VIII. Additional Priority Recommendation-- Health Care

Families of people with disabilities have consistently identified health care coverage as important to them. The Task Force recognizes that health care coverage is the emerging social issue for the 1990's. We recognize that the Department of Mental Health and Mental Retardation does not carry primary responsibility for shaping public policy regarding health care. However, we believe that the Department should begin to equip itself with the requisite knowledge and skills to participate as an active partner concerning health care coverage for its constituencies, including people with mental illness, mental retardation, autism, special needs and their families.

HEALTH CARE

The Task Force believes that quality health care is the right of all people, including people with disabilities and their families. Unfortunately, our experience has been that people with disabilities are often denied health insurance completely, assigned to high risk pools with higher co-payments, deductibles and higher premiums, and as a result are often dependent upon public health insurance such as Medicaid. Such dependency guarantees that families must remain poor to maintain this coverage since Medicaid is an income eligible program. Our belief is that families of people with disabilities often find any health insurance vehicle they can and hang on to it as long as possible, always in fear that a change in their income, marital status, or health of family members could jeopardize their coverage.

RECOMMENDATION:

The Task Force recommends that health insurance coverage should be available to people with disabilities and their family members on the same basis as people without disabilities. We recommend further that the Department of Mental Health and Mental Retardation become knowledgeable about barriers affecting families inabilities to obtain or maintain health insurance and of alternatives to the present health care coverage system.

ADDITIONAL RECOMMENDATIONS:

1. Continue to implement the Maine Health Plan with inclusion of people with disabilities and their families.

2. The Department of Mental Health and Mental Retardation should advocate with the federal government to remove deeming from Medicaid policy for families with children with disabilities under the age of twenty-one.

3. The Department of Mental Health and Mental Retardation in conjunction with advocacy groups should monitor recent legislation requiring health insurance companies to provide coverage to people with disabilities after a one-time exclusion for pre-existing conditions.

IX. Other Recommendations

ASSISTIVE TECHNOLOGY

The Department must develop the capacity and resources to make assistive technology available to families to assist in the activities of daily living in order to promote greater independence, productivity, integration into the community and increased contributions to society.

COMMUNITY INTEGRATION & PUBLIC AWARENESS

The Department of Mental Health and Mental Retardation should undertake state-wide public awareness efforts to increase community support of people with disabilities and their families.

CRISIS INTERVENTION

The Department of Mental Health and Mental Retardation should offer crisis intervention services to people with disabilities and their families throughout the life-cycle of the family member until the family support system has been fully developed.

EARLY INTERVENTION/PREVENTION

The Task Force recommends that the Department of Mental Health and Mental Retardation, in conjunction with Child Development Services and the Department of Human Services, define its role in early intervention/prevention services in such a way that children with disabilities and their families receive needed early intervention services. Early intervention can also mean provision of needed services to a person with disabilities at the earliest possible moment. Such intervention can reduce the effects of a disability, prevent further deterioration, and lead to a more favorable prognosis.

EDUCATIONAL SERVICES

In conjunction with the Department of Education, the Department of Mental Health and Mental Retardation should assure that families with disabilities have access to advocacy and educational services throughout the child's school years.

FAMILY COUNSELING

The Task Force recommends that the Department of Mental Health and Mental Retardation develop the capacity to offer families a full range of counseling services.

FINANCIAL ISSUES

Families should be offered additional financial supports to obtain services and purchase items important to them in raising a family member with a disability at home.

FUTURE PLANNING

The Task Force recommends that the Department of Mental Health and Mental Retardation establish the capacity to provide families with planning for people with disabilities. Planning should address services addressed in this report and should be available to families at all times but especially during significant transition points: birth, entrance into preschool services, entrance into the school system, change of schools, graduation and community living.

Future planning should address residential services, vocational services, transportation, personal care assistance, financial planning, recreation and leisure services, family planning, genetic counseling, continuing education, respite care, self-advocacy, service coordination, legal planning, and wills, trusts and guardianship.

INTEGRATED CHILD CARE

The Task Force recommends that integrated child care opportunities for children with disabilities be available at no increased cost or inconvenience for families.

RECREATION

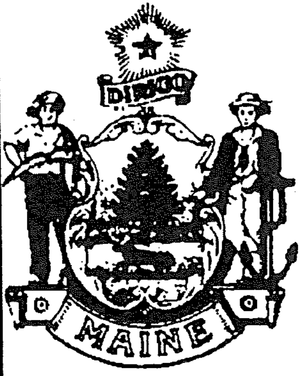
The Department of Mental Health and Mental Retardation should assure that people with disabilities and their families receive opportunities for recreational and leisure activities at the local level in programs which are also available to people without disabilities.

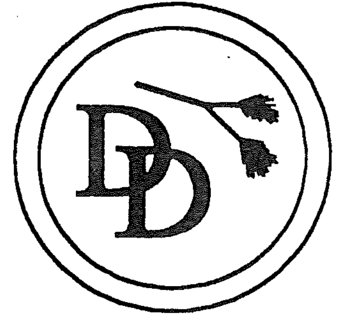
SELF-ADVOCACY

The FSTF recommends that the Department of Mental Health and Mental Retardation, in conjunction with advocacy and self-advocacy groups, make available self-advocacy training opportunities throughout the life span of the individual with disabilities.

SERVICE COORDINATION

The Department of Mental Health and Mental Retardation should offer quality, family-focused service coordination services to people with disabilities and their families to address both the present needs and the future of the person with a disability and other family members.





1992 - 1994

THREE YEAR STATE PLAN

Maine Planning & Advisory Council on Developmental Disabilities
State House Station #139
Augusta, Maine 04333
(207) 289-4213 or
1-800-244-3990

FAMILY BELIEF STATEMENTS

What is family support?

Families with members with disabilities contribute much to the economic health and social fabric of the state, improving the quality of life for all Maine families. Family support recognizes and respects the primary role of the family in the lives of family members. It strives to support families in their natural roles by building upon their unique strengths as individuals and families. It promotes normal patterns of living at home and in the community, maintains family unity, and reunites families with members who have been placed out of the home.

Family supports are needed throughout the lifespan of the individual with the disability. Family needs change over time, thus family support must be flexible and responsive to the uniqueness of individual families.

Family members with disabilities have preferences and personal aspirations to live and work, to learn and grow, and have relationships just as others in the community.

Family support embraces the right of families to make choices based upon individual family preferences. Families must be viewed as making significant public policy contributions to the choices offered by the family support system.

Family supports should maximize the family's control over the services and support they receive.

Families need opportunities to connect with similar families for the purpose of sharing information, support, and ideas.

Family support will help friends, neighbors, and citizens to better understand, accept and include people with disabilities and their families in community activities.

Family support recognizes that families are the experts and primary decision makers about their children with disabilities. They are the constant in their child's life while the service system and personnel within those systems change.

All children, regardless of disability, belong with families and need enduring relationships with adults.

Families must receive the supports necessary to care for their children with disabilities at home.

Family support embraces the right of adults to define their own family.

COMMUNITY INCLUSION BELIEF STATEMENTS

What is community inclusion?

Community inclusion is a basic human right, reflecting our society's long-standing belief in democratic ideals. Community inclusion recognizes and respects the rights of all people to be included in all aspects of community life. It recognizes that people with disabilities, like all citizens, need the same access to community resources because the community greatly influences a person's development, learning, and contributions to society. Community inclusion recognizes that all people need to be involved in activities which confirm their sense of worth as full and complete members of society.

Our focus should shift from people being in the community to being part of the community.

The unity and well-being of the community requires its attending the needs of all its members. Community inclusion means celebrating the gifts and capacities of all people as community members.

People are more satisfied when they have choices and can act on their wishes and needs according to their own values and preferences.

People need and seek the acceptance, recognition, and respect that come from satisfying relationships. For children, friendships need to be promoted. For adults, relationships must be freely entered into.

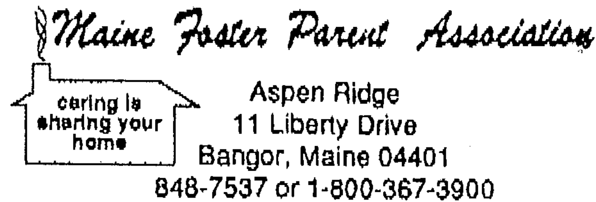
People should be informed of and have the opportunity to act on all the rights and duties of citizenship.

With the experience of being part of the regular classroom, students can learn the academic and social skills needed to succeed in the real world after they leave school.

People should have choices about where in the community they prefer to live and have the right to decide which housing most closely matches their preferences.

Work is a life activity through which an adult person's life experiences, satisfactions and self-esteem are significantly defined. People with disabilities should fully and equally participate in the work force.

Physical accessibility, technology, and transportation are inseparably linked to community inclusion. They must be available to people with disabilities and their families.



Aspen Ridge
11 Liberty Drive
Bangor, Maine 04401
848-7537 or 1-800-367-3900

September 19, 1991

To Members of the Committee on Health, Social Services and Economic Security:

The Maine Foster Parent Association feels strongly that the formation of a Department of Child and Family Services is in the best interest of children, families and the State of Maine. We urge that prevention and early intervention be the goal and that this be reflected in the mission of this new Department by the directive to screen families into the system upon referral rather than out as is presently the case.

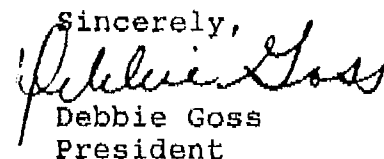
Regarding items seven and eight from "options under discussion", it seems ideal to us that a family be assigned one worker, responsible for assessment of that family's needs who would also continue to function as broker and advocate for that family. This family caseworker would design, coordinate and oversee an individualized plan which would neither neglect nor overlap services essential to that family's well being. This would be of benefit, not only to the family which would have an ongoing relationship with one person but for social workers whose present compartmentalized view of his or her client limits intervention options.

Given the large percentage of state wards who are adjudicated we would also urge that existing information from the Department of Corrections be incorporated into a central information and intake system and the formation of a family court be considered.

As the largest single provider group to state wards, Maine Foster Parent Association expects to work closely with the committee charged with the development of regional boards which would plan and implement appropriate services for Maine's children.

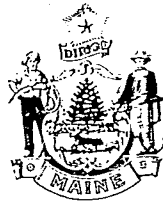
We thank you for this opportunity to express our opinions and concerns and look forward to an interactive relationship with this and future committees.

Sincerely,



Debbie Goss
President

John R. McKernan, Jr.
Governor



Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

To: Paul Saucier, Legislative Council
Joyce Benson, State Planning Office

From: Peggie Dore, Administrative Secretary

Date: September 12, 1991

It is my understanding that the Government Restructuring Committee has requested the attached information. Enclosed are copies for the Committee members.

Please call me at 289-2546 if I can be of further assistance.

State House Station 11, Augusta, Maine 04333 — *Offices Located at* 221 State Street
Telephone: (207) 289-2736

Access Commission
Adaptive Equipment Loan Fund
AFDC Advisory Council
AIDS Patient Services
Androscoggin County Child Abuse & Neglect Council
Bath/Brunswick Child Abuse & Neglect Council
Bridgton Task Force on Child Abuse & Neglect
Brunswick Scan Committee
Certificate of Need Advisory Committee
Child Development Services Board
Child Welfare Advisory Committee
Children's Residential Treatment Committee
Commission on Nursing Supply and Availability
Committee on Transition
Cumberland County Child Abuse & Neglect Council
Developmental Disabilities Council
Division for the Blind & Visually Impaired Advisory Council
Division of Deafness Advisory Committee
Down East Community Hospital Scan
Drug Utilization Committee
EMMC Scan
Franklin County Child Abuse & Neglect Council
Governor's Commission on Supported Employment
Governor's Commission on Domestic Abuse
Hancock Child Abuse and Neglect Council
Health Policy Advisory Council
Home Health Advisory Committee
Juvenile Justice Advisory Group
Kennebec County Child Abuse & Neglect Council
Knox County Child Abuse & Neglect Council
Lincoln County Child Abuse & Neglect Council
Maine Committee on Aging
Maine Health Policy Advisory Committee
Maine High Risk Organization Board
Maine Human Development Commission
Medicaid Advisory Commission
Mid Maine Medical Scan Committee
Miles Memorial Hospital Scan Team
Oxford County Child Abuse & Neglect Council
Penobscot Child Abuse and Neglect Council
Piscataquis Child Abuse and Neglect Council
Project Search CDS Local Coordinators Committee
Refugee Advisory Council
SCAN
Somerset County Child Abuse and Neglect Council
Somerset County Child Development
Southern Maine Child Development Center
State Independent Living Council
Victim's Rights Commission
Waldo County Child Abuse and Neglect Council
Waldo County Child Development Services
Washington Child Abuse and Neglect Council
York County Child Abuse & Neglect Council

Briefing Memo

To: Rollin Ives, Commissioner

Through: Deputy Commissioner - Programs [ ] Finance [ ]

From: Jamie P. Morrill, Assistant Deputy Commissioner

Subject: Time/Costs of DHS Advisory Committees

Date: February 11, 1991

Issue Activated By:

Request by Commissioner

Background:

This Department expends an enormous amount of resources, both case and staff time, to participate on, staff or fund Advisory Committees. This expenditure of resources has more recently come to light as all DHS programs are prioritized due to budget constraints. To get a more accurate picture of the resources expended, Bureau Directors were asked to list the various advisory committees in which staff are involved, and approximate the costs of that involvement. The survey results are as follows:

Highlights:

Bureau	# of Committees	DHS Cost to Staff	DHS Cost to Participate	DHS Funds	Total DHS Cost	Other Funds (Approx.)
BOR	8	$10,280	$ 6,600	$24,000	$40,880	$ 70,400
BIM	1	-0-	-0-	$21,000	$21,000	-0-
BEAS	6	-0-	$ 5,800	$66,000	$71,800	$307,200
BC&FS	115*	$24,855	$70,024	unknown	$94,879	$868,000
OPRD	7	$14,539	$ 1,674	$ 600	$16,813	$356,000
BOH	40	$33,590	$25,102	$13,254	$71,946	$ 24,000
BMS	7	$10,790	$ 6,929	$ 8,475	$26,194	$ -0-
Total	164	$94,054	$116,129	$133,329	$343,512	$2,259,000

*Approximately 20 of these Committees are already counted in other Bureaus.

Of these 164 committees, 52 are required by either state or federal statute and are as follows:

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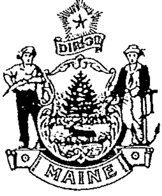

MAINE COMMISSION ON MENTAL HEALTH

State House Station 153 - Augusta, Maine 04333
(207) 626-3018

David Gregory, Esq.
Chair
Ruth Cumler
Vice Chair

Lelia Batten
Merrill R. Bradford, Esq.
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Carol Stewart
Janet Stratton, Esq.
Sallie Tarbell
Malcolm Wilson

Reid S. Scher
Executive Director

September 20, 1991

Comments of the Maine Commission on Mental Health

In Response to the Interim Report of the

Committee on Health, Social Services and Economic Security

1) The Commission believes that the committee's initial findings identify important issues and provide a good foundation for its work with one exception. Finding 6. notes that confidentiality requirements may deter system coordination. While these protections may create inconvenience, we would strongly recommend that such requirements not be weakened, given the nature of the information that is a part of the therapeutic process and the harm that can come to the client from the dissemination of the information. excepting emergencies, it should be the right of the client to control the circulation of confidential information.

2) Regarding the options under discussion, which seem to revolve around the creation of a Department of Child and Family Services and a Department of Physical and Mental Health, the Commission would make the following points:

a) There are benefits to be gained from the creation of a Department of Physical and Mental Health, which include the closer coordination of rehabilitation services with mental health services, the potential for the elimination of obstacles created in the administration of the Medicaid system to the development of the mental health system and the potent al for greater access to appropriate and needed physical health services for persons with mental illness.

b) There are great concerns that the mental health system and services will be a greatly reduced priority in a department that includes the large and extremely physical health bureaucracies. The Commission would stress the need for continuing independent oversight and advocacy as a means of maintaining needed and appropriate focus on mental health at the policy making levels of government.

c) Option 11. calls for the grouping of overlapping and closely related services in one department or agency. Along these lines, the Commission is very concerned that, by grouping mental health with physical health, the medical model of mental health care will come to predominate, as opposed as to the psychosocial rehabilitation and other models closer to social service delivery models. There is a close relationship between services currently provided by the Department of Human Services and the mental health service system, such as alcohol and substance abuse services, protective services and a variety of benefit and economic security services. The Commission's concern is that such a configuration, with the stated principal of grouping closely related services, would ultimately drive a wider wedge between these systems by virtue of their continued separation.

d) Several members express concern that the treatment orientation of the Bureau of Children With Special Needs will be lost in the vast protective bureaucracies with which it will be combined. We would strongly urge that the integrity of children's mental health services be maintained in this reconfiguration.

3) The Commission notes that the interim report gives little consideration to the role of the private sector in the restructured departments. We would point out that the private sector already carries much of the load of service delivery through contracted services. We would urge consideration of the role of the private sector in the changing system. Regional coordination would have an impact on the private sector and create the potential for greater changes in this relationship. The Government Restructuring Commission has an opportunity to make a reasoned contribution to this changing relationship and we would urge that this be taken into consideration in your deliberations.

These comments represent the major issues identified by the Commission in consideration of the interim report. The Commission wishes to congratulate the committee for having accurately identified many of the major problems afflicting the system and for laying the groundwork for a series of positive, corrective actions. We remain available to provide whatever input you might wish.

Joyce
pay 2

John R. McKernan, Jr.
Governor

Lynn Wachtel
Commissioner

Leonard Dow
Director of Community Development

Department
of

ECONOMIC AND COMMUNITY DEVELOPMENT
OFFICE OF COMMUNITY DEVELOPMENT

MEMORANDUM:

TO: Special Commission on Governmental Restructuring
Committee on Health, Social Services and Economic Security

FROM: Margaret Marshall, Chair *Margaret Marshall*
Interagency Task Force on Homelessness & Housing Opportunities

RE: Interim Report

DATE: September 20, 1991

##

On behalf of the Interagency Task Force on Homelessness and Housing Opportunities I submit the following comments on the interim report.

<u>Section III - Initial Findings:</u>

The Task Force concurs with all findings identified in the Interim Report.

<u>Section IV - Options Under Discussion:</u>

The Task Force, at the request of the Committee, limits our comments to the following options as priorities.

<u>Option 7:</u> Develop a central information and intake system for all services.
<u>Comments:</u> This would provide the "One Stop Shopping" recommended by the Task Force in the report "By Sundown" submitted to the committee.

Option 8: Create a unified case management system for families with primary responsibility vested in a single lead agency.

Comments: Again, the focus is on the "One Stop Shopping". After the initial call the client is referred to an agency to develop a program for that person or family and take on the responsibility of assuring that the client is being served. "If you don't get help, call me back." (Page 13, By Sundown report.)

Option 11: Group overlapping, duplicating, and closely related services, and locate each group in one department or agency.

Comments: This option would eliminate the need for the client to go from one agency to another. It would eliminate the fragmentation of services.

Option 12: Regardless of the configuration of State agencies, raise the coordination and collaboration to priority status. Provide a strong interdepartmental coordinating mechanism with authority to mediate disagreements.

Comments: A Board or Commission established with a office and staff support at the Executive level to ensure that coordination and collaboration would take place.

Advocating
Self Help & Self Reliance
For Maine Citizens

MCAA

132 STATE STREET, P.O. BOX 5402, AUGUSTA, MAINE 04332-5402 (207) 622-5838 FAX (207) 622-0314

To: Committee on Health, Social Services, and Economic Security

From: Dana Totman, President

Subject: Government Restructuring

Date: September 19, 1991

The Maine Community Action system is a statewide service delivery mechanism for providing services to low income families and individuals. Our system serves 100,000 different Maine families annually. We maintain 22 full time offices, all which provide intake, information, referral and various programmatic services. Additionally, we provide these same services at over 100 itinerant sites. Collectively we have approximately 1300 personnel delivering 75 million dollars of services and programs to Maine's families. Our funding comes from nearly all state departments. We deliver education, health, energy, housing, transportation, employment, income transfer, case management, economic development, volunteer, nutrition, and advocacy related services.

Our system is comprised of eleven community based organizations. In some capacity we serve each of the eleven consumer groups identified by the committee. With this as a background I'm sure you'll agree our interest in this committee's work is very great. We could provide lengthy and detailed comments on each of the 19 options. We will, however, limit our comments to three general recommendations and one specific recommendation.

1. We suggest you approach the restructuring from the perspective of two consumer groups: people with mental or physical disabilities or problems and people with economic or social problems.

2. We suggest you promote the State's ability to plan, contract, monitor and track social service programs.

3. We recommend that you promote the abilities of community based organizations to provide programs and services which are effectively coordinated and easily accessible.

4. We offer specific recommendations related to option four should you eliminate the Division of Community Services. These comments are attached in the form of a recent letter to the governor.

Again we are very interested in the work of this commission and would be pleased to share information and ideas as you proceed. Thank you.

File / MCAA Bob

Advocating
Self Help & Self Reliance
For Maine Citizens

132 STATE STREET, P.O. BOX 5402, AUGUSTA, MAINE 04332-5402 (207) 622-5838 FAX (207) 622-0314

August 30, 1991

The Honorable John R. McKernan, Jr.
Governor of Maine
State House Station #1
Augusta, Maine 04333

Dear Governor McKernan:

The recent resignation of Nicola Kobritz as Director of the Division of Community Services, and the legislation currently on your desk which would abolish the Division, prompt me to write on behalf of the member organizations of the Maine Community Action Association to share our thoughts. Our ten agencies serve 100,000 Maine families annually and provide the delivery mechanisms through which several Division programs reach Maine people.

I am not writing to influence your decision regarding the Division itself. Our interest is in the future of three specific programs currently administered by the Division. If you choose to sign L.D. 1768, currently on your desk, or to otherwise transfer any of these three programs to other administrative units, we would like you to be aware of our thoughts.

<u>We recommend the fuel assistance program be transferred to the Maine State Housing Authority for the following reasons:</u>

1. The weatherization program and fuel assistance are very closely aligned. One grant provides funds for both programs. One application form provides access to both programs. One plan is written that outlines both programs. The community action agencies deliver both programs. Because the Maine State Housing Authority administers weatherization, any alternate administration of fuel assistance would fragment the two programs. We feel that the LIHEAP Block Grant should be administered by one agency, should have a plan written by one agency, and should have a one stop application process.

2. The community action agencies are all currently delivering programs through contracts with MSHA. The relationship between MSHA and the agencies is excellent. This relationship will allow a smooth transition of LIHEAP as existing contracting and reporting systems can be used with minimal programmatic disruption.

3. The individual with the most expertise and experience administering the LIHEAP program, George Bates, is now the Director of Energy Programs for MSHA. With federal funding uncertainties and delays, George is the person best prepared to effectively manage LIHEAP in difficult times.

4. The LIHEAP program is consistent with other MSHA programs. Heating costs are a very significant piece of overall housing costs in Maine. Rental subsidies, housing rehab, furnace repair, low income housing are all MSHA programs with similar purposes to LIHEAP.

5. The data associated with the LIHEAP program can be invaluable information for housing research and planning. The MSHA will have information on 60,000 Maine homes including age, cost, type, occupancy level and condition. This data will assist with future MSHA planning efforts.

6. The MSHA has significant experience operating programs that have financial assistance go to third parties on behalf of low income citizens. In home loan programs the funds go to banks, in home repair programs the funds go to contractors and in rent subsidy programs funds go to landlords. Similarly the LIHEAP program requires funds to go to fuel vendors. The third party recipient concept is the same for LIHEAP as for other MSHA programs.

7. Transferring LIHEAP to MSHA will cause the least disruption. The community action agencies maintain over 100 outreach sites for LIHEAP applicants and make over 5,000 home visits to applicants. The agencies provide outreach, eligibility determination, budget counseling, benefit determination, check processing, and vendor payments to each of the 60,000 clients at a cost of only $26. The MSHA is prepared to continue this efficient and effective system.

We recommend the Head Start program be transferred to the Bureau of Child and Family Services within the Department of Human Services for the following reasons:

1. Head Start is a program that serves children and families like the Bureau does.

2. Head Start's nutrition and social services components are directly linked to this DHS Bureau and are directly or indirectly financially supported by DHS funding.

3. The linkage between Head Start and Day care are important elements to the program's operation and common administration of the two programs will enhance the coordination.

4. The Head Start providers all currently receive funds from this Bureau so a relationship is already in place.

We recommend the Community Services Block Grant be transferred to the Department of Economic and Community Development for the following reasons:

1. There are many similarities in the purposes of the Community Development Block Grant program and the Community Services Block Grant program.

2. The Community Services Block Grant (CSBG) program requires a degree of advocacy related to the responsiveness of other state delivered programs. This effort would be greatly compromised if the CSBG program were housed in a department that delivers the same programs being assessed by the CSBG program. The Department of Economic and Community Development provides the appropriate neutrality.

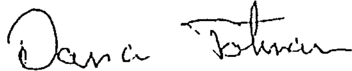
3. The flexibility of the CSBG program provides significant opportunities to develop partnerships and innovative approaches to addressing community problems. The similar flexibility of other DECD programs creates great potential to respond to unique regional needs.

4. The CSBG program and most DECD programs both are essentially coordinated at the state level with programmatic decisions made locally. This state/local relationship is critical for the CSBG program.

The Maine Community Action Agencies have a great interest in the future of these three programs. We recognize that the issues are complex and the decisions on the appropriate agencies to administer them will be far reaching. No one will feel the effect of changes in these programs more than the 100,000 Maine families served by our member agencies. We urge you to consider these recommendations as you determine what actions to take relative to the future of the Division of Community Services. If I or any of the other directors of community action agencies in Maine can be of assistance to you or your staff on these matters, feel free to call upon our services. We share your desire to serve the Maine families who rely on these programs for a better life. I can be reached at (207) 442-7963 if you wish to discuss these issues in greater detail.

Thank you for your consideration.

Sincerely,



Dana W. Totman
President

DWT:psg

MAINE ASSOCIATION OF REHABILITATION SERVICES

P.O. Box 227 - Belfast, ME 04915 - 207-338-2080

PRESIDENT
Harold Siefken
Group Home Foundation, Inc.
Belfast
VICE PRESIDENT
Richard Sprague
MDI Helpers, Inc.
Bar Harbor
TREASURER
Deborah Beam
Tri-County Mental Health Services, Inc.
Social Learning Center
Lewiston
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Central Aroostook A.R.C.
Presque Isle
Cerebral Palsy Center
Portland
Community Support Services
Recource Center
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Bath
Goodwill Industries of Maine, Inc.
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Green Valley A.R.C.
Island Falls
Independence A.R.C.
Brunswick
Ken-a-Set A.R.C.
Waterville
Mobius, Inc.
Damariscotta
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of Penobscot Valley
Bangor
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Bangor
Pathway's, Inc.
Auburn
Pottle Hill, Inc.
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Developmentally Disabled
Portland
Sandy River Rehabilitation Center
Dryden
Sebasticook Farms
St. Albans
Southern Aroostook A.R.C.
Houlton
Sunrise County Handicapped Programs
Machais
The Coastal Workshop
Camden
Wordford's, Inc.
Portland

September 19, 1991

Special Commission on Governmental Restructuring
Committee on Health, Social Services and Economic Security
State House Station #13
Augusta, Me 04333

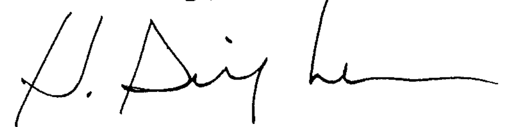
Dear Chairpersons:

I will be unable to attend the hearing on September 20, 1991. However, I am enclosing a copy of a position paper that the Maine Association of Rehabilitation Services developed earlier this year titled Recommendations for Restructuring and Streamline State Government.

This paper represents the position of the membership and was developed by the membership as a whole. As a result, the twenty-five member agencies fully support these recommendations.

Thank you for your consideration.

Sincerely,



Harold Siefken
President

Enc.

March 26, 1991

MAINE ASSOCIATION OF REHABILITATION SERVICES

RECOMMENDATIONS FOR RESTRUCTURING AND STREAMLINING

STATE GOVERNMENT

I. INTRODUCTION

The Maine Association of Rehabilitation Services (MARS), a statewide organization representing twenty-five private non-profit community agencies, makes the following recommendations to assist state government in meeting the needs of people with disabilities while balancing the budget. The recommendations deal with three areas: regulatory issues - cost versus benefit; privatization of services; and restructuring state government. We believe that these recommendations will result in lower cost while sacrificing no program accountability or services to people.

II. REGULATORY ISSUES - COSTS VERSUS BENEFITS

Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP)

A major benefit of MAAP was to have been its ability to improve accountability while concurrently reducing the number of audits (and therefore the cost) conducted in private agencies. It has failed on both counts.

Due to the increased expectations of MAAP, costs for private audits have increased dramatically. Multiple audits of single agencies continue to be the norm and some agencies are experiencing delays of several years until state auditors can schedule them.

MARS RECOMMENDS THAT THE JOINT STANDING COMMITTEE ON APPROPRIATIONS AND FINANCIAL AFFAIRS SOLICIT TESTIMONY ON MAAP'S EFFECTIVENESS AND, AS A RESULT, CONSIDER ITS RESTRUCTURE OR ELIMINATION.

Residential Facility Licensing, Handicapped Accessibility Regulations, ANSI Fire and Life Safety Codes, and related standards

These standards, as promulgated by the Bureau of Mental Retardation, Department of Mental Health and Mental Retardation, Bureaus of Rehabilitation and Medical Services, Department of Human Services, State Fire Marshalls Office, Department of Public Safety, have created a myriad of conflicting expectations for community agencies. Additionally, the state government agencies responsible for these standards and regulations are inconsistent in their application.

This scenario drives up both capital and administrative costs, duplicates efforts among state agencies and often does not result in significant safety or program improvements.

MARS RECOMMENDS THAT THE JOINT STANDING COMMITTEE ON HUMAN RESOURCES SOLICIT TESTIMONY FROM VARIOUS PUBLIC AND PRIVATE AGENCIES REGARDING THE OVERLAPPING AND INCONSISTENT REGULATORY REQUIREMENTS AND TAKE THE NECESSARY STEPS TO STREAMLINE THE REGULATORY PROCESS.

National Accreditation of Private Non-Profit Service Providers

The Bureaus of Mental Health, Mental Retardation and Rehabilitation mandated that all private non-profit agencies be accredited by a national accrediting body, Commission for the Accreditation of Rehabilitation Facilities (CARF) or Accreditation Council on Services for People with Developmental Disabilities (ACDD), by July, 1990 or face a withdrawal of state funding.

MARS upholds the importance of national accreditation standards since the cyclical nature of the process ensures continuous attention to standards of national merit. It is also important that these state agencies recognize that the accreditation process usually results in increased costs to private agencies.

MARS RECOMMENDS THAT:

1. NATIONAL ACCREDITATION CONTINUE TO BE A MAJOR PART OF THE FORMULA FOR ASSURING QUALITY OF SERVICES AMONG PRIVATE PROVIDERS AND AGENCIES IN THE COMMUNITY.

2. THE THREE BUREAUS INVOLVED IN MANDATING NATIONAL ACCREDITATION, IN COOPERATION WITH MARS AND THE MAINE ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES, SURVEY ALL PARTICIPATING AGENCIES TO ASSESS THE COST OF BRINGING AGENCIES INTO FULL COMPLIANCE WITH THESE NATIONAL STANDARDS BY THE END OF THE 1993 ACCREDITATION CYCLE.

3. THESE STATE AGENCIES EXERT THEIR INFLUENCE ON THE NATIONAL ACCREDITING BODIES TO MINIMIZE THEIR FEES, KEEP REALITY IN THE STANDARDS, AND THEREFORE HOLD DOWN THE COSTS TO THE PRIVATE PROVIDERS AND AGENCIES.

4. ALL PROVIDERS OF SERVICES TO ADULTS WITH DISABILITIES BE ACCREDITED BY ONE OF THE NATIONAL ACCREDITING BODIES. THIS INCLUDES PRIVATE INDIVIDUAL PROVIDERS, PRIVATE NON-PROFIT AND FOR-PROFIT AGENCY PROVIDERS.

III. PRIVATIZATION OF SERVICES

The Maine Association of Rehabilitation Services recommendations in this area deal with four service areas: case management; professional services; institutional services; and advocacy services. We believe that the privatization of these services will result in closer ties to the community in which they are offered, foster more individual choice, create healthy competition, and reduce expense to the taxpayers.

Case Management

Historically, case management has been done by state agency personnel. Given the size of the geographic regions covered, this form of case management frequently results in major decisions being made for individuals with disabilities by people who have little, if any, contact with the consumer. Service is often diluted, lacking in creativity, and expensive.

It is important to note that other states have adopted a private (as opposed to public) case management service delivery system with success.

MARS RECOMMENDS THAT:

1. THE DEPARTMENTS OF HUMAN SERVICES AND MENTAL HEALTH AND MENTAL RETARDATION WORK TOGETHER WITH PRIVATE AGENCIES TO AMEND THE STATE MEDICAID PLAN TO ALLOW THIRD PARTY BILLING FOR CASE MANAGEMENT BY PRIVATE VENDORS.

2. NATIONAL ACCREDITATION STANDARDS BE APPLIED TO THIS SERVICE AND BE A PREREQUISITE FOR MEDICAID FUNDING.

3. THESE STATE AGENCIES AND THE PRIVATE PROVIDERS AND COMMUNITY AGENCIES WORK COLLECTIVELY TO FORMULATE THE CHECKS AND BALANCES NECESSARY TO MINIMIZE "CONFLICT OF INTEREST: OR "VESTED INTEREST". IT SHOULD BE NOTED THAT NO SUCH SYSTEM OF CHECKS AND BALANCES CURRENTLY EXISTS IN THE PUBLICLY OPERATED CASE MANAGEMENT SYSTEM.

Professional services

The goal is to attract and cultivate a broader array of qualified professionals to serve persons who have severe or complex disabilities. Currently, persons with disabilities may go without service altogether as an increasing number of clinicians have significantly limited the number of Medicaid clients they serve.

MARS RECOMMENDS THAT THE DEPARTMENTS OF HUMAN SERVICES AND MENTAL HEALTH AND MENTAL RETARDATION WORK TOGETHER TO RESTRUCTURE THE MEDICAID RATES FOR THESE SERVICES TO ACHIEVE EQUALITY WITH PRIVATE SECTOR AND DEPARTMENT OF EDUCATION RATES.

Institutional Services

Except for persons with disabilities, most health care and long term services are provided in the private sector. Given the tremendous expense and questionable quality of state run services, this denial of consumer choice becomes all the more incredible. It has been repeatedly demonstrated that services provided in state institutions can be provided in a more effective, nurturing and cost effective manner in small community based facilities.

MARS RECOMMENDS THAT:

1. THE JOINT STANDING COMMITTEE ON HUMAN RESOURCES ESTABLISH A TASK FORCE SPECIFICALLY TO ORGANIZE THE INFORMATION, PROCEDURES AND RESOURCES NECESSARY TO SERVE THESE INSTITUTIONALIZED PEOPLE IN THE COMMUNITY.

2. ALL PARTICIPANTS ACKNOWLEDGE THAT BOTH SYSTEMS WILL REQUIRE FUNDING DURING THE TRANSITION PERIOD.

3. COMMUNITY RESOURCES (PRIVATE PROVIDERS, PRIVATE AGENCIES, HOSPITALS, ETC.) BE EQUIPPED WITH THE RESOURCES AND TRAINING NECESSARY TO OFFER CRISIS INTERVENTION AT THE COMMUNITY LEVEL.

Advocacy Services

Currently, advocacy services for adults and children with disabilities are provided by state government through the Office of Advocacy, Department of Mental Health and Mental Retardation and by a private agency, Maine Advocacy Services. The organizational placement of the Office of Advocacy within the Department of Mental Health and Mental Retardation creates a conflict of interest and at best results in a muted voice of advocacy. However, beyond the organizational difficulties, the presence of two agencies providing advocacy services to the same populations is a significant duplication of effort and a waste of the state's limited financial resources.

MARS RECOMMENDS THAT:

1. THE JOINT STANDING COMMITTEES ON HUMAN RESOURCES AND STATE AND LOCAL GOVERNMENT HOLD HEARINGS TO DETERMINE WHAT THE CURRENT NEED FOR ADVOCACY SERVICES ARE AND HOW THEY SHOULD BE PROVIDED.

2. BASED UPON THE TESTIMONY RECEIVED THE COMMITTEES SHOULD TAKE THE STEPS NECESSARY TO ALLOW THE ELIMINATION OF THE CONFLICT OF INTEREST AND DUPLICATION OF EFFORT BY COMBINING THE CURRENT EFFORTS OF THESE TWO ORGANIZATIONS IN A SINGLE PRIVATE AGENCY WITH THE POWERS AND RESOURCES NECESSARY TO BE AN EFFECTIVE ADVOCATE FOR ADULTS AND CHILDREN WITH DISABILITIES.

These recommendations are based on a long-term comprehensive approach to systems change, eventually resulting in cost savings including a reduction in state employees and state operated services.

IV. RESTRUCTURING STATE GOVERNMENT

While most of the comments that follow are directed toward the Bureau of Mental Retardation, MARS does not mean to imply that this is the only portion of state government that could benefit from restructuring.

MARS has identified several problem areas in the current organization structure of the Bureau of Mental Retardation: inconsistent regional operations, no apparent coordinated planning, lack of a clear mission, their authority is not commensurate with their responsibility for services to their clientele, no capability for research and development, and inadequate central office staffing.

MARS RECOMMENDS THAT:

1. THE BUREAU OF MENTAL RETARDATION ENGAGE IN A PLANNING PROCESS WITH PRIVATE SERVICES PROVIDERS TO REVISE ITS MISSION AND NARROW ITS FOCUS TO REFLECT THE CAPABILITIES OF THE CURRENT COMMUNITY SERVICE DELIVERY SYSTEM AND THE NEEDS OF ITS CLIENTS.

MARS believes that with a revised mission and a narrowed focus, the regional office structure, as it is currently organized, can be eliminated.

2. THE RESPONSIBILITY AND AUTHORITY FOR THE ICF/MR, TITLE-XIX DAY HABILITATION AND REASONABLE COST REIMBURSED BOARDING CARE PROGRAMS BE MOVED FROM THE DEPARTMENT OF HUMAN SERVICES TO THE BUREAU OF MENTAL RETARDATION.

This would eliminate the current problem of the Bureau of Mental Retardation having the responsibility for ensuring services to people with mental retardation without having the authority to manage a majority of the funding that pays for the services

3. THE JOINT STANDING COMMITTEE ON STATE AND LOCAL GOVERNMENT SOLICIT TESTIMONY ON THE ORGANIZATIONAL PLACEMENT OF THE BUREAU OF REHABILITATION WITHIN STATE GOVERNMENT AND THE PRIVATIZATION OF MANY OF THE SERVICES THAT THE BUREAU OF REHABILITATION NOW PROVIDES AND TAKE THE STEPS NECESSARY TO MAKE THESE CHANGES POSSIBLE.

Currently, the Bureau of Rehabilitation, due to its relatively small size, is lost within the organizational structure of the Department of Human Services. Many of the previous statements and recommendations regarding the Bureau of Mental Retardation also apply to the Bureau of Rehabilitation since many of its direct services could be or are already being delivered by private providers.

While we have referenced individual legislative committees in our recommendations we recognize that multiple legislative committees will have a joint role in restructuring and streamlining state government and the services it provides.

September 19, 1991

Special Commission on Governmental Restructuring
Committee on Health, Social Services and Economic Security
State House Station #13
Augusta, Me 04333

Dear Chairpersons:

I will be unable to attend the hearing on September 20, 1991.

I am a member of the Govenor's Commission to Analyze the Service Delivery System for Persons With Mental Retardation and Co-Chair of the Employment and Residential Services Subcommittee. While the Commission has not completed its work yet, I am enclosing a copy of the Report and Recommendations of the Subcommittee for your information.

Thank you for your consideration.

Sincerely,

Harold Siefken

Enc.

Final

June 5, 1991

EMPLOYMENT AND RESIDENTIAL SERVICES SUBCOMMITTEE REPORT AND RECOMMENDATIONS

Members: Ruth Benedict, DHS; Richard Estabrook, DMH&MR; Elizabeth Granthem, DHS; Charlene Kinnelly, Uplift, Inc.; Date Lowe, Green Valley Association for Retarded Citizens, Inc., Co-Chair; James Mehan, Katahdin Friends, Inc.; Betsy Rush, Foster Home Operator; Harold Siefken, Group Home Foundation, Inc., Co-Chair.

The Sub-Committee reviewed the following documents:

Maine Association of Private Residential Providers - Suggestions for a More Efficient State Government

Maine Association of Rehabilitation Services - Recommendations for Restructuring and Streamlining State Government

Medicaid Financing of Services for Maine's Citizens with Mental Retardation: A Follow-up Report

Proposed Rules to Clarify and Extend the Rights of All Persons with Mental Retardation

A Plan for People - Part II

While reviewing these documents, during several meetings, the Sub-Committee had wide ranging discussions about the current state of community service delivery, its problems, the changes in the delivery of services, the problems in delivering services that meet the needs of the entire population of people with mental retardation and how is it going to be done.

Among the many things that were discussed, some key points were raised:

1. there is little substantive disagreement among community service providers or the Sub-Committee members about community integration or the increased emphasis on individualization of service provision;

2. the population of people with mental retardation is composed of four major groups - those currently or formerly institutionalized, those who graduated from public school more than 5 or 10 years ago, those who were never institutionalized, lived at home and whose parents are no longer able to care for them, and those who are ready to or have recently graduated from public school;

3. the service delivery system must acknowledge the differing needs of these divergent population groups;

4. the Bureau of Mental Retardation must develop a research and development capability and assume a leadership role in the service delivery system;

5. if no additional resources are made available then the recommendations of the Plan for People - Part II and other similar plans can not be implemented, except in the most minimal way, while continuing to meet the differing needs of the populations groups described in paragraph 2.

All of the discussions concluded with "Where will the additional money come from to develop and implement the recommendations of the Plan for People - Part II and other similar documents?" Since there are only two ways to make income available - generate more or re-allocate existing money the Sub-Committee offers the following recommendations:

1. That a "pooled-loan" program be developed through the efforts of one or more state-wide provider associations and state government. The purpose of the program would be to offer below market rate financing for capital projects and cash flow loans. If a revolving loan fund for cash flow purposes is not possible through a program of this nature then state government and the legislature should give serious consideration to the establishment of such a fund.

2. That the Bureau of Mental Retardation develop a "research and development" capacity. The central office of the Bureau of Mental Retardation must have additional staff that can be dedicated to becoming experts on state and federal funding issues, federal legislation and regulation, new and innovative funding sources from both the private and public sectors, as well as, the availability of consultants to assist community service providers with programmatic issues and problems. This information is not generally available now and must be to insure a well designed and up to date service delivery system.

3. That a "cost analysis" of current and future rules and regulations be done to insure that the added cost of the regulation are justified and funded by the agency proposing the regulation.

4. That the Department of Mental Health and Mental Retardation should get out of the delivery of direct services - institutional, case management, advocacy, and professional services and concentrate on developing and managing the in-house system necessary to ensure that the resources necessary to deliver the desired services are available and effectively utilized.

5. That the recommendations of the Medicaid Financing of Services for Maine's Citizens with Mental Retardation - A Follow-up Report, especially those dealing with the need to increase the ability of the Department of Mental Health and Mental Retardation to manage a medicaid funded service program, the under utilization of Title - XIX at Pineland Center and the transfer of those parts of the Medicaid program that fund programs for people with mental retardation from DHS to DMH&MR be implemented.

6. That the state institutions, Pineland Center, Elizabeth Levinson Center, Aroostook Residential Center, be fully funded by Title - XIX and the General Fund money currently financing part of these state institutions be used to finance the necessary development and on-going costs of the expanded community service delivery system. The "freed-up" General Fund money (currently there is $10 million in General Fund money in Pineland Center's budget alone) could be used to "seed" Title - XIX programming but the majority should remain "pure" state funds in order to retain the required flexibility to do the innovative programming necessary to meet the needs of the many populations of people with mental retardation.

7. That the Maine Advisory Committee on Mental Retardation monitor the implementation of these recommendations and make quarterly status reports to the Governor, Legislature, and members of the Governor's Commission on the progress of implementation.

Maine Transit Association

Serving the transportation needs of Maine's people from Fort Kent to Kittery

September 18, 1991

Mr. Roland Caron, Co-Chair
Ms. Rosalyne Bernstein, Co-Chair
Special Commission on Governmenal
Restructuring Committee
State House Station 13
Maine State Legislature
Augusta, ME 04333

Dear Mr. Caron and Ms. Bernstein:

On behalf of the Maine Transit Association, I would like to take this opportunity to applaud your efforts in restructuring State Government to meet its citizens needs. The following comments are synthesized from a discussion our association held this past week. I hope the comments are helpful to you and your purpose.

1. I don't think the State of Maine realizes there are a variety of transportation programs which serve the State. There are at least seventeen transportation providers who contract with various bureaus within the Department of Human Services, Department of Mental Health and Mental Retardation and Department of Transportation. All of these contracts with all of these different bureaus are for the same thing - purchasing mobility for Maine's citizens.

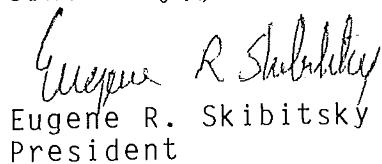
2. The problem above would be relieved by assigning one department/bureau to oversee purchased public/social service transportation contracts with the State. Not only would the operators be relieved of countless hours of bureaucratic paper pushing, but the State could channel personnel resources into areas where they are really needed. The State, by having a single agency responsible for transportation would also cut down on the amount of duplicative services it is buying simply because one agency/bureau would make sure contracts are coordinated. Because various State agencies and bureaus purchase transportation services from a number of private/public agencies the consumer is most often at a loss as to which system to ride.

Androscoggin Valley COG
Aroostook Regional Transportation
Biddeford - Saco - OOB Transit Committee
The Bus
Casco Bay Island Transit District
Community Concepts
Coastal Transportation
Downeast Transportation
Eastern Transportation
Greater Portland Council of Governments
Greater Portland Transit District
Kennebec Valley CAP
Penquis CAP
P.R.O.P.
Regional Transportation Program
Waldo County Transportation
Washington-Hancock CAP
Western Maine Transportation
YCCAC Transportation

3. Presently there is really no technical or regulatory agency responsible for all the oversight which is needed in transportation. There is no single set of transportation safety regulations or source to which operators can go for technical assistance or help in gearing up for the latest technologies.

Transportation services today operate in a vast maze of bureaucratic departments, agencies and bureaus. Some bureaus do not even know that transporation services exist. Both the state and operators are involved in too much paper work; there needs to be a streamlining of the process which can best be achieved by having one department responsible for the purchase of transportation services in the state. That agency would also provide technical assistance to the programs in the field.

Sincerely,



Eugene R. Skibitsky
President

ERS:jh

York County Community Action Corporation
11 Cottage St. / P.O. Box 72 / Sanford, ME 04073

Telephone: (207) 324-5762
324-3928
283-1446
748-1766
247-3665

September, 1991

Rosalyne Bernstein, Co-Chair
Roland Caron, Co-Chair
Special Commission on Governmental Restructuring
Committee on Health, Social Services & Economic Security
State House Station 13
Augusta, Maine 04333

Dear Ms. Bernstein and Mr. Caron,

As a Regional Transportation Agency providing a variety of transportation services under contract with the State, I would like to offer comments on the Committee's Interim Report.

Given the extremely brief time line that you have to work within, I would like to both commend you for the clarity and accuracy of the initial findings of the Committee, and support a number of the options listed in the Interim Report.

<u>Option #9</u> - Elimination of multiple contracting and evaluation is a high priority for YCCAC where we not only have two fiscal years for State contracts (7/1-6/30 or 10/1-9/30), but multiple lengthy, client-specific contracts and monthly or quarterly reporting forms. (Report for our Area Agency on Aging attached.) Tracking of units of service provided requires a computer and two full time staff, for a relatively small amount of contract dollars. These administrative costs wind up reducing the contract dollars available for direct service to target groups.

<u>Option #13</u> - The Bureau of Medical Services currently allows Medicaid providers to electronically submit billings via computer modem. The problem is that it requires more time expenditure (and cost) to the provider, and we are not reimbursed despite potential for major savings by the State. Since transportation providers rates have not been adjusted to reflect acknowledged service cost increases since October 1985, there is <u>no</u> incentive for us to use this more efficient process.

<u>Option #15 & #18</u> - As a provider receiving over 20 different sources of funds, categorical funding is a major issue. Over the last several years as federal and state resources have grown more scarce, and demand for transportation (and other) services has increased, our contracts have begun to use a "triage" type approach: only those Maine residents in the most dire need,

Other Locations:

Head Start Program
P.O. Box U, Wentworth St.
Biddeford, Maine 04005
282-6290

Biddeford Community Action Center
Ross Center, Washington St.
Biddeford, Maine 04005
282-5513

Kittery Community Action Center
Community Center, Cole St.
Kittery, Maine 03904
439-2699

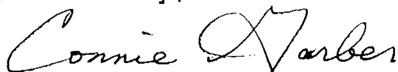
those at risk of abuse, neglect or institutionalization, are targeted for service. The concept of "an ounce of prevention " has been lost. More and more specific requirements are placed on who can be served, and what they can be provided with. Less and less emphasis has been placed on the "health maintenance organization" (HMO) approach to minimizing the seriousness of an individual's problems by early, less costly intervention.

Every year at regional, state and national meetings and Congressional hearings, the issue of lack of access to health care, training, and employment is raised. In a rural state like Maine, even if the best health care network were in place, if a person does not have a way to get to the doctor, the service is of no value. The same is true for elderly wishing to remain in their own homes, handicapped people wanting to get a job for which they have been trained, or a single parent needing to get their children to day care and be free to find employment. If there is no private automobile available, the inadequately funded public transportation system in Maine may be a poor second choice that may be unable to respond to their needs. We will never be in a position where big cities with buses and trains on every corner offer residents a variety of choices on how to get where they need to go. But the lack of a State Transportation Policy to maximize access to services and provide quality, safe transportation (not merely what a Bureau can get for the least amount of money, without regard to licensing, training or safety standards) means that Maine's citizens are looking forward to less and less mobility as dollars shrink.

As a member of the Maine Transit Association (representing public transportation providers throughout the State), I would urge the Committee to consider one fundamental question in your deliberations: If <u>any</u> service is only as valuable as a person's ability to access it, is there a better way to structure all of the services provided by the State? By providing greater mobility through the Regional Transportation Providers, and focusing on community based services in general, I believe everyone will benefit from a "HMO" approach to the growing number of serious problems facing Maine and its citizens.

I would be happy to provide any further information that you might require.

Sincerely,



Connie Garber
Transportation Director

Attachment

Southern Maine Area Agency on Aging 9/13/89

QUARTERLY SERVICE REPORT FORM

YEAR-TO-DATE TRANSPORTATION STATISTICS

SERVICE PROVIDER ____________ REPORT PERIOD ________ to ________

YEAR-TO-DATE UNDUPLICATED PASSENGERS ____________ RESIDENCE

Code	Number
U	______
R	______

YEAR-TO-DATE NUMBER OF PASSENGER MILES ____________

PASSENGER CHARACTERISTICS

1. AGES:

60-64 ______	70-79 ______	90-94 ______
65-69 ______	80-84 ______	95-99 ______
70-74 ______	85-89 ______	100+ ______

2. SEX: Male ________ Female ________

3. ETHNIC ORIGIN:
   a) American Indian/Aleutian ______
   b) Asian Pacific Islander ______
   c) Black, Not Hispanic Origin ______
   d) White, Not Hispanic Origin ______
   e) Hispanic ______
   f) Refused ______

   Total Minority ________

4. ENGLISH SPEAKING ____________ NON-ENGLISH SPEAKING ____________

5. PRIMARY LANGUAGE:

01 ____ French	43 ____ Micmac
02 ____ Spanish	47 ____ Passamaquoddy
04 ____ Am. Sign	54 ____ Russian
14 ____ Chinese	55 ____ Swedish
31 ____ Italian	____ Other
41 ____ Maliseet	

6. POVERTY LEVEL:
   a) 100% or below ____
   Minority ____
   Non-Minority ____
   b) 125% or below ____
   Minority ____
   Non-Minority ____

7. FRAIL/DISABLED: ____________

DEFINITIONS ON THE REVERSE

DEMOGRAPHIC DEFINITIONS

MINORITY ELDERLY: Persons aged 60+ who are either: American Indian/Alaskan Native; Asian/Pacific Islander; Black, not of Hispanic origin; or Hispanic.

FRAIL/DISABLED ELDERLY: Persons aged 60+ having a physical or mental disability, including having Alzheimer's disease or a neurological or organic brain disorder of the Alzheimer's type, that restricts the ability of an individual to live independently.

RURAL ELDERLY: Persons aged 60+ residing in rural areas within the PSA.

For our purpose these cities and towns of 10,000+ will be coded "U" for urban:

Auburn
Augusta
Bangor
Bath
Biddeford
Brunswick
Gorham
Lewiston
Limestone
Lisbon
Portland
Presque Isle
Saco
Sanford
Scarborough
South Portland
Waterville
Westbrook
Windham
York

All other cities, towns and places will be coded "R" for rural.

LOW-INCOME NON-MINORITY ELDERLY: All persons aged 60+ with an annual income at or below the Federally established poverty level, EXCEPT the minority elderly, as defined above.

LOW-INCOME MINORITY ELDERLY: Minority elderly, as defined above, with annual income at or below the Federally established poverty level.

These minority categories are prescribed by and defined in OMB Directive 15, "Race and Ethnic Standards for Federal Statistics and Administrative Reporting, "Statistical Policy Handbook, 1978, U.S. Department of Commerce, Office of Federal Statistics and Standards, P. 37-38.

Maine Association of Substance Abuse Programs Inc.

71 Sewall Street, P.O. Box 5067, Augusta, Maine 04330 207-622-1777

September 20, 1991

TO: Special Commission on Government Restructuring
FR: Maine Association of Substance Abuse Programs
Lynn Duby, President
RE: Partnership for Services

Enclosed please find the MASAP suggestions for creating more responsive governmental structure and policies in order to maximize resources and the provision of needed substance abuse services to Maine citizens.

Yours is an important venture for Maine that could devise improved methods of operating state government . We believe it is essential that your perspective be from the citizens viewing the services of government rather than from the perspective of the government as provider of services. Our comments are intended to reflect the experience of community based agencies in trying to live with state funding, rules and regulations and the effect of these factors on providing services to low income clients. Community agencies are very close to the citizens, and non-profits specifically are controlled locally. Non-profit Human Service Agencies must often be the bridge between state government and its citizens. This role is becoming increasingly untenable with progressively less funding and more regulations. The Partnership between local agencies and state government to the benefit of low income citizens is quickly disappearing.

Please feel free to contact any of the MASAP members for further or more specific information.

Thank you for your consideration.

Coordination of Services for Consumer Access and Cost Savings

Departments develop in response to their sphere of interest, in the process they tend to create procedures and justify their expertise and become myopic in their perspective on clients and services. If there was only one Department this would not necessarily be a problem.All would be represented fairly and evenly based on the competency and openess of the administration. In the real world there are multiple departments each with their own interest, procedures and levels of administrative capabilities. The result is duplicative administrative procedure, competing clients and programs priority and added confusion for all fostered by departmental myopia.

In 1989, the legistature recognizing the extent of this problem in the area of substance abuse , created the Office of Substance Abuse to focus planning, financing and monitoring with a single body of state govermnent. The legislation and structure exist but the administrative leadership has not been forthcoming to effect the change.

For example in 1991, one community based substance abuse agency still has funding from 3 Departments, involving 6 Bureaus (and 6 contract officers) with over 11 state and financial reportin forms and three separate state licenses (with 3 licensing specialis Furthermore, local programs are developed to meet the diretions of all of these competing interests even though the clients are essentially all the same.

The costs are enormous;funding is wasted by State Departments on unneccessary administrative cost at both the state and local levels as well as confusion and lack of services for clients.

With their mandate for action OSA could be the model for structuring state government to reduce cost and improve client services. Without the power, it will only be an example of hollow restructuring of government.

<u>Proposed Resolution to the Problem</u>:

A. <u>Single State Agency for Substance Abuse</u>

The legislature and governor need to insure the leadership to consolidate all budget, planning and contract monitoring with consistent rules and regulations within the Office of Substance Abuse.

Cost Savings:

1. Reduce state contract officer positions
2. Reduce state data processing positions
3. Reduce state administrative positions
4. Reduce local agencies administrative expenses
5. Reduce local agency staff turnover

B. Single State Licensing Bureau

The Legislature needs to consolidate all licensing functions into a single licensing bureau to insure protection of the public good and consistent regulations.

Cost Savings:

1. Reduce state licensing staff
2. Reduce local agency administrative expenses

II. Public - Private Partnership - Economic

In substance abuse services as with many other human services state funds are used to subsidize services to low income clients. These funds are usually matched with local funding sources, client fees, medicaid and donations in order to operate programs.

However, in a five year period (FY 86-87 to FY 90-91) state cost of living increases for existing substance abuse services averaged about 2% per year. This was approximately 10% less than necessary to address inflationary trends. Salaries for substance abuse counselors have, in addition, been historically low (ie, significantly less than equivalent state employee salaries).

At the same time, the various state departments have increased the administrative tasks required (ie, licensing, contracts, reporting, auditing) which have real local costs associated. Staff have to do the paperwork.

It is common in treatment agencies for clinical staff to spend 43-50% of their time on paperwork.

Proposed Resolution to the Problem:

1. Rainy Day Fund

The Legislature should create a rainy day fund to be used for the support of social services in the event of economic downturns.

2. Index Cost of Living Adjustments

Core social services provided by non-profits be automatically built in for COLAS equivalent to the inflation index. State government COLAS are close to automatic whereas community agencies are the last recipients of surplus funds.

III. Public - Private Partnership - Local Input

Although Maine is a small state, state government is too far removed from the realities of local communities to be entirely responsible for the planning services. State departments must be responsible for state wide uniformity without adequate knowledge of the particular complexity of local areas. As a result local non-profits cannot maximize local resources.

Proposed Resolution to the Problem:

1. Regional Social Services Planning Commission

The creation of regional coordination and planning bodies can increase knowledge for effective planning sensitivity to local needs, and involve the unique local resources (ie, business, municipalities, United Ways, volunteers, etc.) to maximize the impact of services.

State government officials often are unable or unwilling to identify efforts funded by non-state resources as a part of the overall continuum of care. The result fo myopically looking at only state funded activity is a distorted view of the system and/or inaccurate approach to planning for overall service delivery.

A NEW VISION: EMPOWERING PEOPLE FOR CHANGE

MAINE'S MODEL FOR UNIFYING STATE SERVICES FOR CHILDREN & FAMILIES

FINAL REPORT OF THE PRESIDENT'S & SPEAKER'S BLUE RIBBON COMMISSION ON CHILDREN & FAMILIES

AUGUST 1991

Printed under appropriation 01094A1001012

DONALD V. CARTER

1927-1990

VISION — CARING
Our Late Colleague: The Epitome of a Dedicated & Caring Person

As Maine and the Nation debated the dilemmas faced by children and families, State Representative Don Carter was one of the first with vision.

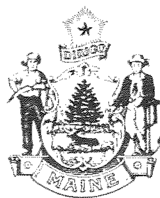
With his customary quiet wisdom, Representative Carter testified on June 7, 1989:

> *"It is especially important that State policy emphasize helping children* ***before*** *a serious problem exists. Today, most state funds and programs offer to help children* ***after*** *a problem exists... All too often we deal with the symptoms of child abuse, juvenile delinquency, or infant mental health. Many kids have problems that come from similar root causes. We must deal with root causes."*

In recognition of Don's life, his service to all Maine citizens, and his caring for children, we dedicate this report to him with our sincere appreciation and deep affection.

We will deal with root causes.

Our thanks to Representative Donald V. Carter.



Charles P. Pray
President of the Senate

John L. Martin
Speaker of the House

114th Maine Legislature
President's and Speaker's
Blue Ribbon Commission On Children And Families
State House Station #155
Augusta, Maine 04333
Telephone (207) 289-2288

August 1991

Hon. Charles P. Pray
President of the Maine Senate
State House Station #3
Augusta, Maine 04333

Hon. John L. Martin
Speaker of the Maine House of Representatives
State House Station #2
Augusta, ME 04333

Dear Mr. President and Mr. Speaker:

We are pleased to submit the report of the Blue Ribbon Commission on Children and Families. This is the product of lengthy discussions, reviews, rewrites, and further deliberations on the part of the members, the staff, and interested parties. We commend the work of those individuals.

This report should be seen as part of a continuing process. The Commission designed a schematic plan, not a detailed plan. We provide a foundation for an appointed Commissioner to use when moving forward into the more detailed ingredients for implementation. The end result should be a more efficient and focused approach to meeting the needs of children with problems, but more importantly, an approach which emphasizes prevention and early intervention as a means for reducing those problems.

Other states which have moved to the separate state agency approach have tended to develop agencies to serve special problem children, adolescents, and their families. The enclosed report outlines an approach which addresses children in general, with a coordinated approach to not only treating already established problems, but to reducing future problems. This is an approach which has the potential to be a national model.

Our major recommendations include the establishment of a Department for Children and Families, a list of existing entities to be transferred into such an agency, a time frame and process for the more detailed planning and implementation phase, a Joint Select Committee of the Legislature to address children's issues, a permanent Commission to assist with monitoring and advising state government, a Family Foundation to support the Department by conducting research current to the needs of children and being involved in training, planning, and advocacy activities, a summary of revenue sources to support a transition to and operation of the Department, and principles and guidelines for its establishment.

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Due to the establishment of the Special Commission on Governmental Restructuring, we have made the assumption that this report will move to that body prior to any legislative action. Therefore, we have not prepared legislation as part of the content of this report. We have printed a number of the enclosed report for distribution, while the more detailed addendum which contains supporting materials will be printed in very limited quantities. It was felt that the cost of printing at this time should be reduced by proceeding in this manner.

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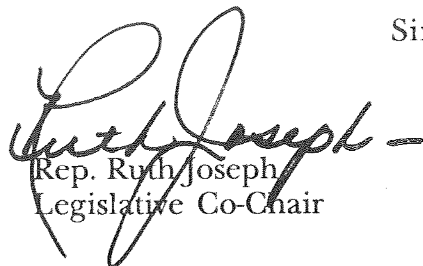

Rep. Ruth Joseph
Legislative Co-Chair

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PRESIDENT'S AND SPEAKER'S BLUE RIBBON COMMISSION ON CHILDREN & FAMILIES

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PROLOGUE

It was difficult to select the basic words and phrases to explain and describe our **New Vision: Empowering People for Change** to help children. It was difficult to concisely describe the culture of Maine, its impact on children and families, the kinds of problems which affect them, and the complex bureaucracies which are intended to help children and families. It was equally difficult to enumerate fundamental principles to guide our model for change. Yet, the Commission firmly believes that with a positive method of implementation, it is possible for the essence of our vision and its language to become the daily approach for helping children.

The Blue Ribbon Commission recommends action to empower people to ensure that children have better opportunities for fulfilling their potential, for people to attain family well-being, and for sustaining society. The Commission found that the following definitions are essential to the foundation for our vision and to understanding easily the language used throughout this report.

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The greatest struggle for the Commission was to agree on terms to describe the problems affecting children and families. We made a conscious decision not to use words that label or stigmatize. The report tries not to use terms such as "delinquent," "substance abuser," or "abused child." We decided not to refer to singular, pigeon hole problems, categorical names for programs, or "brand name" labels for problems.

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2. Conditions

Throughout this report "conditions" is used to refer to any of the multiple problems affecting children and families. Because of our commitment to emphasize positive child development, healthy family functioning, and family well-being we made a conscious attempt to use language which highlights strengths rather than weaknesses. We do not wish to label youngsters or families by phrases that may inadvertently contribute to reinforcing problems, diminishing competencies, or predicting unacceptable performance. By underlining the positive, we do not want to confuse.

The conditions to which we refer include a variety of problems which can negatively affect children and families including those listed in the next paragraph. The Commission believes that the following conditions do negatively impact children and deserve the attention of the State:

> *Poor pre-natal care, infant deprivation, early childhood problems, pre-school handicaps, alcoholism, low aspirations, adult or child abuse and neglect, drug abuse, family problems, childhood health handicaps, juvenile delinquency, mentally ill children, emotionally disturbed youth, mentally retarded youngsters, kids in poverty, school dropouts, special education conditions, special needs, spousal abuse, truancy, teen pregnancy, teen suicide, and a host of other matters related to the essential components of child development or other human problems.*

The Blue Ribbon Commission was charged with preparing legislation to implement its recommendations for establishing a department to have unified responsibilities for offering functionally integrated services. This task was delayed because of the current debate about the roles and responsibilities of government and by the current fiscal crisis. We offer our recommendations for unified services and the reduction of duplication and fragmentation. We also recognize that the significant consolidation and functional integration we propose to attain through reorganization must be carefully timed and planned to fit into other policy and restructuring proposals. Therefore, the Blue Ribbon Commission has not included draft legislation in this report. We respectfully urge the Governor and the Legislature to fully implement our recommendations in a prudent and timely manner of their choosing.

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We acknowledge the diligent and extended work done by members of the Blue Ribbon Commission. Commission members possess broad, in-depth knowledge and comprehensive practical experience. Their greatest strength was in outlining the essential components of child development and the fundamental necessity of describing a new vision for empowering people to change Maine's services for children and families. The greatest gift the members offered Maine's citizens is their unrelenting commitment to challenge government, society, and themselves to better fulfill responsibilities for children.

Our very special appreciation goes to the panel of editors, professional and support staff who contributed to this report. They unselfishly invested productive ideas and many uncompensated hours far beyond the call of duty to assure a successful conclusion of the Blue Ribbon Commission's endeavor.

Executive Summary

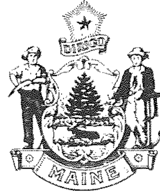
A NEW VISION: EMPOWERING PEOPLE FOR CHANGE

MAINE'S MODEL FOR UNIFYING STATE SERVICES FOR CHILDREN & FAMILIES

FINAL REPORT OF THE PRESIDENT'S & SPEAKER'S BLUE RIBBON COMMISSION ON CHILDREN & FAMILIES

AUGUST 1991

Printed under appropriation 01094A1001012



Charles P. Pray
President of the Senate

John L. Martin
Speaker of the House

114th Maine Legislature

President's and Speaker's
Blue Ribbon Commission On Children And Families
State House Station #155
Augusta, Maine 04333
Telephone (207) 289-2288

August 1991

Hon. Charles P. Pray
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State House Station #3
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DONALD V. CARTER

1927-1990

VISION — CARING
Our Late Colleague: The Epitome of a Dedicated & Caring Person

As Maine and the Nation debated the dilemmas faced by children and families, State Representative Don Carter was one of the first with vision.

With his customary quiet wisdom, Representative Carter testified on June 7, 1989:

> *"It is especially important that State policy emphasize helping children* ***before*** *a serious problem exists. Today, most state funds and programs offer to help children* ***after*** *a problem exists... All too often we deal with the symptoms of child abuse, juvenile delinquency, or infant mental health. Many kids have problems that come from similar root causes. We must deal with root causes."*

In recognition of Don's life, his service to all Maine citizens, and his caring for children, we dedicate this report to him with our sincere appreciation and deep affection.

We will deal with root causes.

Our thanks to Representative Donald V. Carter.

Our major recommendations include the establishment of a Department for Children and Families, a list of existing entities to be transferred into such an agency, a time frame and process for the more detailed planning and implementation phase, a Joint Select Committee of the Legislature to address children's issues, a permanent Commission to assist with monitoring and advising state government, a Family Foundation to support the Department by conducting research current to the needs of children and being involved in training, planning, and advocacy activities, a summary of revenue sources to support a transition to and operation of the Department, and principles and guidelines for its establishment.

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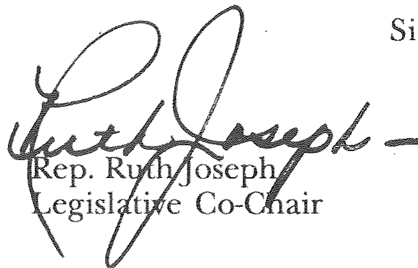

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CHAPTER 1

EXECUTIVE SUMMARY

Editor's Note: *The Blue Ribbon Commission recognizes that due to the extensive debate about the state budget and the anticipated recommendations of the Restructuring Commission, the proposed recommendations and timetables may need to be adjusted when implemented.*

MISSION OF THE BLUE RIBBON COMMISSION

The Blue Ribbon Commission on Children and Families was initiated in early May, 1990 by the Honorable Charles P. Pray, President of the Maine Senate and the Honorable John L. Martin, Speaker of the Maine House of Representatives. Its mission was to:

- Develop a plan to establish a distinct cabinet-level Department for Families and Children;
- Prepare legislation implementing a department with unified responsibilities for offering integrated services to Maine's children and families;
- Define the principles and components essential for State services to be well coordinated to fully attain a functionally integrated pattern of unified and consolidated administration and service delivery; and
- Identify methods of service delivery which are holistically oriented, child-focused, and family-focused.

BACKGROUND

During the 1980's the issue of "children and families at-risk" evolved into substantial and unresolved public policy debate. Our fellow citizens, educators, law enforcement personnel, business people, clergy, state leaders, and others became concerned. Simple questions were asked with increasing frequency.

> *"What's wrong with kids today?"*
> *"Can't that family control their kids?"*
> *"How do we sustain our society when children and families are at-risk?"*

"Are kids learning to fulfill their potential?"
"Who's raising our children?"

The Blue Ribbon Commission conducted 16 meetings from May 1990 through April 1991. We attempted to answer some of the above concerns. All meetings were open to the public and included parents and community members. The basis for the Commission's formation and deliberations was L.D. 1666, which the Legislature considered in 1989 and 1990. The legislation proposed the establishment of a Department for Families and Children.

National authorities who addressed the Commission provided information on programs and planning efforts in other states about services for children at-risk and their families. Their presentations included information about strategies developed at the national level, the laws of all states, the plans and policies of other states, and their own hands-on experience. The twenty members of the Commission deliberated major policy issues at length, using work sheets, consulting with key administrators of children's programs, and conducting research of their own. Members reached consensus on the findings and recommendations which are included in this report.

Our report, **A New Vision: Empowering People For Change — Maine's Model For Unifying State Services For Children And Families** documents the fact that children and families at-risk are matters of national and state concern. Maine and the nation are engaged in a public policy debate regarding the best methods to address problems and potential problems associated with child development and family life. There is emerging consensus on principles to encourage positive child development, positive family life, and for guiding and restructuring service delivery. There is a growing field of information about how government and communities can become more supportive of at-risk families and children. Actions taken by other states provide a sound foundation for building a positive future. The need for innovative public and private action in Maine is becoming increasingly clear.

Our report consolidates the latest knowledge and best experience. We build on the work of national authorities and other states.

SUMMARY OF FINDINGS

The Blue Ribbon Commission on Children and Families finds:

1. **THERE IS A NEED TO ASSURE THE AVAILABILITY OF SERVICES FOR MAINE'S CHILDREN AND FAMILIES.** Many Maine children do not have adequate opportunities for personal development. Families in Maine are often isolated and lack natural support networks and other ties to the community. This isolation contributes to a

diminished capacity to fully and productively participate in the public and private life and business of the community. Isolation compounds the proliferation of problematic conditions such as poverty, substance abuse, illiteracy, and other human problems which significantly limit the potential for health family life and individual development. In addition, the Commission finds that current services are overloaded and not able to meet the needs of Maine's at-risk families and children.

2. **STATE GOVERNMENT HAS RESPONSIBILITIES FOR AND ROLES TO PERFORM IN PROVIDING SERVICES FOR MAINE'S CHILDREN AND FAMILIES.** When children and families are severely affected by poverty, substance abuse, illiteracy, and other human problems that diminish their ability to fully participate in the public and private life of the community, the State has roles to fulfill. These roles involve encouraging healthy child and family development, coordinating a range of supportive services for children and families at-risk, providing financial assistance, intervening to protect children who are abused and/or neglected, and making other services available to families and children who need them.

3. **CURRENT PRACTICES FOR PROVIDING SERVICES FOR CHILDREN AND FAMILIES IN MAINE LACK COORDINATION AND PURPOSE.** There are a number of state agencies currently providing services for children and families. These agencies are not coordinated, share no unified mission, and offer no single point of entry, responsibility, or accountability. The Legislative and Executive branches of government have responsibilities for developing policy and providing services for children and families. Neither branch of government has coordinated, unified, or efficient mechanisms for carrying out its responsibilities.

4. **CURRENT STATE POLICIES RELATIVE TO FUNDING SERVICES FOR CHILDREN AND FAMILIES ARE INCOMPLETE AND INEFFECTIVE.** The State currently fails to maximize the use of federal dollars and previously has not claimed all available federal matching for both administrative and supportive service costs. We recognize recent policy and budgetary actions to claim federal funds more appropriately. It is estimated that over $40 million in federal dollars could be obtained if the state chooses to seek them.

5. **THE STATE CURRENTLY WASTES RESOURCES THROUGH PIECEMEAL POLICIES, FRAGMENTED, INEFFICIENT, AND COSTLY DUPLICATION OF SERVICES, ORGANIZATIONAL UNITS, AND ADMINISTRATIVE PRACTICES.** Over 1,000 state employees provide services for Maine's children and families at a cost of over $100 million dollars a year. Many of these employees carry out duplicative efforts, doing the same work that counterparts in separate agencies

perform. Significant savings would result from the consolidation of duplicative services, organizational units, administrative practices, service contracts, and administrative oversight and audits.

6. **A LACK OF VISION LEAVES SERVICES WITHOUT AUTHORITY OR CAPACITY.** Maine's policy of maintaining multiple state agencies, side-by-side similar state functions, and overlapping responsibilities provides at-risk children and families services which are fragmented, inefficient, costly, and lacking in well-defined authority. Because the present piecemeal state approach lacks unified vision to guide child development and comprehensive family services, the state's ability to encourage appropriate and adequate community supports and community resources for children at-risk is compromised.

SUMMARY OF RECOMMENDATIONS

The Blue Ribbon Commission on Children and Families makes the following recommendations:

1. Adopt a Unified Mission Statement

The Blue Ribbon Commission recommends that the State adopt the following mission statement to govern its roles in the provision of service to children and families:

> *The State of Maine declares that each family has primary responsibility to provide for the developmental and human needs of its members and that state government has a responsibility to help families fulfill that obligation when they are unable to do so. Children have the right to a consistent nurturing environment and to the opportunity to attain their potential for development.*
>
> *The mission of government is to complement the roles of families, support networks and society in order to enhance their strengths. State government has the responsibility to intervene on behalf of children at-risk and to encourage the return to, or creation of, a nurturing family environment. The state's response should include supportive services and interventions that offer a functionally integrated continuum of appropriate and reasonable support, either directly or in concert with private organizations. Services should address the cognitive, educational, emotional, health, physical, and social needs of children and their families. The state's intervention is subject to the rights of*

families and children, their preferences, statutory authorization, and the availability of funds.

NOTE: The Commission recognizes the efforts of the Governor's Task Force to Improve Services for Maine's Children, Youth and Families in the development of the mission statement.

2. *Define the Roles of Government*

The Blue Ribbon Commission recommends that the roles of State government in providing services for children and families be more concisely defined and that the State base the services it provides in well articulated principles. These guiding principles are outlined later in this report, as are the responsibilities that the Commission believes reside with State government.

3. *Creation of Joint Select Committee for Children & Families*

The Commission recommends the establishment of a Joint Select Committee for Children and Families to be a focal point for public policy discussion of children's and families' issues and to offer oversight of state administered services. The Commission recommends that the Joint Select Committee for Children and Families be created by Joint Order during the 1991 session of the Legislature as an eventual companion to legislation enacting a Department for Families and Children.

Members of the Commission have divided opinions about the effective date for establishing the Joint Select Committee. Some recommend the effective date for the formal transition period to a unified department be the same as that for the establishment of the Joint Select Committee (i.e., October 1, 1991). Others recommend that the two occur separately, creating the Committee effective immediately upon passage of the joint order (i.e., June, 1991.)

4. *Establish a Unified Department for Families & Children*

The Commission recommends that a distinct department for children and families be established to unify responsibilities for providing integrated delivery of functionally consolidated supportive services for families and children who need them. The department should be formed by consolidating, transferring, and revitalizing existing programs, administrative practices and personnel.

The programs and agencies recommended for consolidation are currently housed in the Department of Corrections, the Department of Education, the Executive Department, the Department of Human Services, the Department of Mental Health and Mental Retardation, and the Interdepartmental Council. As part of this consolidation, the Commission also recommends initiating a unified case management

system which is holistically-based, comprehensive, designed to stress education, human development, and preparation for the job market, and organized around the needs of high-risk children and their families. Members of the Commission strongly recommend that the transition to and full operation of the new unified department take place by January 1, 1993.

5. *Consolidation of Existing Committees*

The Commission recommends the consolidation of ten existing committees into a single independent advocacy organization for children and families. (Those committees and commissions are listed fully in the body of this report.) The Maine Commission for Children and Families should be an independent group designed to advocate for children and families and to provide an additional check and balance between the public and the State.

6. *Creation of a Family Foundation*

The Commission recommends the establishment of the Maine Family Foundation. This foundation is envisioned as a public-private partnership established to develop and promote positive family life, positive child development, primary prevention, early intervention, improvements in state policy and services, effective program administration, and research relative to children.

7. *State & Local Education Coordination*

In order to assure improved educational outcomes for all school age children, particularly those served by the Department for Children and Families, the Blue Ribbon Commission recommends that significant and substantial actions be taken to define, develop, and increase the coordination and cooperation between special education services personnel at the local level and the personnel and services of the Department for Children and Families.

8. *Medicaid for Children*

The Commission recommends full exploration of the transfer of the administrative responsibilities for the Medicaid program to the Executive Department.

9. *Transition Services for Children At-Risk*

The Commission believes that all children who are receiving supportive services through the Department for Children and Families and preparing to live independently should be eligible for transition services, modeled on the Transition Committee's program. The Commission recommends that the department's transition policy and

program be designed to prepare all service recipients for independence from the Department's supportive services. This process and policy should be implemented after January 1, 1993.

10. Unified School District within the Department

The Commission recommends that during the transition process, the Department for Children and Families undertake an exploration of the establishment of a unified school district or intermediate educational unit within the Department.

11. Pineland Center

The Commission recommends that the goals, principles, and purposes that guide services for the Department for Children and Families be applied to services provided to the small number of children residing at Pineland Center.

12. Primary Prevention & Other Services

The Commission recommends that state supportive services focus on primary prevention and early intervention. Prevention and early intervention should be components of a comprehensive continuum of services and should be offered in concert with other private and public resources in the community.

Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

Declaration of Responsibility for Maine's Children

More than ever before, we, the people of Maine, must accept our responsibility to guarantee the well-being of all Maine's children. Daily we hear reports of children being abused, living in poverty, becoming homeless, and growing up illiterate and unable to earn a legitimate wage. Our private interests and public policies put our children's welfare secondary to the demands of technological change, economic uncertainty, and the needs of adults who were themselves shortchanged as children. In defiance of these conditions, we assert that our children come into the world with certain inherent rights:

- *To be cherished and accepted in their families.*
- *To be nurtured by their families in a way that meets their individual needs, so that they can grow in ability to reach their fullest potential.*
- *To receive sensitive, continuing help in understanding, accepting and developing pride and confidence in their ethnic and religious heritage.*
- *To grow in trust in themselves and others through continuing, loving care and respect as unique human beings.*
- *To grow up in freedom and dignity in a community of people who accept them with understanding, respect, and friendship.*
- *To receive help in overcoming any deprivation in their physical, emotional, intellectual, social, or spiritual growth.*
- *To be given education, training, and career guidance to prepare them for a useful and satisfying life.*
- *To receive preparation for citizenship and parenthood.*
- *To be raised in an atmosphere free from the suffering of physical and emotional abuse.*
- *To be loved.*

(Adapted, with permission, from the Bill of Rights for Maliseet Children, Houlton Band of Maliseet Indians)

By protecting these rights, communities create nurturing environments for children. Promoting such nurturing environments will bring strength to our families, our communities, our state, and our nation.

Our children's lives are at stake. Maine's future prosperity is at stake. Our own honor is at stake. We must act to leave our children a world better that the one we inherited. As we value life, prosperity, and honor, we pledge to win for Maine's future generations those ideals that we ourselves hold most dear: the expectation of well-being for all Maine families, the hope for peace, and self respect.

(Reprinted with permission of Ad Hoc Children's Committee)

CHAPTER 1

EXECUTIVE SUMMARY

Editor's Note: *The Blue Ribbon Commission recognizes that due to the extensive debate about the state budget and the anticipated recommendations of the Restructuring Commission, the proposed recommendations and timetables may need to be adjusted when implemented.*

MISSION OF THE BLUE RIBBON COMMISSION

The Blue Ribbon Commission on Children and Families was initiated in early May, 1990 by the Honorable Charles P. Pray, President of the Maine Senate and the Honorable John L. Martin, Speaker of the Maine House of Representatives. Its mission was to:

- Develop a plan to establish a distinct cabinet-level Department for Families and Children;
- Prepare legislation implementing a department with unified responsibilities for offering integrated services to Maine's children and families;
- Define the principles and components essential for State services to be well coordinated to fully attain a functionally integrated pattern of unified and consolidated administration and service delivery; and
- Identify methods of service delivery which are holistically oriented, child-focused, and family-focused.

BACKGROUND

During the 1980's the issue of "children and families at-risk" evolved into substantial and unresolved public policy debate. Our fellow citizens, educators, law enforcement personnel, business people, clergy, state leaders, and others became concerned. Simple questions were asked with increasing frequency.

> *"What's wrong with kids today?"*
> *"Can't that family control their kids?"*
> *"How do we sustain our society when children and families are at-risk?"*

"Are kids learning to fulfill their potential?"
"Who's raising our children?"

The Blue Ribbon Commission conducted 16 meetings from May 1990 through April 1991. We attempted to answer some of the above concerns. All meetings were open to the public and included parents and community members. The basis for the Commission's formation and deliberations was L.D. 1666, which the Legislature considered in 1989 and 1990. The legislation proposed the establishment of a Department for Families and Children.

National authorities who addressed the Commission provided information on programs and planning efforts in other states about services for children at-risk and their families. Their presentations included information about strategies developed at the national level, the laws of all states, the plans and policies of other states, and their own hands-on experience. The twenty members of the Commission deliberated major policy issues at length, using work sheets, consulting with key administrators of children's programs, and conducting research of their own. Members reached consensus on the findings and recommendations which are included in this report.

Our report, **A New Vision: Empowering People For Change — Maine's Model For Unifying State Services For Children And Families** documents the fact that children and families at-risk are matters of national and state concern. Maine and the nation are engaged in a public policy debate regarding the best methods to address problems and potential problems associated with child development and family life. There is emerging consensus on principles to encourage positive child development, positive family life, and for guiding and restructuring service delivery. There is a growing field of information about how government and communities can become more supportive of at-risk families and children. Actions taken by other states provide a sound foundation for building a positive future. The need for innovative public and private action in Maine is becoming increasingly clear.

Our report consolidates the latest knowledge and best experience. We build on the work of national authorities and other states.

SUMMARY OF FINDINGS

The Blue Ribbon Commission on Children and Families finds:

1. **THERE IS A NEED TO ASSURE THE AVAILABILITY OF SERVICES FOR MAINE'S CHILDREN AND FAMILIES.** Many Maine children do not have adequate opportunities for personal development. Families in Maine are often isolated and lack natural support networks and other ties to the community. This isolation contributes to a

diminished capacity to fully and productively participate in the public and private life and business of the community. Isolation compounds the proliferation of problematic conditions such as poverty, substance abuse, illiteracy, and other human problems which significantly limit the potential for health family life and individual development. In addition, the Commission finds that current services are overloaded and not able to meet the needs of Maine's at-risk families and children.

2. **STATE GOVERNMENT HAS RESPONSIBILITIES FOR AND ROLES TO PERFORM IN PROVIDING SERVICES FOR MAINE'S CHILDREN AND FAMILIES.** When children and families are severely affected by poverty, substance abuse, illiteracy, and other human problems that diminish their ability to fully participate in the public and private life of the community, the State has roles to fulfill. These roles involve encouraging healthy child and family development, coordinating a range of supportive services for children and families at-risk, providing financial assistance, intervening to protect children who are abused and/or neglected, and making other services available to families and children who need them.

3. **CURRENT PRACTICES FOR PROVIDING SERVICES FOR CHILDREN AND FAMILIES IN MAINE LACK COORDINATION AND PURPOSE.** There are a number of state agencies currently providing services for children and families. These agencies are not coordinated, share no unified mission, and offer no single point of entry, responsibility, or accountability. The Legislative and Executive branches of government have responsibilities for developing policy and providing services for children and families. Neither branch of government has coordinated, unified, or efficient mechanisms for carrying out its responsibilities.

4. **CURRENT STATE POLICIES RELATIVE TO FUNDING SERVICES FOR CHILDREN AND FAMILIES ARE INCOMPLETE AND INEFFECTIVE.** The State currently fails to maximize the use of federal dollars and previously has not claimed all available federal matching for both administrative and supportive service costs. We recognize recent policy and budgetary actions to claim federal funds more appropriately. It is estimated that over $40 million in federal dollars could be obtained if the state chooses to seek them.

5. **THE STATE CURRENTLY WASTES RESOURCES THROUGH PIECEMEAL POLICIES, FRAGMENTED, INEFFICIENT, AND COSTLY DUPLICATION OF SERVICES, ORGANIZATIONAL UNITS, AND ADMINISTRATIVE PRACTICES.** Over 1,000 state employees provide services for Maine's children and families at a cost of over $100 million dollars a year. Many of these employees carry out duplicative efforts, doing the same work that counterparts in separate agencies

perform. Significant savings would result from the consolidation of duplicative services, organizational units, administrative practices, service contracts, and administrative oversight and audits.

6. **A LACK OF VISION LEAVES SERVICES WITHOUT AUTHORITY OR CAPACITY.** Maine's policy of maintaining multiple state agencies, side-by-side similar state functions, and overlapping responsibilities provides at-risk children and families services which are fragmented, inefficient, costly, and lacking in well-defined authority. Because the present piecemeal state approach lacks unified vision to guide child development and comprehensive family services, the state's ability to encourage appropriate and adequate community supports and community resources for children at-risk is compromised.

SUMMARY OF RECOMMENDATIONS

The Blue Ribbon Commission on Children and Families makes the following recommendations:

1. Adopt a Unified Mission Statement

The Blue Ribbon Commission recommends that the State adopt the following mission statement to govern its roles in the provision of service to children and families:

> *The State of Maine declares that each family has primary responsibility to provide for the developmental and human needs of its members and that state government has a responsibility to help families fulfill that obligation when they are unable to do so. Children have the right to a consistent nurturing environment and to the opportunity to attain their potential for development.*
>
> *The mission of government is to complement the roles of families, support networks and society in order to enhance their strengths. State government has the responsibility to intervene on behalf of children at-risk and to encourage the return to, or creation of, a nurturing family environment. The state's response should include supportive services and interventions that offer a functionally integrated continuum of appropriate and reasonable support, either directly or in concert with private organizations. Services should address the cognitive, educational, emotional, health, physical, and social needs of children and their families. The state's intervention is subject to the rights of*

families and children, their preferences, statutory authorization, and the availability of funds.

NOTE: The Commission recognizes the efforts of the Governor's Task Force to Improve Services for Maine's Children, Youth and Families in the development of the mission statement.

2. *Define the Roles of Government*

The Blue Ribbon Commission recommends that the roles of State government in providing services for children and families be more concisely defined and that the State base the services it provides in well articulated principles. These guiding principles are outlined later in this report, as are the responsibilities that the Commission believes reside with State government.

3. *Creation of Joint Select Committee for Children & Families*

The Commission recommends the establishment of a Joint Select Committee for Children and Families to be a focal point for public policy discussion of children's and families' issues and to offer oversight of state administered services. The Commission recommends that the Joint Select Committee for Children and Families be created by Joint Order during the 1991 session of the Legislature as an eventual companion to legislation enacting a Department for Families and Children.

Members of the Commission have divided opinions about the effective date for establishing the Joint Select Committee. Some recommend the effective date for the formal transition period to a unified department be the same as that for the establishment of the Joint Select Committee (i.e., October 1, 1991). Others recommend that the two occur separately, creating the Committee effective immediately upon passage of the joint order (i.e., June, 1991.)

4. *Establish a Unified Department for Families & Children*

The Commission recommends that a distinct department for children and families be established to unify responsibilities for providing integrated delivery of functionally consolidated supportive services for families and children who need them. The department should be formed by consolidating, transferring, and revitalizing existing programs, administrative practices and personnel.

The programs and agencies recommended for consolidation are currently housed in the Department of Corrections, the Department of Education, the Executive Department, the Department of Human Services, the Department of Mental Health and Mental Retardation, and the Interdepartmental Council. As part of this consolidation, the Commission also recommends initiating a unified case management

system which is holistically-based, comprehensive, designed to stress education, human development, and preparation for the job market, and organized around the needs of high-risk children and their families. Members of the Commission strongly recommend that the transition to and full operation of the new unified department take place by January 1, 1993.

5. Consolidation of Existing Committees

The Commission recommends the consolidation of ten existing committees into a single independent advocacy organization for children and families. (Those committees and commissions are listed fully in the body of this report.) The Maine Commission for Children and Families should be an independent group designed to advocate for children and families and to provide an additional check and balance between the public and the State.

6. Creation of a Family Foundation

The Commission recommends the establishment of the Maine Family Foundation. This foundation is envisioned as a public-private partnership established to develop and promote positive family life, positive child development, primary prevention, early intervention, improvements in state policy and services, effective program administration, and research relative to children.

7. State & Local Education Coordination

In order to assure improved educational outcomes for all school age children, particularly those served by the Department for Children and Families, the Blue Ribbon Commission recommends that significant and substantial actions be taken to define, develop, and increase the coordination and cooperation between special education services personnel at the local level and the personnel and services of the Department for Children and Families.

8. Medicaid for Children

The Commission recommends full exploration of the transfer of the administrative responsibilities for the Medicaid program to the Executive Department.

9. Transition Services for Children At-Risk

The Commission believes that all children who are receiving supportive services through the Department for Children and Families and preparing to live independently should be eligible for transition services, modeled on the Transition Committee's program. The Commission recommends that the department's transition policy and

program be designed to prepare all service recipients for independence from the Department's supportive services. This process and policy should be implemented after January 1, 1993.

10. Unified School District within the Department

The Commission recommends that during the transition process, the Department for Children and Families undertake an exploration of the establishment of a unified school district or intermediate educational unit within the Department.

11. Pineland Center

The Commission recommends that the goals, principles, and purposes that guide services for the Department for Children and Families be applied to services provided to the small number of children residing at Pineland Center.

12. Primary Prevention & Other Services

The Commission recommends that state supportive services focus on primary prevention and early intervention. Prevention and early intervention should be components of a comprehensive continuum of services and should be offered in concert with other private and public resources in the community.

Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

CHAPTER 2

INTRODUCTION

The members and staff of the Blue Ribbon Commission on Children and Families searched for words and phrases to describe their vision for addressing the complicated, recurring, and sometimes unpleasant conditions that can and do affect families and children in Maine. The difficulty arose from trying to succinctly describe the kinds of multiple problems which face families and children and from problems associated with recognizing differing views of what constitutes appropriate remedies, a growing volume of professional jargon, and, deeply rooted ideological convictions and beliefs. The Commission has attempted to submit a final report which is clear, does not stigmatize or label, and is consistent in the language that it uses to describe the problems and concerns it has identified and the changes that it envisions.

Commission members believe that all children in Maine deserve equal access to opportunity, regardless of their socioeconomic status, cultural and racial background, or other individual histories or characteristics. The Commission members also believe that state government, families, communities, schools, health care providers, places of worship, and places of work all contribute to the lives of children and families and to the opportunities available to them.

This report is predicated upon these and several other basic beliefs: that the well being of Maine's children and families is important to the overall health of society; that each segment of society contributes to family life and the well-being of children; that society has a role to fulfill in addressing the causes of, and consequences for, families and children at-risk.

The Blue Ribbon Commission believes that a full range of resources need to be available for children and families. Members believe that all segments of society can be service delivery networks and support families and children so that they may fully participate in the opportunities that are crucial to their well-being and to the health of the community and the state. This report recommends enhancing the lives of children and families through reorganizing, revitalizing, and consolidating government programs and services and increasing the

involvement of communities and members of the general public in the development and delivery of services to children and families at-risk.

GUIDING PRINCIPLES OF THE COMMISSION

The following principles and beliefs guided the work of the Commission:

1. All segments of Maine society should be empowered to participate in serving as supportive networks for families and children with, or without the participation of State government. Voluntary, private, and joint-public-private efforts should exist.

2. Society as a whole benefits when there is a strong sense of shared community responsibilities for the well-being of children and families, respect for individual differences, and a commitment to helping all members of the community become active and productive participants in the public and private life and business of the community.

3. Improving the participation of communities and the efficiency of government programs and services will take time. Improvements will be implemented gradually through a well designed plan of action.

4. Resources and service delivery networks should exist to encourage community involvement in the well-being of its children and families and to provide direct help to children and families at-risk or in need.

5. All segments of society are interdependent and can be sources of support and service delivery for families and children. Community involvement can contribute significantly to family well-being, development, and the protection and care of children.

6. Changes in economic, social, and family patterns have a significant impact on children and families. Services for families and children should be flexible so that they can respond to and address changes as they occur.

7. Poverty, illiteracy, substance abuse, physical and sexual abuse, and other social and human ills contribute to the break-down of families and to a host of other problems for children. These problems can cross generations and are basic to many at-risk children and families experiencing significant difficulties becoming productive participants in the public and private life and business of the community. Public policies which ignore these root causes and fail to offer preventive actions may be ineffective.

8. There is a need for a concentrated and coordinated effort to increase opportunities for children and families at-risk and to empower communities and society as a whole to participate in this effort. The State has significant roles and responsibilities to fulfill in this effort.

9. Primary prevention of, and early intervention in, problematic conditions which affect children and families is crucial to the success of any government response.

10. Services for families and children should be appropriate for the age and developmental level of the child involved, holistically oriented, and child- and family-centered. Interdisciplinary teams are an effective way to deliver services.

FACTORS AFFECTING FAMILIES & CHILDREN IN MAINE

Rapid changes in the economic, social, and family patterns of our society have a significant impact on children and families in Maine.

Many families now consist of one parent, generally a mother. The numbers of women with children who enter the work force have increased dramatically and have radically altered the traditional model of family life known to us for the past thirty years. Far fewer children in the 1990s grow up in established nuclear and extended families with grandparents and other supportive family members available for help than did in the 1950s. In addition, nuclear families are increasingly disengaged not only from extended families, but also from the support of other segments of society.

Close knit neighborhoods, extended families living in close proximity, active school and community groups, a consistent work presence over a long period of time, and conditions more supportive of family life, were common twenty years ago. They are increasingly less common in 1991.

In addition to changes in social and family structure, in Maine today and across the country, growing numbers of families and children struggle with poverty, some form of abuse, poor pre-natal or newborn care, health conditions that consume family resources, difficulty with learning or completing school, and other human difficulties which limit their capacity to participate fully in their community. The cost in human potential, state and community services, and other vital resources is enormous.

According to the 1989 report of the Maine Committee on Primary Prevention:

- 10,000 juveniles are arrested each year;
- 2,100 come under the supervision of the Department of Corrections;
- 16,250 are chemically dependent or at risk of becoming chemically dependent;
- 2,600 drop out of high school;
- 25,000 are referred for child abuse or neglect;
- 15,000 experience serious emotional problems;
- 480 are seen in hospitals because of self-destructive threats or attempts; and
- 2,800 become pregnant.

These figures attest to the significance of the problems facing Maine's children and families and to the costs for society. They also point to the importance of providing help and supportive services that are effective and to the need for government to fulfill its roles.

CHAPTER 3

FINDINGS

A. A Need Exists for Services for Families & Children

There are growing numbers of children and families in Maine who are mired in poverty, substance abuse, illiteracy, and other human problems which significantly affect their ability to fully participate in the opportunities for productive participation in the public and private life and business of the community. Growing numbers of children are referred to the State for a wide range of conditions and problems. Service providers and state programs are overloaded with requests for assistance that cannot be met within existing resources. The need for services is greater than the services available.

B. Government has Roles & Responsibilities to Fulfill

The Blue Ribbon Commission on Children and Families believes that the State has roles to fulfill in:

- Encouraging healthy child development through programs such as child development services, Head Start, intervention for children with developmental disabilities, family support programs, public health nursing, and the Women, Infants, and Children's Program (WIC).
- Defining and coordinating the range of supportive services which are necessary to protect and help children and families at-risk.
- Supplementing financial and other resources for families who are unable to adequately provide for their children.
- Offering children with special needs appropriate early intervention, home-based care, family support, and other community services.
- Providing protection, residential care, and treatment for children who are abused or neglected.
- Making services available for persons with mental illness and children with emotional disabilities in, or as close as possible to, their home communities.

- Developing and assuring the availability of community corrections and corrections programs for juvenile and adult offenders which are responsive, rehabilitative and habilitative, and which provide sufficient space and programming.

C. Current State Services for Children & Families Lack Coordination & Purpose

State policies and supportive services for children are currently conducted through a wide variety of organizational fiefdoms, spread throughout an array of state bodies, agencies, and administrative committees. There is no unified mission, no coordinated well defined public policy, and no "single case manager" responsible for addressing the increasingly complex needs of children and families in Maine. There is also no single, strong, independent voice of advocacy or expertise.

The Legislative and Executive Branches of government both lack a single authority which is accountable for policy development, oversight, outcomes, and action related to State and community involvement in the lives of Maine's children and families.

The Legislative branch has at least five joint standing committees which have significant defined roles and responsibilities for selected policies affecting children. They are: Appropriations and Financial Affairs, Corrections, Education, Human Resources, and State and Local Government. No single legislative committee has unified responsibility for oversight and policy considerations affecting children and families.

The Executive Branch has at least five major departments with significant roles and responsibilities for operating selected programs affecting children and families. There is no single administrative department or commissioner with full-time responsibility for managing state programs affecting children and families. Current services are fragmented, uncoordinated, inefficient, and delivered inappropriately to children whose needs have been inadequately defined or whose needs have been defined by labels, not individual assessment. Some Commission members believe that the current fragmentation of services contributes to, rather than ameliorates, the problems of Maine's children and families.

The Commission heard from parents of at-risk children and service providers about the lack of a single state organization with authority to make decisions and to which requests for help can be addressed. Legislators expressed concern that there is no coherent policy. Rather, there are a number of divergent policies and contradictory bureaucratic voices defending individual turfs and separate priorities at appropriations and other public policy hearings. The Commission found that many state bureaucrats have limited understanding of how proposals tie

together to create a single mission or unified agenda for children and families. Children with multiple needs are served by multiple agencies with multiple workers and multiple case plans. Services are disjointed and fragmented.

The Commission believes that state supportive services should not continue to be operated by a wide array of state agencies and administrative committees. Service delivery should not continue to be coordinated by numerous inter-agency administrative committees with little authority, which are further limited by turf issues. The Commission believes that the many administrative committees are time consuming, expensive, and relatively unproductive.

D. State Funds Can Be Saved & Invested in Children's Services

The Commission found that through more efficient use of state dollars, savings can be realized. The resulting savings can be used to increase services for children and families. Eliminating administrative duplication and inefficiency will make more money available for service delivery.

In addition there are millions of dollars available in federal funds that previously have gone unclaimed.

We recognize recent policy and budgetary actions to claim federal funds more appropriately. The Commission believes that its recommendations will result in savings which are significant. Policy-makers will be called to decide how to invest the savings – return it to the general fund, redirect it to other programs, or invest it in services for children and families. The Commission strongly recommends that the savings which result from consolidation and unification be reinvested in programs for children.

E. Fiscal Policies Incomplete & Ineffective

In many programs, significant amounts of state general fund dollars have financed 100% of ***administrative*** costs even though federal matching funds could have covered as much as 50% of the cost. For every $500,000 of state general fund dollars that now pay fully for administrative costs, the Blue Ribbon Commission finds that 20% could be recouped from the federal government. In some programs, this percentage of uncollected federal money may be as high as 60%.

The Interim Plan for Development of a Medicaid Plan for Children and Families of Maine, written by The Institute for Human Services Management and C.A.R.E.S., Inc. and published in 1991, presents detailed information on the State's failure to obtain available federal revenues. This report indicates that a $2 million investment will result in additional federal funds for children totaling $46 million in the first three years, and an additional ongoing annual revenue of $20 million. One reason for these shortcomings is the fragmentation of services and the lack of coordination between agencies and departments.

There are substantial combined total savings to be gained from restructuring, unifying, reducing duplication, and making fuller use of federal funds.

Long-term savings can be attained through enhanced prevention and early intervention services for children and families. Clearly, it is feasible to reduce the future number of at-risk people who may become participants in the criminal justice, corrections, mental health or welfare systems of local and state governments at great expense to taxpayers.

With a unified Department for Families and Children, a family-focused approach, interdisciplinary teams, unified case management, and a Family Foundation, it is possible to prevent more at-risk children from becoming at-risk adults who participate in government programs. If we prevent five children from becoming adult patients at a state institution for people who are mentally ill, we will reduce future costs for taxpayers by an average of $350,000 per year.

It is better to pay a little now than to pay a lot more later. More importantly, it is better to care for children today than to treat adults who are mentally disabled tomorrow.

F. State Resources Wasted through Duplication

During the fiscal year ending June 30, 1990, more than 1,000 state employees located within five state agencies utilized over $100 million dollars a year offering supportive services for at-risk children and their families. Of those employees, 168 carried out only administrative functions. The Commission finds that these administrative costs could be significantly reduced through the creation of a unified Department and the elimination of duplicative administrative functions. For example, four of the five state agencies providing services to children and families currently contract with the same community providers for the provision of residential care and treatment. These four departments utilize four separate contracts, budget requirements, and audit procedures. In a unified department, these overlapping requirements and costs would be significantly reduced. A savings for State government and for community providers would be realized.

CHAPTER 4

RECOMMENDATIONS

The Blue Ribbon Commission on Children and Families calls for a redefinition of the roles and responsibilities of government, a redirection of resources, more use of community and other non-state support networks and resources, a consolidation of state government's children's bureaus, organizations, and administrative practices, and the functional integration of state administered services for children.

The Commission believes these steps will unify and focus state services for children and families and establish reasonable limits on the roles and responsibilities of State government. The Commission believes that adoption of these recommendations will increase the number of children in Maine who live in healthy families, who thrive, who are supported and encouraged by nurturing natural support networks, and, will reduce the numbers of children who rely on state-delivered supportive services. The Commission also believes that these changes will result in state services which are more efficiently and effectively administered, less costly, more capable of offering child- and family-centered help, and more reliant on local, family, and community-based resources.

The Commission makes the following recommendations.

I. Adopt a Unified Mission Statement

The Blue Ribbon Commission recommends that the State adopt a unified mission statement governing its roles in providing services to children and families. That mission statement is as follows:

> *The State of Maine declares that each family has primary responsibility to provide for the developmental and human needs of its members and that state government has a responsibility to help families fulfill that obligation when they are unable to do so. Children have the right to a consistent nurturing environment and to the opportunity to attain their potential for development.*

The mission of government is to complement the roles of families, support networks and society in order to enhance their strengths. State government has the responsibility to intervene on behalf of children at-risk and to encourage the return to, or creation of, a nurturing family environment. The state's response should include supportive services and interventions that offer a functionally integrated continuum of appropriate and reasonable support, either directly or in concert with private organizations. Services should address the cognitive, educational, emotional, health, physical, and social needs of children and their families. The state's intervention is subject to the rights of families and children, their preferences, statutory authorization, and the availability of funds.

II. DEFINE THE ROLES OF GOVERNMENT

The Blue Ribbon Commission recommends that the roles of state government in providing services for children and families be more concisely defined and that the State base the services it provides in well defined principles. These guiding principles, outlined on pages 14 and 15 of this report, guided the work of the Commission and should be adopted by the State to serve as the principles that guide its programs and services.

The Commission also recommends that the roles of government be clearly defined to include the following: (1) encouraging child development through a variety of programs and services, (2) increasing opportunities for children with developmental disabilities, (3) providing family support services, (4) providing public health nursing, (5) defining and coordinating the range of supportive services which are necessary for children and families at-risk, (6) providing financial and other resources to families who are unable to adequately provide for their children, (7) offering children with special needs appropriate early intervention, home based care, family support, and other community services, (8) providing protection, residential care and treatment for children who are abused or neglected, (9) making services available for persons with mental illness and children with emotional disabilities in, or as close as possible to, their home communities, and (10) developing and assuring the availability of community corrections and corrections programs for juvenile and adult offenders which are responsive, rehabilitative and habilitative, and which provide sufficient space and programming.

III. ESTABLISH A UNIFIED DEPARTMENT FOR CHILDREN & FAMILIES

The Commission recommends that a distinct department for children and families be established with unified responsibilities for

providing integrated delivery of functionally consolidated supportive services for children and families in need. The Commission has identified programs within five state agencies that form parts of Maine's response to the needs of children and families. The Commission strongly believes that the fragmented pieces can be revised and integrated as the functional heart of a unified Department for Families and Children. The Commission recommends that the following programs be transferred out of their existing agencies and into a unified Department for Families and Children:

CORRECTIONS: Juvenile correctional services including youth detention, the Maine Youth Center, juvenile probation and parole, juvenile community corrections services.

EDUCATION: Child development services including the Interdepartmental Coordinating Committee for Pre-school Handicapped Children, 0-5 programs, and PL 99-457 programs.

EXECUTIVE DEPARTMENT: Head Start, children's substance abuse programs funded by the Office of Substance Abuse.

HUMAN SERVICES: Bureau of Child and Family Services including child care and purchased social services, Bureau of Health including the Public Health Nursing Program, Maternal and Child Health Program, Adolescent Pregnancy & Parenting, Family Planning Program, Genetic Disease Program, Handicapped Children's Program, Women, Infant & Children Program, Pre-natal Program, and the Family Preservation Program of the Bureau of Income Maintenance.

MENTAL HEALTH AND MENTAL RETARDATION: Bureau of Children with Special Needs including the Elizabeth Levinson Center, Military & Naval Children's Home, Infant Development Center, and community services for children, Bureau of Mental Health's AMHI adolescent Unit or its successor(s), Bureau of Mental Retardation children's programs except those provided at Pineland Center.

SERVICES HOSTED IN SEVERAL AGENCIES: Committee on Transition and Interdepartmental Council.

ADDITIONAL RECOMMENDATIONS FOR THE UNIFIED DEPARTMENT INCLUDE:

Creation of a Unified Case Management System

The Blue Ribbon Commission places great emphasis on functionally integrating and improving the delivery of state administered services. The Commission believes strongly that developing a unified case

management system which is holistically based, comprehensive, designed to stress education, human development, and preparation for the job market, is necessary to appropriately address the needs of children and families at-risk.

One case manager per child/family is recommended as part of the consolidation of service practices including case management focused on primary prevention, early intervention, and other help designed to improve family well-being. In addition, the Commission recommends extensive utilization of interdisciplinary teams capable of offering a comprehensive range of integrated supports and resources which address the needs of children and families.

Employee Preparation

Employee preparation and retraining for all affected state employees and non-state agency employees is strongly recommended. This training should take place well in advance of November 30, 1992. The Commission also believes that extensive employee participation in planning and implementing the consolidation of administrative and service delivery functions is crucial to a successful outcome.

Transition Process & Timetable Recommended

The Commission strongly recommends the transition to the unified department include the following key actions and preparations in the sequence and of the duration suggested below. *(Editor's Note: The Blue Ribbon Commission recognizes that due to the extensive debate about the state budget and the anticipated recommendations of the Restructuring Commission, the dates outlined in this timetable will need to be adjusted)*

- Legislation authorizing transition enacted – June 1991
- Joint Select Committee authorized – June 1991
- Commissioner and other key leaders appointed – October 1, 1991
- Enabling legislation enacted including transfer of funds and statutory change – April 1992
- Administrative plan completed – September 30, 1992
- Employee preparation and training complete – November 30, 1992
- Department operational (all programs and staff transferred – January 1, 1993.

The Commission recommends that key leaders be appointed by October 1, 1991 and that the administrative plan for the Department be complete by September 30, 1992, with four Interdepartmental Council positions transferred to work with the Commissioner to complete the administrative plan and facilitate the transition. Existing bureau directors, division directors, program managers, and regional managers should participate as members of a senior workgroup for administrative

planning. The responsibility for funds, program management, and service delivery should be transferred and operational simultaneously, unifying the department no later than January 1, 1993.

To functionally consolidate services, the Commission recommends the integration of 0-5, child development services, 3-5, Headstart, 0-18 health programs, 0-18 children's mental health and mental retardation programs, the integration of child welfare, juvenile justice, and juvenile substance abuse, and increased coordination with special education programs and the development of a unified school district plan.

Guidelines for Department Implementation & Operation

The Commission believes that implementing a unified Department for Children and Families will require a transition plan and implementing legislation. The plan should be consistent with the unified mission statement recommended earlier and should include:

- Direction to offer educational, developmental, health, medical, mental, social, and correctional services for children and families. The Department should be authorized to address issues related to family functioning, child development, and conditions affecting children including, but not limited to, adult or child abuse and neglect, drug or alcohol abuse, preschool education, early childhood development, low aspirations, family problems, family violence, juvenile delinquency, medical problems, mental health problems, emotional disturbance, mental retardation, poverty, school dropouts, special education, spousal abuse, truancy, teen pregnancy, suicide, and other conditions which place children and families at-risk.

- Authorization for the Commissioner to develop a plan which is consistent with the Blue Ribbon Commission on Children and Families' recommendations and recommendations of the Joint Legislative Committee for Children and Families. Subject to the availability of funds, the plan must include services which are family-and child-focused, which focus on strengthening natural and community support networks, which are holistic in nature and designed to restore the capability of the nuclear family. The plan should create a one-case manager-one-family approach, consolidate the administrative and service functions of government which help children and families, eliminate unnecessary layers of bureaucracy, and offer a comprehensive continuum of care with unified access points, application process, assessment practices and casefile, strong accountability and quality assurance, a procedure for evaluating outcomes, pilot programs and model projects, and a service delivery model which integrates the administrative and service functions of government at the regional and central office levels. The plan should identify cost savings.

Organization & Staffing

More than 1,000 existing state employees will be involved in the transition to a unified Department for Children and Families. The Commission recommends that the first step for the Commissioner of the new department is to prepare an organization and staffing plan, well defined lines of communication and responsibility, a reliable inventory of resources, and an assessment of the target populations to be served.

The Commission's review of the current staffing and financial resources highlighted the need for flexibility and the necessity for restructuring government in the immediate future. In November of 1989, it was estimated that by June 30, 1990, the five major state agencies offering help for children had 7,338 staff positions and funds totalling $1,681,000,000. By April of 1990, the same five agencies, as part of their fiscal year 1991 funding, had 7,265 staff positions and $1,792,000,000.

By March 14, 1991, the total general fund resources available for fiscal year 1991 dropped by $43 million in some accounts and rose by $65 million in others. Federal allocations dropped by $7.3 million in some accounts and increased by $37 million in others. Also, several hundred staff positions were abolished or vacant and all staff were required to take five days off during the final three months of the fiscal year. The March 1991 changes had an enormous impact on agencies providing services for families and children. The budgets for 1992 and 1993 are still undecided at the time this report was prepared.

This changing fiscal picture makes it difficult for the five child-serving agencies to estimate their actual costs or resources or to document the number of unduplicated children and families which they serve. Each agency, and frequently each program within an agency, maintains separate data not readily comparable or compatible. It is also difficult to determine if, for what purpose, how frequently, or how well one child or one family is served by these five agencies.

Because of the changing nature of funding and staffing patterns in government, the Commission makes the following additional recommendations relative to the establishment of the unified Department:

- One Commissioner should be designated to the Department for Children and Families. This individual should work in cooperation with the other affected Commissioners to secure resources for the effective and efficient management of the unified Department. Funds for indirect administrative allocations for the unified Department should be based upon the present average percent of indirect administrative costs across the transferred agencies and services. This percent should be applied to define the funds to be transferred from the Department of Human Services,

the Department of Mental Health and Mental Retardation, the Department of Corrections, the Department of Education, and other agencies to the unified department.

- The Department should include at a minimum one Commissioner, two deputy commissioners – one for finance and one for program, secretarial and support staff, an appropriate number of assistant attorney generals, purchase of service staff, financial support staff, quality assurance staff, and others.

- The bureaus, units, regional staff, space allocations, support budgets and program budgets presently assigned to those units designated for transfer should be transferred in total to the unified department.

- Personnel costs, all other dollars, and capital funds for the new department should come via a direct transfer from existing agencies and programs targeted for consolidation. When administrative costs for a program are now located in undifferentiated accounts, a percentage share should be determined and transferred.

- For all transferred programs and services, the transfer of administrative and support resources should apply to all organizational levels: departmental, central office, bureaus, regions, itinerant locations, and indirect costs such as the state-wide cost allocation plan.

- The Commissioner should be appointed prior to the formal transition process and should, at a minimum, prepare a transition plan which includes: A financial package and the transfer of resources; organizational charts and proposed staffing, plans for reducing duplication of programs and staff, utilization of staff to be transferred during the transition period for the preparation of plans, transition costs and cost savings, a five year plan for enhancing the services and programs for children and families, and a break down of service types, needs, geographical areas, costs, and community participation.

IV. Creation of Joint Select Committee for Children & Families

The Commission recommends the establishment of a Joint Select Committee for Children and Families to be a focal point for public policy discussion of children's and families' issues and to offer oversight of state administered services. The Commission recommends that the Joint Select Committee for Children and Families be created by Joint Order during the 1991 session of the Legislature as a companion to eventual legislation enacting a Department for Families and Children.

The Committee should consist of 13 members of the Legislature, including 3 members of the Senate appointed by the President of the Senate and 10 members of the House of Representatives appointed by the Speaker of the House of Representatives as follows: 2 members of the Joint Standing Committee on Appropriations and Financial Affairs, 2 members of the Joint Standing Committee on Education, 2 members of the Joint Standing Committee on Human Resources, 2 members of the Joint Select Committee on Corrections, 2 members of the Joint Standing Committee on State and Local Government, and 3 additional members of the Legislature. Members should be compensated in accordance with Title 3, M.R.S.A., section 2 and the Legislative Council should provide staffing for the Committee within existing resources.

V. Creation of a Family Foundation

The Commission recommends the establishment of the Maine Family Foundation. This foundation is envisioned as a public-private partnership established to develop, encourage, enhance, and promote positive family life and positive child development. This will be accomplished through the development of primary prevention and early intervention proposals, support for applied research in the fields of family life, child development, program administration, information collection and dissemination, evaluation, training and coordination, and policy and program recommendations. The Foundation should also conduct, commission and/or publish studies, and participate in local, state, and national research efforts designed to benefit children and families.

The Foundation should make recommendations relative to the management and delivery of family and children's programs and assure a continuing commitment to positive family development and the well-being of Maine's children and families. The Foundation should be funded by public dollars and private contributions.

VI. Consolidation of Existing Committees

The Commission recommends the consolidation of ten existing committees into a single independent advocacy organization for children and families.

The Advisory Committee on Children with Special Needs, the Child Welfare Advisory Committee, the Child Care Advisory Committee, the Committee on Primary Prevention, the Juvenile Justice Advisory Group, the Maine Advisory Committee on Mental Retardation (transferring adult mental retardation functions to the Developmental Disabilities Council), the Residential Treatment Centers Advisory Group, the Task Force on Children's Mental Health, the Task Force on Early Intervention, and the Task Force on Family Support should be merged

together into the Maine Commission for Children and Families. This consolidation will, the Commission believes, bring more effective, efficient, and accountable family and children's participation in oversight and planning.

The Maine Commission for Children and Families should be an independent group designed to advocate for children and families and to offer an additional check and balance for the public and the State.

The Commission believes that approximately $250,000 is spent each year administering and maintaining eight of the ten identified committees. Members recommend that $175,000 of this amount be used to fund the Maine Commission on Children and Families and $75,000 be returned to programs and services provided by the unified department. It is recommended that the Commission be authorized to hire three staff persons: an executive director, analyst, and secretary.

VII. State & Local Education Coordination

In order to assure improved educational outcomes for all school age children, particularly those served by the Department for Children and Families, the Blue Ribbon Commission recommends that significant and substantial actions be taken to define, develop, and increase the coordination and cooperation between special education services personnel at the local level and the personnel and services of the Department for Children and Families.

"Child find", needs identification, and referral activities should be increased and, where appropriate, case management services should become available in cooperation with the Department for school children who are at-risk. In addition, pupil evaluation practices and polices should be evaluated and revised, advocacy and assistance for children and parents should be improved prior to, and during, the pupil evaluation process, and a comprehensive range of services should be cooperatively developed based on the needs identified through the pupil evaluation process.

VIII. Medicaid for Children

Access to basic health care is crucial to the well-being of our children. The Commission recommends full exploration of transferring administrative responsibilities for the Medicaid program to the Executive Department. This proposal extends beyond the mission of the Blue Ribbon Commission thus the concept was not discussed in depth. However, the Commission recommends further consideration be given to this idea, particularly as the discussion of restructuring government continues.

IX. Transition Services for Children At-Risk

Children at-risk who have special needs are eligible for educational supportive services through State government until they reach the age of 20. The State Committee on Transition coordinates services for selected children who "age out" of eligibility by preparing them and their families for the world after school. The Commission believes that all children at-risk who are receiving supportive services through the Department for Children and Families and preparing to live independently should be eligible for transition services, modeled on the Transition Committee's program. That program includes preparation and follow-up utilizing an interdisciplinary support network of community resources and specialists. The Commission recommends that the inclusion of all at-risk children who are preparing to live independently from Department services take place following the January 1, 1993 start-up of the Department for Children and Families.

X. Unified School District within the Department

The Commission recommends that the Department for Children and Families undertake during the transition process, an exploration of the establishment of a unified school district or intermediate educational unit within the Department. This district should enable local education units and the Department to meet legal mandates appropriately and to fully access available and appropriate funding, particularly federal resources. A unified school district should ensure that students who are in the care of the Department for Children and Families receive educational services in a consistent and equitable manner and assure continuing educational growth while within the jurisdiction of a local educational unit, regardless of whether or not students reside in a facility directly administered or funded by the Department.

XI. Pineland Center

The Commission recommends that the goals, principles, and purposes that guide services for the Department for Children and Families be applied to services provided to the small number of children residing at Pineland Center.

XII. Primary Prevention & Other Services

The Commission strongly supports primary prevention programs and early intervention as components of a comprehensive continuum of supportive services. Primary prevention and early intervention should be offered in concert with private and public resources, involve all

segments of society, and include networks of private and public service providers.

Closing Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

Declaration of Responsibility for Maine's Children

More than ever before, we, the people of Maine, must accept our responsibility to guarantee the well-being of all Maine's children. Daily we hear reports of children being abused, living in poverty, becoming homeless, and growing up illiterate and unable to earn a legitimate wage. Our private interests and public policies put our children's welfare secondary to the demands of technological change, economic uncertainty, and the needs of adults who were themselves shortchanged as children. In defiance of these conditions, we assert that our children come into the world with certain inherent rights:

- *To be cherished and accepted in their families.*
- *To be nurtured by their families in a way that meets their individual needs, so that they can grow in ability to reach their fullest potential.*
- *To receive sensitive, continuing help in understanding, accepting and developing pride and confidence in their ethnic and religious heritage.*
- *To grow in trust in themselves and others through continuing, loving care and respect as unique human beings.*
- *To grow up in freedom and dignity in a community of people who accept them with understanding, respect, and friendship.*
- *To receive help in overcoming any deprivation in their physical, emotional, intellectual, social, or spiritual growth.*
- *To be given education, training, and career guidance to prepare them for a useful and satisfying life.*
- *To receive preparation for citizenship and parenthood.*
- *To be raised in an atmosphere free from the suffering of physical and emotional abuse.*
- *To be loved.*

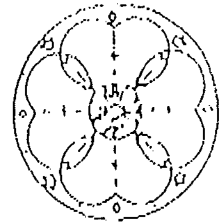
(Adapted, with permission, from the Bill of Rights for Maliseet Children, Houlton Band of Maliseet Indians)

By protecting these rights, communities create nurturing environments for children. Promoting such nurturing environments will bring strength to our families, our communities, our state, and our nation.

Our children's lives are at stake. Maine's future prosperity is at stake. Our own honor is at stake. We must act to leave our children a world better that the one we inherited. As we value life, prosperity, and honor, we pledge to win for Maine's future generations those ideals that we ourselves hold most dear: the expectation of well-being for all Maine families, the hope for peace, and self respect.

(Reprinted with permission of Ad Hoc Children's Committee)

Central Maine Indian Association, Inc.



Sharing Resources and Ideas

FAX No. # 942-2927

FACSIMILE TRANSMITTAL SHEET

SENDING PARTY

FROM: Claire Bolduc - Terry Polchies

DATE: 20 September 1991

RECEIVING PARTY

TO: Paul Saucier

ORGANIZATION OR FIRM: Comm. Gov't Restructuring

FACSIMILE NUMBER 289-1275

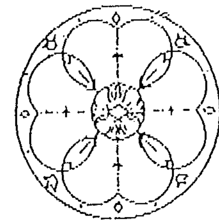
NUMBER OF PAGES, W/O COVER 2

SPECIAL INSTRUCTIONS: Bonjour et Merci

If you are having difficulties in receiving this facsimile transmission, please contact the person listed below at (207) 942-2926 or 942-2927

Thank you Claire Bolduc

Central Maine Indian Association, Inc.



TESTIMONY BEFORE THE
SPECIAL COMMISSION ON GOVERNMENTAL RESTRUCTURING
COMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY
BY
TERRY POLCHIES, EXECUTIVE DIRECTOR
CENTRAL MAINE INDIAN ASSOCIATION, INC.
20 SEPTEMBER 1991

Thank you for this opportunity to present some thoughts from the members and staff of Central Maine Indian Association. This Commission has an enormous task - and a rich opportunity to positively affect the lives of our constituency. We have read the Interim report, and are appreciative of the work already done, and assure you of our gratitude for your commitment and hard work to date.

We were particularly interested in the Function Statement, which, to us, is missing a most important statement about the State's absolute and inexorable commitment to the common weal, to the flowering of each citizen's personal potential, and to sustainable family and community life. These commitments would reassure our community about the future of their families, their children and their communities. We urge the committee to consider this suggestion.
We support the notion that the delivery of services is indeed a State responsibility.

We searched also for a commitment to the provision of free health and social services, and did not find it. Such a commitment would reassure all citizens - since any of us might be in the position of needing continuing health/social services, and few of us have employer-provided insurance coverage.

The Initial Findings are a satisfactory description of problems we would have identified from our work loads. Yet, we would add one. The State and its Agencies does not have a clear, concise, inclusive goal for the common weal and for the development of its most important resource: people. We would ask you to include such a goal in the Options. A Goal could unify the efforts of the dedicated professionals in all the state agencies, and serve as a benchmark for the beginning of this new effort to restructure and optimize State services.

We have considered the gaps and problems identified and have the following suggestions:

1. Services ought to be decentralized - particularly in rural settings, so that no citizen is further than 25 miles from a social service provider. This may mean one social worker, and a meeting room in West Athens, but that one person with continuing training could be

157 Park Street, P.O. Box 2280, Bangor, ME 04402-2280 Telephone (207) 942-2926 or (207) 942-2927

the point of entry for the residents of that 25 mile catchment area. The meeting room can provide space for residents to meet service providers, meet each other, provide a place to "get away from the house". In larger communities, the meeting space could easily be used to provide day care services for mental health consumers, for example.

Decentralization can also be served by paying for professionals to circuit ride through a district. This would certainly provide the profession with new and important information about the consumer in his/her natural setting.

Single points of entry to the systems of health and social services could be a phone system, staffed by highly trained ombudsmen.

2. The question of shortage of trained professionals is worth extra attention, as the findings do not address the lack of indigenous health and allied health professionals. For example, there are no Native American physicians... There are no recruitment initiatives in the functionally bilingual and bicultural communities - despite the fact that these communities have a higher than average need for prevention and treatment services. We urge the committee to add culture and language to their understanding of our communities.

We also observe that the State agencies do not make optimum use of their highly trained personnel: in effect MSW's are often taken up by tasks that can be accomplished by clerical support persons, and they could be allowed to do the "social work" that clients so desperately need.

3. We believe that Prevention and Early Intervention are still difficult concepts for planners and policy makers, and unwieldy for service providers like ourselves. We believe that Prevention merits extra attention and development from a wide group of consumers, providers, and natural community leaders. Our work loads indicate that Prevention is a misnomer, that in our prevention work, we are "breaking cycles". Framing the question in this way yields new insight about the real work of prevention and intervention, and the tasks are easier to outline and plan. Goals are easier to set. We suggest that the issues of Prevention and Early Intervention be revisited by another Commission before final reports and recommendations are presented to the Governor and Legislature.

4. The other options in the Report seem most reasonable, and with the addition of culture, language, decentralization, and clear State goals for the development and support of all citizens, we can imagine that the implementation of these options could be os service to our members/clients.

Thank you for your invitation to participate, and we would be happy to answer any questions you might have about our work or our suggestions.

Maine Foster Parent Association

Aspen Ridge
11 Liberty Drive
Bangor, Maine 04401
848-7537 or 1-800-367-3900

September 19, 1991

To Members of the Committee on Health, Social Services and Economic Security:

The Maine Foster Parent Association feels strongly that the formation of a Department of Child and Family Services is in the best interest of children, families and the State of Maine. We urge that prevention and early intervention be the goal and that this be reflected in the mission of this new Department by the directive to screen families into the system upon referral rather than out as is presently the case.

Regarding items seven and eight from "options under discussion", it seems ideal to us that a family be assigned one worker, responsible for assessment of that family's needs who would also continue to function as broker and advocate for that family. This family caseworker would design, coordinate and oversee an individualized plan which would neither neglect nor overlap services essential to that family's well being. This would be of benefit, not only to the family which would have an ongoing relationship with one person but for social workers whose present compartmentalized view of his or her client limits intervention options.

Given the large percentage of state wards who are adjudicated we would also urge that existing information from the Department of Corrections be incorporated into a central information and intake system and the formation of a family court be considered.

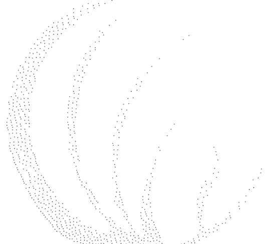
As the largest single provider group to state wards, Maine Foster Parent Association expects to work closely with the committee charged with the development of regional boards which would plan and implement appropriate services for Maine's children.

We thank you for this opportunity to express our opinions and concerns and look forward to an interactive relationship with this and future committees.

Sincerely,

Debbie Goss
President

Alliance for the Mentally Ill of Maine



MEMORANDUM

TO: Special Commission on Governmental Restructuring, Committee on Health, Social Services and Economic Security.
FROM: Michael J. Fitzpatrick, Alliance for the Mentally Ill of Maine
DATE: September 20, 1991
RE: Brief Comments on Committee's Interim Report

The Alliance for the Mentally Ill of Maine which has twenty-one (21) affiliates throughout Maine has a membership of over 1,000 families.

We are excited by your reorganization efforts. They hold promise to create a more accessible and balanced system of care. The following are brief comments on four (4) key areas:

1. REGIONAL BOARDS TO PLAN AND IMPLEMENT COMMUNITY MENTAL HEALTH SERVICES.

   Maine's mental health system remains fractured with uneven resource distribution. This option has the potential of creating a coordinated and accountable system of care for persons with mental illnesses that truly respond to local needs. It should promote healthy competition and require services to be more readily accessible to the persons they serve.

   We welcome this change.

2. THE CREATION OF A DEPARTMENT OF PHYSICAL AND MENTAL HEALTH THAT WOULD INCLUDE THE BUREAUS OF PUBLIC HEALTH, MENTAL HEALTH, MENTAL RETARDATION, REHABILITATION SERVICES AND MEDICAID SERVICES.

   Access to effective community based inpatient and outpatient services is the highest priority of families with a loved one with mental illness. Mental illness thrusts a person into many service systems. Service provider turf and communication issues complicate an already confusing, ill funded system.

   An example of these problems is the inability of the Bureaus of Mental Health and Rehabilitation to philosophically and practically combine their resources. This has served to create a system that is fraught with delays and regulations which effectively discourage many persons with mental illness who wish to go to work.

Box 222, Augusta, ME 04332
(207) 622-5767 / 1-800-464-5767

Mental illness is Maine's number one health problem. History and stigma continue to separate mental illness from other health problems. A Department of Physical and Mental Health would seem to be a natural match and meaningful start toward combining and coordinating those services that are so crucial to the needs of persons with mental illness and their families.

The two (2) shortcomings that concern us are that the medicalization of care for those with mental illness may too narrowly focus the scope of the system of care and that within a larger department of health, mental illness may lose the focus it now, at long last, has achieved.

3. DEPARTMENT OF CHILD AND FAMILY SERVICES.

We are continuing to work with families who have children with mental illness. They have to transition the mental health, education, social service and, at times, youth correctional systems. Much of the pain and frustration that these families feel is directly related in the incomprehensible maze this service system presents. A Department of Child and Family Services may be a critical step toward creating a responsive and understandable system of care. The time is now to create systems that are flexible, accessible and responsive to the needs of those who use them.

While AMI-ME has some concerns that moving the service boxes around will not be as effective as we hope, we feel strongly that your reorganization efforts are worthwhile and a long time coming.

4. CONFIDENTIALITY.

Finally, confidentially requirements within the mental illness service system continue to interfere with families becoming part of their loved ones treatment team. In most circumstances, the families involvement is essential to assure the best possible treatment.

Thanks for the opportunity to respond to your efforts.

Dist 8/23 HHS

John R. McKernan, Jr.
Governor

DEPARTMENT OF LABOR
Telephone (207) 289-3788
FAX (207) 289-5292

Charles A. Morrison
Commissioner

August 23, 1991

SUBCOMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY

DOL SERVICES TO UNEMPLOYED/UNDEREMPLOYED

INTRODUCTION:

* DOL is a human resource development agency committed to providing services and programs to people and businesses to ensure the security and skills of Maine's work force, both today and in the future.

* We provide:

-- Labor exchange and job training services;

-- Income protection via unemployment insurance benefits;

-- Health and safety protection for the public and workplaces;

-- Regulation of working conditions;

-- Career education and labor market information; and

-- Labor-management relations services.

* For our "Unemployed/Underemployed" clients, 97% of the DOL effort (about $200 million) is devoted to this population.

* Services are nearly all federally funded, and are delivered through a decentralized network reaching all parts of the state.

* Because our programs are mostly federally-funded, we are geared to meeting federal performance standards. Our programs have been nationally recognized; we received the NAB award for excellence.

* Delivery of our services is coordinated through MHRDC to avoid duplication and overlap of programs.

P.O. Box 309, Augusta, Maine 04332-0309 — *Offices Located at* 20 Union Street

* RETI is an example of how we maximize services and avoid duplication/overlap with other organizations.

* DOL is unique in that many of our services require or are encouraged to have private sector involvement and oversight (PICs, BES and JS Advisory Committees, JMG, LMI Affiliates, and various boards -- Health & Safety, Boilers, Elevators).

* Our use of technology to improve productivity and to enhance our ability to deliver services is one of our strongest attributes:

-- Voice activated computers are used to collect information from clients;

-- We are expanding this to include a voice response system to enable clients to obtain information regarding eligibility status;

-- All offices are highly automated from on-line terminals to stand-alone systems;

-- Our systems are data-based and networked;

-- We have in place artificial intelligence systems to automatically and uniformly process routine functions;

-- We utilize portable terminals to access data bases from on the road remote locations; and

-- We are looking at placing user-friendly touch screens in our offices and other public places to widen service delivery.

* All target groups are treated the same so that all available resources are applied to clients based on individual needs.

* I emphasize this because we play a role in serving the "Physically Disabled," which I will address briefly here rather than later in the day as indicated in your agenda.

DISABLED

* We coordinate our services to clients with disabilities, whether physical or mental, with other agencies (Voc. Rehab, Mental Health, Goodwill, Voc. Tech. Centers).

* Our unique role is to provide "Try Out Employment" or paid work experience to see if the person can actually succeed on the job.

* Perhaps what is most needed to improve services to the disabled is better case management.

DUPLICATION/OVERLAP OF SERVICES TO THE UNEMPLOYED/UNDEREMPLOYED

* DOL is the federally-recognized designated agency for delivery of job training, labor exchange, unemployment benefits and labor market information, although some overlap exists with other agencies and in the private sector (private employment agencies, supplemental unemployment benefits from unions, testing and training by other agencies).

* AFDC recipients are a target group for both DHS & DOL because of federal legislation. (ASPIRE-JOBS).

* New legislation does not always consider existing resources and responsibilities when creating new demands (e.g., family medical leave and whistleblower protection are assigned to MHRC for enforcement, but these are of an employment standards nature).

EMERGING ISSUES

* Workforce trends indicate an immense need for skills training and upgrading because most of the labor force for the year 2000 is already working, but yet about half of the new jobs created between now and then will be phased out or restructured.

* Workplace literacy and competency based education and training must be made more relevant to the workplace and world of work. (SCANS report)

* Business, together with government and community based organizations, must assume greater responsibility for improving productivity and meeting the employment and training challenges to the year 2000.

* To meet the increasing needs of all of government's customers, unified, multi-agency, cooperative approaches to human resource development must be established.

* Dwindling resources and increasing complexity require that information and data bases be shared and integrated among all agencies.

* The rural nature of the state and lack of adequate public transportation are becoming larger issues since it is more difficult to deliver services to some remote areas.

NUMBER 1 CHANGE -

* Improving service to all customers by:

-- Providing meaningful coordination of program planning and delivery (strengthen MHRDC);

-- Breaking down the artificial and self-imposed barriers to inter-agency cooperation;

-- Increasing the funding capabilities of our systems (e.g., STAR funding via UI tax offset);

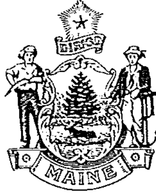
-- Increasing our funding flexibility and stability (use of federal-state-local funds, removal of UI-JS funds from federal budget);

-- Improving communication to the public of what services are provided and who provides them; and

-- Integrating (not necessarily combining) services so that programs are interrelated when customers have more than one need (one-stop shopping).

# # #

Dist 8/23 HHS



John R. McKernan, Jr.
Governor

Charles A. Morrison
Commissioner

James F. Nimon
Executive Director

DEPARTMENT OF LABOR
BUREAU OF EMPLOYMENT AND TRAINING PROGRAMS

August 23, 1991

SUBCOMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY

DOL SERVICES TO UNEMPLOYED/UNDEREMPLOYED

THE HEALTH OCCUPATIONS TRAINING (HOT) PROGRAM

INTRODUCTION

The HOT program has three separate parts that provide for: (1) increased training of Job Training System (JTS) participants for Certified Nurses Aide (CNA), Home Health Aide (HHA), and Licensed Practical Nurse (LPN) occupations; (2) training JTS participants for technical health occupations; and (3) reducing the shortage of Registered Nurses (RNs) by providing a loan payback program for employed RNs in Maine.

Following is a brief summary of each part:

Part One:

The Maine Department of Labor's (DOL) JTS provides outreach, recruitment, orientation, selection, preoccupational training, supportive services and needs-based stipends to HOT trainees who are generally selected from the JTS's applicant pool.

Maine's Technical Colleges provide the vocational training.

Since upgrading is such an important element of this program, all CNAs trained are contacted within a year of job placement to determine if they want to participate in training in order to be upgraded to LPN. LPNs trained during the first year are also contacted to determine if they are in a position to participate in training to be upgraded to RN.

Hospital Street, State House Station #55, Augusta, Maine 04333
Telephone (207) 289-3375

All training costs are met by the JTS providers using existing DOL and Department of Human Services (DHS) funds.

Part Two:

The State's JTS provides outreach, recruitment, orientation, selection, preoccupational training, supportive services, and needs-based stipends for participants who are usually selected from the JTS's applicant pool.

Skill training is accomplished through the participating hospitals who either deliver the training in-house or through sub-grants to other training entities such as a Technical College. The participating hospitals bear the cost of occupational training.

Funding for this program comes from existing job training funds held by the JTS, State general revenue funds, and from funds provided by the participating health care facilities. The State appropriation is being provided to help defray the costs of training materials. The participating hospitals bear the rest of the occupational training costs.

Part Three:

Legislation has been passed making it an allowable cost under the Maine Health Care Finance Commission for hospitals to repay the Government Student Loans of RNs employed at that institution. The Department of Human Services has amended its rules of reimbursement so that the State's other health care facilities (nursing homes, home health agencies, and rural health centers) can also charge loan payback as a reimbursable cost.

OVERLAP WITH OTHER AGENCIES

There is no overlap in the delivery of services or administration of this program. In fact, HOT is an example of a program where close collaboration exists between the DOL JTS, the DHS, Maine's Technical College System, and Maine's health care system network.

EMERGING ISSUES

The issues identified by Commissioner Morrison regarding the need to retrain the work force apply. Small health care facilities continue to need multi-skilled and multi-certified employees. There is a need for continued support for increased vocational training programs to respond to the critical shortage of trained and certified health care professionals.

Finally, there is a need to continue to explore ways to leverage Federal or private funds to match State general revenue funds. It is estimated that the JTS leveraged $850,000 of Federal funds to supplement the $250,000 contribution from State general revenue funds.

#1 RECOMMENDATION FOR IMPROVEMENT

Rural hospitals and other small health care facilities need to make full use of all the retention tools at their disposal. Any decrease in funding for health provider training is bound to affect the ability of these facilities to retain qualified staff. This is a human resource issue that needs to be collectively addressed and funded by the JTS and post-secondary systems.

Department: DOL - BETP

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Eligible job training clients interested in health occupations training	Health Occupations Training (HOT)	Eligible for any job training program	Health occupations training (Same as JTPA II-A)	369	$249,294

(use as many pages as needed to list all services provided to each client group)

Department: DOL - BETP

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Economically disadvantaged Adults & Youth with identified barriers to employment.	JTPA Title II-A	Economically disadvantaged	Assessment, basic/remedial education, occupatioal skills training, supportive services, job counselling, search and placement.	3,467	$5,389,500
Economically disadvantaged youth	JTPA Title II-B	Economically disadvantaged age 14-21	Exposure to work, basic/remedial education, school retention	1,030	$2,143,858
Dislocated workers	JTPA Title III	Dislocated due to mass layoff or plant closing	Readjustment and retraining services (Same as JTPA II-A)	1,738	$2,332,767
UI Claimants	STAR	Eligible UI claimants	Occupational skills training (Same as JTPA II-A)	1,280	$1,668,799
Economically disadvantaged above Title II-A threshold	MTI	Eligible under State MTI guidelines	Occupational skills training (Same as JTPA II-A)	1,476	$ 730,419
Eligible job training clients interested in health occupations training	HOT	Eligible for any job training program	Health occupations training (Same as JTPA II-A)	369	$ 249,294
Displaced Homemakers	DH	Eligible Displaced Homemakers	Assessment job counseling, referral support services	561	$ 519,883

(use as many pages as needed to list all services provided to each client group)

Department: DOL - BETP

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
UNDUPLICATED COUNT OF JOB TRAINING SYSTEM PARTICIPANTS - PY '90 TOTAL PARTICIPANTS				5,716	
Youth (age 14-21)				1,423	
Women				3,451	
Handicapped				866	
High School Dropouts				915	
Economically Disadvantaged				3,838	
Older Workers (Age 55+)				330	

(use as many pages as needed to list all services provided to each client group)

TOTAL P.07

Department: Labor
Bureau of Employment Security
Job Service Div.

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
All people seeking employment.	Employment Service	Unemployed, Underemployed, New Entries, Re-entries	Work registration, Veteran Service, Employment Counseling, Job Referral/Placement, Job Bank, Computer Job Matching, Labor Market Information, National Job Bank, TJTC, TAA, STAR	147,000	5.3 m Admin. 1.0 m Training 6.3 m Total
* SUB-GROUPS					
Female 42%	" "	" "	All Services	61,740	No
Male 58%	" "	" "	All Services	85,260	breakout
Youth 24%	" "	" "	All Services	35,280	of
Veterans 14%	" "	" "	All Services	20,580	funds
Disabled 2%	" "	" "	All Services	2,940	
Minority 2%	" "	" "	All Services	2,940	
Eligible Claimants 9%	" "	" "	All Services	13,230	

(use as many pages as needed to list all services provided to each client group)

* 5 year average percentage applied to June 1991 year end figures.

Department: LABOR 7/1/90 - 6/30/91

Bur. of Employment Security
Unemployment Comp. Div.

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of ~~Clients~~ Payments	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Total/Partially Unemployed Workers	Unemployment Insurance Regular Program	Total or Partially Unemployed	Cash Benefit Payments	1,043,641	$160.9 M
" " " " "	UCX Unemployment Comp. for Exservice Personnel	" " "	" " " " " "	2,789	$ 0.5 M
" " " " "	UCFE Unemployment Comp. for Federal Employees	" " "	" " " " " "	9,939	$ 1.7 M
" " " " "	TRA Trade Readjustment Allowance	Unemployed Due To Foreign Imports	" " " " " "	8,346	$ 1.1 M
" " " " "	DWB Dislocated Worker Benefits	Unemployed Benefits To Dislocated Workers	" " " " " "	11,677	$ 1.8 M
" " " " "	DUA Disaster Unemployment Assistance	Unemployed Due To A Major Disaster	" " " " " "	0	0.0
" " " " "	Unemployment Insurance Extended Benefits	Total or Partial Unemployed	" " " " " "	104,875	$ 15.7 M
" " " " "	Unemployment Comp. for Federal Employees Extended Benefits	" " " "	" " " " " "	1,234	$ 0.2 M

(use as many pages as needed to list all services provided to each client group)

Department: Education

Division of Alcohol and Drug Education Services

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
Maine school children and the teachers, administrators, counselors, etc., who work with them	Alcohol and drug prevention and education programs and services	To prevent problems related to alcohol and other drug use, abuse, and dependency	The division carries out a strategy of statewide leadership, guidance, and direct on-site services to schools for the establishment and maintenance of developmentally oriented, age-appropriate alcohol and other drug prevention and education programs and services.	210,200 children, 16,500 administrators and teachers, 525 guidance counselors, and 219 school nurses	$1,177,362

(use as many pages as needed to list all services provided to each client group)

TEA TALKS

A series of morning discussions with national experts on issues related to reimbursement of integrated treatment for individuals with the dual disorders of mental illness and substance abuse. Each talk will consist of approximately a one and one half hour presentation followed by a half hour discussion.

ECONOMIC ASPECTS IN PROVIDING INTEGRATED TREATMENT

August 27, 1991
9 - 11
Alfred's Restaurant
Kennebec Room
Civic Center Drive
Augusta

Thomas G. Mcguire, Ph.D. **Economist**
Dr. Maguire is a professor of economics at Boston University and a 1991 recipient of the Carl A. Taube Award for leadership in mental health services research from the American Public Health Association. He has played a key role nationally in assisting with mental health services financing within the public and private sector. Dr. Mcquire is an NIMH Senior Research Fellow.

QUALITY MANAGED CARE

September 10, 1991
9 - 11
Alfred's Restaurant
Kennebec Room
Civic Center Drive
Augusta

Maureen T. Hennessey, Ph.D. **Psychologist**
Dr. Hennessey is currently an Executive Director with CIGNA and manages the mental health and chemical dependency healthcare of the Missouri CIGNA Healthplan and the local employee assistance program for their national EAP network. She has also managed mental health and chemical dependency care for Connecticut General Insurance Company and Heritage Healthplan. Dr. Hennessey has served as a national consultant with government agencies and with the private sector in the area of managed care.

CLINICAL INSIGHTS AND RESEARCH FINDING

October 2, 1991
9 - 11
Day's Inn
390 Western Avenue
Augusta

Robert E. Drake, M.D., Ph.D. **Psychiatrist**
Dr. Drake is director of the New Hampshire-Dartmouth Psychiatric Research Center and associate professor of psychiatry at Dartmouth Medical School. He is widely regarded as the leading researcher in the area of dual diagnosis within the nation and consults with numerous government and private agencies on this topic. Dr. Drake is an NIMH Senior Research Fellow.

Individuals are asked to pre-register for each of these sessions by mailing $3 for each talk to Pam Boucher at MH&MR, Station #40, Augusta, Maine 04333 (289-4203) along with your name, address, phone #, and date requested. On-site registration will take place from 8:30 - 9 a.m.

The work of the Dual Disorders Reimbursement Task Group is funded, in part, with grants from the federal Office for Treatment Improvement, National Institute on Drug Abuse, National Institute of Mental Health and by the Bingham Consortium for Health Research.

STEPS OF COMPREHENSIVE ALCOHOL AND OTHER DRUG IMPLEMENTATION

SCHOOL/COMMUNITY TEAM DEVELOPMENT

SCHOOL/COMMUNITY TEAM

TWO-DAY STAFF INSERVICE EDUCATION AND AWARENESS

POLICY AND PROCEDURE

STUDENT ASSISTANCE TEAM TRAINING/IMPLEMENTATION

CLIMATE

PROJECT GRADUATION
PROJECT HOLIDAY
SAFE HOMES
NON-SCHOOL STUDENT FUNCTION POLICY
PRO-ACTIVE POLICE RESPONSE

SUPPORT GROUPS

STUDENT AWARENESS

CURRICULUM

STAFF DEVELOPMENT

MODELING

MISSION STATEMENT

THE DIVISION OF ALCOHOL AND DRUG EDUCATION SERVICES

MAINE DEPARTMENT OF EDUCATION

The Division of Alcohol and Drug Education Services of Maine's Department of Education is responsible for carrying out state government's core strategies in alcohol and other drug prevention and education for local schools in coordination with the Office of Substance Abuse. It creates school and community teams whose function is to provide leadership for locally controlled comprehensive alcohol and other drug prevention and education programs. It provides direct services to teams and schools as they develop, implement, maintain, and evaluate their programs. It conducts training activities for school personnel to help ensure that all Maine school children have a developmentally oriented, age-appropriate, up-to-date, and accurate curriculum for alcohol and other drug education in Kindergarten through grade 12. It further supports local efforts through administration of the Federal Drug-Free Schools and Communities Act and provision of technical assistance and audiovisual resources. It assists the Division of Special Education in developing school building level Student Assistance Teams whose purpose is to help high risk youth. Together these strategies help ensure that all Maine children have the benefits of high quality prevention and education programming now and in their future.

Dist 8/23 HHS

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

SUBSTANCE ABUSE SERVICES

The focus of substance abuse efforts within the Department of Mental Health and Mental Retardation is on improving the quality of services available to it's constituency: individuals with mental illness, children with special needs, and people with mental retardation.

As a group, this constituency has historically been poorly served when in need of treatment for a substance use/abuse problem in addition to their emotional or intellectual disability. Consequently, duplication of services to this consumer group has not been an issue, rather, lack of access and unavailability of appropriate services have been the norm. The existance of two, quite separate systems, (mental health and substance abuse), has contributed to the tendency to address only one part of an individual's needs which, all too often has resulted in relapse.

The Department continues to work closely with the Office of Substance Abuse (OSA) for the purpose of assuring greater systems integration at the state level. Joint contracts, mutual participation in a variety of working committees, regular informational meetings, data sharing, and joint planning and budgeting are all utilized as means for realizing a more uniform and wholistic system of service delivery for consumers.

Development and maintenance of positive working relationships with substance abuse and mental health providers, family members and consumers is an additional area of emphasis. This goal of developing partnerships which build on mutual interests and foster respect for diversity is currently being addressed through a series of working committees:

- fetal alcohol and drug effects (FADE Prevention Team)
- adolescents with substance abuse and mental health disorders (Adolescent Dual Disorders Documentation Advisory Committee)
- reimbursement for treatment of individuals with co-existing mental illness and substance abuse disorders (Dual Disorders Reimbursement Task Group)

Training and consultation for mental health and substance abuse providers on the interrelationship between mental illness and substance abuse disorders has been, and continues to be, a major thrust of this Department. Aimed at breaking down the professional barriers that exist between substance abuse and mental health professionals, these trainings are designed to build on the strengths which each discipline has to offer while at the same time broadening the capacity of the professional to more ably serve individuals with multiple needs.

The need for community based, person centered, integrated (mental health and substance abuse) treatment by the year 2000 is an area of critical need.

Two reports published in the past year, the Final Report of the State of Maine Systems Assessment Commission and the Maine Dual Disorders Monograph Volume VI call for greater unification and integration of mental health and substance abuse systems and services. This is an overall goal that is shared between the Department and OSA.

Substance abuse services within state government have experienced considerable change as a result of legislation passed in the last two sessions (P.L. 934 and P.L. 601). Many of these changes are still in the process of being implemented and, as such, it is too early to tell what, if any, additional structural changes may be needed.

At this point in time it would be helpful to have a clear structural linkage or requirement between institutes of higher education which train MSW's, psychologists, nurses, substance abuse counselors, rehabilitation counselors, physicians, etc. and the state mental health and substance abuse entities. The purpose of this linkage would be to assure that current teaching within academia is aligned with current thinking as to best practices and consumer needs in the community.

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Department: of Mental Health and Mental Retardation

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Early Intervention/ Prevention (FADE)		Referral request	intake and assessment training and consultation	60 1980	51,664
MR Alcohol		MR/substance abuse	developmental tutors, psychoeducation	23	59,835
County Jails		incarcerated, non OUI	presentence planning, substance abuse assessment, evaluation group	800	130,665
Dual Diagnosis Inpatient		institutionalized at BMHI, AMHI or diversion	substance abuse assessment and evaluation individual and group treatment	250	352,136
Dual Diagnosis Community		mi/sa	assessment and evaluation, individual and group treatment/education	380	354,405
Elderly Services		elderly	information/education for elderly health, mental health and substance abuse	12,000	5,000
Intervention/ Prevention Youth		at risk of being removed from home	homebased care (time limited, family intervention and treatment)	80	132,100

(use as many pages as needed to list all services provided to each client group)

UNMET SUBSTANCE ABUSE SERVICE NEE[illegible]
IN MAINE

TREATMENT SERVICES FOR ADOLESCENTS

Brief Description of Need:

Twelve-percent of the adolescent population in Maine abuses alcohol or other drugs. Between 25% and 33% of Maine's school children come from families where the parents are abusing alcohol or drugs. Unfortunately, however, the existing treatment system is inadequate to respond to this need. Part of the inadequacy is lack of sufficient service capacity to respond to the demand for service. Part, however, is lack of sensitivity of the existing service system to the needs of adolescents as a special population. That is, while some adolescents do get into the existing service system, they are not generally treated by clinicians who are sensitive to adolescent development, and how to motivate young people to become chemically free. In other words, those who get into treatment programs do not always get the best service (except in those few areas where the programs have been specifically designed to serve kids).

Proposed Response:

A series of initiatives is needed to establish a separate service system that can respond to the growing demand for service:

1. Expanded outpatient and aftercare services.

   Basic outpatient and aftercare services, tied to local school systems wherever feasible, need to be established in most areas of the state. A total of 53 full-time equivalent counselors for the indigent is needed across the state to supplement existing counselors. These people would treat 2,900 adolescents per year (74 x 55).

2. Day treatment.

   This service component needs to be established in seven locations, and serve adolescents who require a more intense treatment service, but who have stable family situations. Funds could be used to pay for 21 slots for indigent clients at a rate of $125/day. Approximately 350 clients could be served.

3. 28-day Residential Rehabilitation.

   Specific access to 28-day rehabilitation is needed for indigent adolescents, who are not eligible for Medicaid. Twenty-one slots are needed for indigents; some now get into care under the "bad debt" category. Funds identified could be used to purchase care for the approximately 120 adolescents who demand this service but never get admitted.

4. 6-Month Rehab tation.

An addition 0-bed p is needed to compliment existing services in the Portland and Bangor areas. This program would serve an estimated 20-25 kids per year.

PREVENTION/INTERVENTION SERVICES FOR ADOLESCENTS

Brief Description of Need

Substantial work is being done in Maine's school systems in the area of education and training of both students and teachers regarding substance abuse. In addition, a few school systems are beginning to develop intervention mechanisms -- Student Assistance Programs, designed to identify and intervene with students at high risk of substance abuse, as well as other problems. Included as the target population here, are both the 12% of the population that is chemically dependent, and the 25-33% which come from homes where the parents are abusing. Obviously, there is some overlap between these two groups.

Unfortunately, school systems are not responsible for providing many of the special services needed by this at-risk population -- including such things as self esteem building, building skills of refusal, provision of alternative recreational and other activities, to encourage positive activity as opposed to drug use for escape.

Outside the school system, many professionals also work with kids. These professionals, and their organizations, have not had the benefit of the kind of training that the Department of Education has offered school systems. For example, child welfare organizations, Probation and Parole, and group home staffs which serve troubled kids often lack the expertise that school systems have developed in their understanding of substance abuse, and their ability to recognize it in the children they work with.

Proposed Response

Given the problem, two different types of efforts are needed to encourage the delayed use of drugs by high risk adolescents:

1. Supports to Student Assistance Programs.

Building on OSA efforts, additional funds are proposed to purchase services needed by high risk youth. In particular, skill building training, self esteem building experiences, and establishment of peer leader programs would be supported. Grants of $35,000 could be made available to a total of 10 school systems. Funds could be spent on services purchased from the community, thereby encouraging a partnership between community-based service agencies and the school system.

Training and consultation for systems ng out-of-school youth.

Funds could be used to provide intensive training to groups of professionals which currently work with the kids at the highest risk of substance abuse -- those who have dropped out of school, and become known to the state social service system. Emphasis would be on understanding chemical dependency, identifying its effects on the kids served by the trainees, and the development of a multi-year action plan to respond to those needs. Systems targeted for initial training would include community-based providers, such as the residential treatment centers and group homes which now house many adolescents; as well as the state employees who serve difficult adolescents -- Probation and Parole, Maine Youth Center staff, and the Department of Human Services Child Welfare.

TREATMENT SERVICES FOR CORRECTIONS CLIENTS

Brief Description of Need

On any given day, Maine currently has approximately 2,000 adults in State correctional institutions, including 1,400 in State prisons, and 600 in the Count jails. In addition, 225 are housed at the Youth Center. It has been estimated that 75% of these inmates have a substance abuse problem. Unfortunately, treatment resources both inside the institutions, and upon release, are largely inadequate. The current demand for services by this population will be increased as the Bush drug law enforcement strategies are implemented in Maine and as we add more prison beds.

Correctional clients do not always do well in generic outpatient programs designed for motivated individuals. Expansion of specialized services, both inside and outside the prison walls, is needed. The programs need to be tailored to the particularly resistant client. National models that are successful are available and can be replicated in Maine.

Proposed Response

Expansion of services needs to occur both inside and outside of the institutions, as follows.

For Adults

1. Expansion of treatment in the County jails.

   Some County jails currently have substance abuse counselors, including Androscoggin, Oxford, Franklin, and Kennebec Counties. This item would allow for expansion of treatment services to four other Count jails. It would also support the development of "alternative site programs," particularly for OUI offenders who can be safely housed outside the County jail. This powerful combination of alternate housing, education, and treatment inside the jails would replicate successful activities now being undertaken specifically in Kennebec County.

2. Staff positions w n the correctional facilities.

   Only one institution, the Maine Correctional Center, has a State employee responsible for coordinating and overseeing the substance abuse service needs of prison inmates. An additional 7 positions, one for each of the major correctional programs, are needed to manage the substance abuse treatment problems of existing inmates.

3. Follow-up Outpatient Counseling Upon Discharge.

   Additional outpatient services specifically tailored to the needs of Corrections' clients are also needed. Funds should be made available to support services to 500 inmates upon release, in 10 separate locations.

Subtotal for adults

For Adolescents

1. Residential options for substance abusers leaving the Youth Center.

   Follow-up residential care is needed for residents who have completed the substance abuse programs on the Youth Center campus. This would provide for a 10-bed halfway house for residents leaving the institution, and for the establishment of two pilot 8-10 beds transition homes, one in Lewiston-Auburn, and one in Bangor. The transition homes would provide for follow-up placement for residents leaving the halfway house. In these facilities, residents could be taught continued sobriety skills, as well as independent living skills. On an annual basis, approximately 40 youth would be served by this system of residential placements.

DEMONSTRATION HALFWAY HOUSE FOR PREGNANT WOMEN AND MOTHERS OF YOUNG CHILDREN

Proposed Response

An estimated 40,000 Maine women have severe problems with substance abuse. It is estimated that as many as 1,000 drug and alcohol affected infants are born in Maine annually. Approximately 10% of all admissions to State funded agencies receive child support and/or AFDC. About 26% of all State funded admissions to substance abuse treatment facilities are women. State and National Junior League studies have identified child care as the key factor in prohibiting women from seeking/receiving appropriate substance abuse treatment.

Funding would provide services aimed directly at treating pregnant women and mothers with young children. These women have stayed away from or not completed treatment in the past because traditional programs lack the means to adequately meet the concerns of the population - child care and prenatal care. Funds for this program would be directed to meeting the needs of this population which would enhance the program's ability to work on substance abuse issues and behavioral changes aimed at parenting skills. Networking to existing programs would be emphasized to meet follow-up and aftercare needs. Without additional funding, substance abusing pregnant women and mothers with young children will continue a pattern of substance abuse, physical abuse and a continued burden to the State welfare system. And women will remain limited in receiving the most appropriate treatment component.

A priority is a halfway house for pregnant women and mothers of young children. The total budget for a halfway house (1 10-bed facility) would be very similar to that of Evodia House or Crossroads. These programs are in the greater Portland area. The average annual operational cost for these two facilities is approximately $315,000.

To provide therapeutic day care services, at least two additional staff persons would need to be added to the program (a Master's level person and a non-Master's level person). Separate staff are required for the following reasons:

(a) Day care licensing requirements do not allow the sharing of staff across program areas;

(b) Operating a child care facility is as demanding a job as administering a substance abuse program. This is especially true since children of substance abusing parents often have needs of their own and, therefore, special skills are required of staff;

EQUITABILITY OF SUBSTANCE ABUSE COUNSELORS' SALARIES TO REDUCE HIGH TURNOVER RATES IN PUBLICLY FUNDED TREATMENT PROGRAMS

Proposed Response

Intense competition for qualified substance abuse staff exists within the service system between programs that serve predominately poor clients and those which serve private paying clients. Due to this, public programs have and are experiencing high turnover rates as most qualified clinicians move on to higher salaries elsewhere.

Of the clients served in publicly funded programs, 64% have no medical coverage, nearly half enter treatment unemployed, and 38% are widowed, separated or divorced. The continuing exodus of qualified clinicians leaves these public programs with less qualified staff and longer vacancies. Some agencies have experienced a rate of reduction in clients served as high as 25% due to long vacancies in positions.

COLA FOR COMMUNITY SUBSTANCE ABUSE AGENCIES

Proposed Response

Community substance abuse agencies serve 13,000+ clients with substance abuse issues in Maine yearly. Over half (54%) of those admitted have no insurance coverage. Twenty-five percent of the household income is retirement, AFDC, SSI, disability, town welfare or social security. The average monthly income is $720. There is a need for substance abuse services in Maine, particularly those who serve the client with a difficulty to pay. Agencies have already reduced services because of their inability to attract and retain qualified staff. Remaining staff experience overloading to handle demands. A local study revealed entry level substance abuse counselors found their salaries near the income guidelines qualifying recipients for food stamps.

REPLACEMENT OF LOSS FEDERAL FUNDS TO SUSTAIN A MODEL COMMUNITY YOUTH ACTIVITY PREVENTION PROGRAM IN PORTLAND'S PUBLIC HOUSING PROJECTS.

Proposed Response

This nationally recognized program develops and supports a positive peer leadership network to prevent alcohol and drug abuse, teen pregnancy and other social problems in Portland's public housing projects. The project's goal is to break the cycle of chronic dependence and failure to create a more positive, success oriented environment. With funding, the program could annually maintain peer leadership support for 75 youth, purchase health, social and support services for 100 housing project residents and maintain a variety of alternative community activities for 400 housing project residents.

TEEN PREGNANCY AND SUBSTANCE ABUSE INTERVENTION/TREATMENT

Proposed Response

In Maine, one of every 15 teens becomes pregnant each year. Thirty-five percent of all births to teens have been to teens under age 18. On thousand teens are receiving AFDC at any one time. It is estimated that 2/3 of pregnant teens under age 15 and nearly 1/2 of 15 to 17 year olds do not receive prenatal care in their first trimester. Maine's AFDC expenditures per year for children born to teen parents is about $50 million. Approximately 1,000 drug and alcohol affected infants are born in Maine annually, and 12% of Maine's adolescent population experience problems as a result of substance abuse.

Funds should be targeted at the pregnant and at-risk teen population. Programmatic focus would be directed to educating staff of agencies dealing with teens/pregnancy/substance abuse - rising awareness of the factors common to all (i.e., dysfunctional families, low self esteem, low school performance, etc.). Funds could provide specifically trained counselors to provide services to this population who may be recognized at-risk for substance abuse, pregnancy, for sexually transmitted disease, etc.

ALTERNATIVE TREATMENT SERVICES FOR DUAL-DIAGNOSED CLIENTS

Brief Description of Need

Individuals are admitted to AMHI as a result of chemical dependency. These individuals are admitted, not as a result of a need for mental health services per se, but because they knew the right things to say ("I'm going to kill myself; do something"), and sue to a lack of appropriate community-based substance abuse services (detox, shelter, rehabilitation, intermediate and extended care).

In addition, 50% of all people admitted to AMHI have a diagnosis of substance abuse in addition to their mental health diagnosis. Supports and services that could prevent reinstitutalization of this group are not usually available.

Proposed Response

1. Crisis response.

Existing crisis intervention programs in four Department of Mental Health regions should receive expanded resources to provide clinical intervention, assessment, and evaluation. In addition, the ability to purchase shelter, detoxification, and transportation assistance for selected clients is needed.

2. Short-term residential rehabilitation.

Two 10-bed community-based facilities are needed to provide intensive intervention and treatment for dual-diagnosed individuals. This service would begin the recovery process, and should be connected to other, follow-up services. Admission to this service would be limited to patients without substantial previous substance abuse treatment history -- i.e., good candidates for recovery.

3. Long-term rehabilitation.

Fifty-percent of those people entering shelter and detoxification services would ultimately be willing to take the next step into treatment. This proposal would establish four extended care programs of 10-12 beds each. These programs would stabilize the housing needs of these later-stage substance abusers, and would provide them with a safe environment in which to establish and maintain a pattern of sobriety. Placement in this type of facility would prevent relapse, and potential readmission to AMHI.

4. Supportive living environments.

In addition to the long-term rehabilitation referred to above, permanent supportive living arrangements are needed for an estimated 64 people per year. This item includes money for group home placement, and consultation and group counseling by Licensed Substance Abuse Counselors for the individuals in the group home.

5. Training.

A number of training needs should be addressed, in conjunction with the expansion of services. Individuals requiring training include AMHI staff, community mental and substance abuse treatment professionals, and referral sources to both the mental health and substance abuse systems (e.g., physicians, caseworkers, etc.).

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OFFICE OF SUBSTANCE ABUSE (OSA)
SIGNIFICANT ACCOMPLISHMENTS
(First Seven Months of FY'91)

1. Office staff conducted 45 licensing visits; issued 15 new/renewable program licenses or certificates; conducted 9 follow-up visits to assure corrective action was taken; and conducted 20 technical assistance visits.

2. The Office initiated activity to develop uniform contracting policy, standards, and procedures. Noteworthy is the development of uniform policy that assures greater fiscal accountability at the program level. The new policy clearly outlines when programs' year-end financial reports are due, program action required in returning funds due back to the State, and action that OSA will take if programs are out of compliance.

3. The Office established a interdisciplinary committee to:

   Determine the components of performance-based contracts.
   Determine appropriate performance indicators by type of service.
   Determine appropriate minimal standards for each performance indicator.
   Determine appropriate consequences, procedures, and policies.

4. The Office, working with the Department of Human Services and local treatment providers, developed uniform unit cost definitions and criteria for calculating the cost of purchased service units.

5. Work continued on the development of the new statewide management information system. Office staff redesigned data collection forms to include the federal required data set, revised the training manual, and conducted regional training of local agency staff. The Office continued the development of data reports and submitted the first data tape for federal review. Most important is the development of a data report that allows the Office to collect baseline program performance data and monitor performance by service setting.

6. The Office has implemented a system to monitor treatment capacity by service setting. This effort is essential in assuring program efficiency.

7. The Office prepared the first comprehensive state plan for alcohol and other drug abuse services in Maine in accordance with 5 M.R.S.A., Part 24, Chapter 521.

8. Action was taken to transfer licensing regulations and authority from OADAP to OSA.

9. OSA continues to work with OADAP/DEEP staff to assure continuity of DEEP licensing requirements.

10. OSA has and will continue to work with the Department of Mental Health to develop uniform licensing standards and procedures. This effort will significantly reduce duplication of effort.

11. OSA is in the process of revising licensing regulations to include services delivered in correctional settings. This action will standardize services in jails and correctional institutions.

12. OSA is in the process of developing licensing regulations specific to the dual-diagnosis population.

13. OSA worked with the Bureau of Medical Services to streamline Medicaid regulations and the application process. As a result, treatment services will increase to persons Medicaid eligible. This action also reduces OSA staff time and costs associated in reviewing required program applications.

14. Office staff worked jointly with three independent service providers and one consortium of providers to prepare and submit applications for OTI funds. All agencies were provided with technical assistance including editorial review of draft applications. The consortium was provided with several days of time, facilitating the development of program and interagency working relationships. Three applications were submitted for waiting list reductions. One was submitted for the criminal justice system population. This application was approved but not funded.

15. The Office applied for and won its share of the new Community Youth Activity Program Prevention Block Grant. As a result, new student assistance programs were established in Maine School Administrative District No. 17 ($34,255), Maine School Administrative District No. 56 ($34,254), and Maine School Administration District No. 64 ($21,914).

16. The Office applied for the competitive Community Youth Activity Program Demonstration Grant and was awarded $321,425. A total of $221,796 was awarded to the People's Regional Opportunity Program in Portland. This nationally recognized program develops and supports a positive peer leadership network to prevent alcohol and drug abuse, teen pregnancy, and other social problems in Portland's public housing projects. The project's major goal is to break the cycle of chronic dependence and failure to create a more positive, success-oriented environment. Annually these funds maintain peer leadership support for 75 youth, purchase health, social, and support services for 100 housing project residents, and maintain a variety of alternative community activities. To assure adequate treatment services, the Office allocated an additional $94,500 for adolescent outpatient services, nonresidential services, house-based family counseling, and evaluation/referral services.

17. The Office conducted the most comprehensive study to date to assess the statewide treatment and prevention delivery system. This detailed analysis has been valuable in guiding Office policy and activity.

18. The Office conducted a two-day Governor's conference on employee assistance programs.

19. The Office participated in and partially funded Maine's Red Ribbon campaign this year. Ribbon orders increased over 30 percent to over 120,000 ribbons. The quality and variety of local events showed a commensurate increase.

20. The Office has collected and is compiling budget information from Departments to determine the amount of funding available in FY 92/93 and the projected negative impact due to a potential fiscal shortfall.

21. The Office is working closely with the Department of Mental Health and Mental Retardation in formulating a workplan to fulfill the mandates of the consent decree which impact upon the substance abuse field and dual-diagnosis clients.

SPECIAL COMMISSION ON GOVERNMENTAL RESTRUCTURING,

SUBCOMMITTEE ON HEALTH, SOCIAL SERVICES, AND ECONOMIC SECURITY

GOOD MORNING: MY NAME IS JEREAL HOLLEY. I AM THE FISCAL MANAGER OF THE OFFICE OF SUBSTANCE ABUSE AND HAVE BEEN IN THIS CAPACITY SINCE THE FORMATION OF THE OFFICE LAST JULY, 1990. THE DIRECTOR, RON SPECKMANN IS UNABLE TO BE HERE TODAY BECAUSE OF A PRIOR COMMITMENT.

THE OFFICE OF SUBSTANCE ABUSE WAS ESTABLISHED AS THE SINGLE ADMINISTRATION UNIT WITHIN STATE GOVERNMENT, ACCOUNTABLE DIRECTLY TO THE GOVERNOR, WITH RESPONSIBILITY FOR STATEWIDE PLANNING, PROGRAM DEVELOPMENT, IMPLEMENTATION AND COORDINATION OF ALL THE STATE'S SUBSTANCE ABUSE PREVENTION AND TREATMENT ACTIVITIES AND SERVICES. EFFECTIVE OCTOBER 15, 1991, OSA WILL ALSO BE RESPONSIBLE FOR A STATEWIDE INFORMATION AND CLEARINGHOUSE, STATEWIDE SUBSTANCE ABUSE TRAINING, AND THE DRIVER EDUCATION EVALUATION PROGRAM.

OSA HAS A BUDGET OF APPROXIMATELY 9 MILLION. APPROXIMATELY 12,000 PERSONS ARE SERVED ANNUALLY IN A CONTINUUM OF CARE THAT INCLUDES PREVENTION, EARLY INTERVENTION, OUTPATIENT AND RESIDENTIAL SERVICES.

I AM PLEASED TO REPORT THAT THE OFFICE HAS ACHIEVED A NUMBER OF ACCOMPLISHMENTS SINCE LAST JULY. OUTSTANDING ACCOMPLISHMENTS INCLUDE:

1. THE OFFICE PREPARED THE FIRST COMPREHENSIVE STATE PLAN FOR ALCOHOL AND OTHER DRUG ABUSE SERVICES IN MAINE

2. THE OFFICE HAS CONDUCTED A COMPREHENSIVE FISCAL ANALYSIS TO ASSESS THE CURRENT STATEWIDE DELIVERY SYSTEM.

3. THE OFFICE HAS IMPLEMENTED A STATEWIDE MANAGEMENT INFORMATION SYSTEM.

4. THE OFFICE WORKING WITH A BROAD-BASED COMMUNITY COMMITTEE HAS DEVELOPED AND IMPLEMENTED A PERFORMANCE BASED CONTRACTING MECHANISM.

I HAVE PREPARED A MORE DETAILED LIST OF ACHIEVEMENTS THAT I WILL LEAVE YOU TODAY.

I AM ALSO PLEASED TO REPORT THAT THE RECENT PASSAGE OF L.D. 175, AN ACT RELATED TO THE OFFICE OF SUBSTANCE ABUSE, STRENGTHENS THE OFFICE AND GIVES IT THE FLEXIBILITY TO BETTER ADDRESS THE FIVE BROAD ISSUES IDENTIFIED BY THE SUBCOMMITTEE.

THE OFFICE IS WORKING VERY COOPERATIVELY WITH THE DEPARTMENTS OF HUMAN SERVICES, MENTAL HEALTH, EDUCATION, CORRECTIONS, AND PUBLIC SAFETY. EXAMPLES INCLUDE:

1. MEMORANDUM OF AGREEMENTS WITH THE DEPARTMENT OF HUMAN SERVICES, MENTAL HEALTH AND EDUCATION

2, THE OFFICE HAS WORKED CLOSELY WITH THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TO DEVELOP UNIFORM LICENSING STANDARDS AND PROCEDURES.

3. THE OFFICE IS WORKING CLOSELY WITH THE DEPARTMENT OF EDUCATION IN THE DEVELOPMENT OF ITS STATEWIDE PREVENTION PLAN.

4. THE OFFICE HAS JOINT CONTRACTS WITH THE DEPARTMENT OF CORRECTIONS.

OSA DOES NOT BELIEVE THAT THERE IS A MAJOR PROBLEM WITH DUPLICATION AND/OR OVERLAPPING SERVICES. THE PROBLEM IS THAT THERE ARE NOT ENOUGH SERVICES AVAILABLE. DUE TO THE CURRENT ECONOMIC SITUATION, SERVICES WERE REDUCED BY APPROXIMATELY $1.3 MILLION.

EMERGING ~~SURVEYING~~ ISSUES / NEEDS INCLUDE SERVICES TO THE ADOLESCENT POPULATION, PERSONS INVOLVED WITH THE CORRECTIONAL SYSTEM, WOMEN AND MOTHERS OF YOUNG CHILDREN, AND INDIVIDUALS WITH A DUAL DISORDER. THE OFFICE HAS PREPARED FOR YOUR INFORMATION A LIST OF UNMET SUBSTANCE ABUSE SERVICE NEEDS IN MAINE.

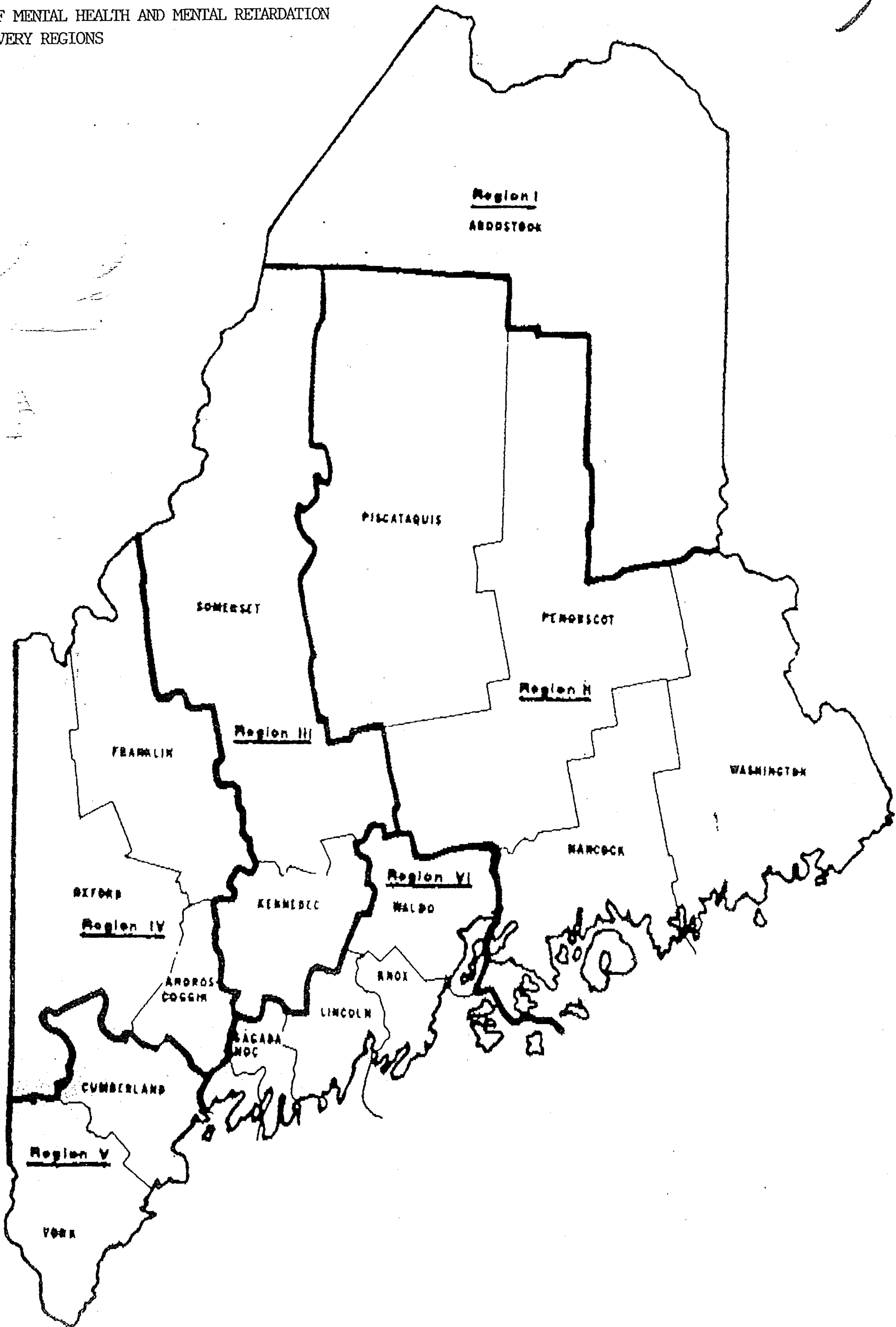
WHAT IS THE NUMBER ONE THING WE WOULD CHANGE? THE MAJOR CHANGE THAT NEEDS TO TAKE PLACE IS ASSURANCE THAT THE CURRENT PREVENTION AND TREATMENT SYSTEM IS EFFICIENT AND EFFECTIVE. MAJOR STEPS HAVE ALREADY BEEN TAKEN WITH THE IMPLEMENTATION OF THE STATEWIDE MANAGEMENT INFORMATION SYSTEM AND PERFORMANCE CONTRACTING. ADDITIONAL ACTIVITIES ARE UNDERWAY WHICH INCLUDE A STATEWIDE NEEDS ASSESSMENT, MONITORING OF TREATMENT UTILIZATION, AND AN AUTOMATED SYSTEM TO ROUTINELY MONITOR PROGRAM PERFORMANCE.

IN CLOSING, I THANK YOU FOR THIS OPPORTUNITY AND I WILL TRY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE NOW.

THANK YOU.

Dist 8/09 HHS

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
SERVICE DELIVERY REGIONS



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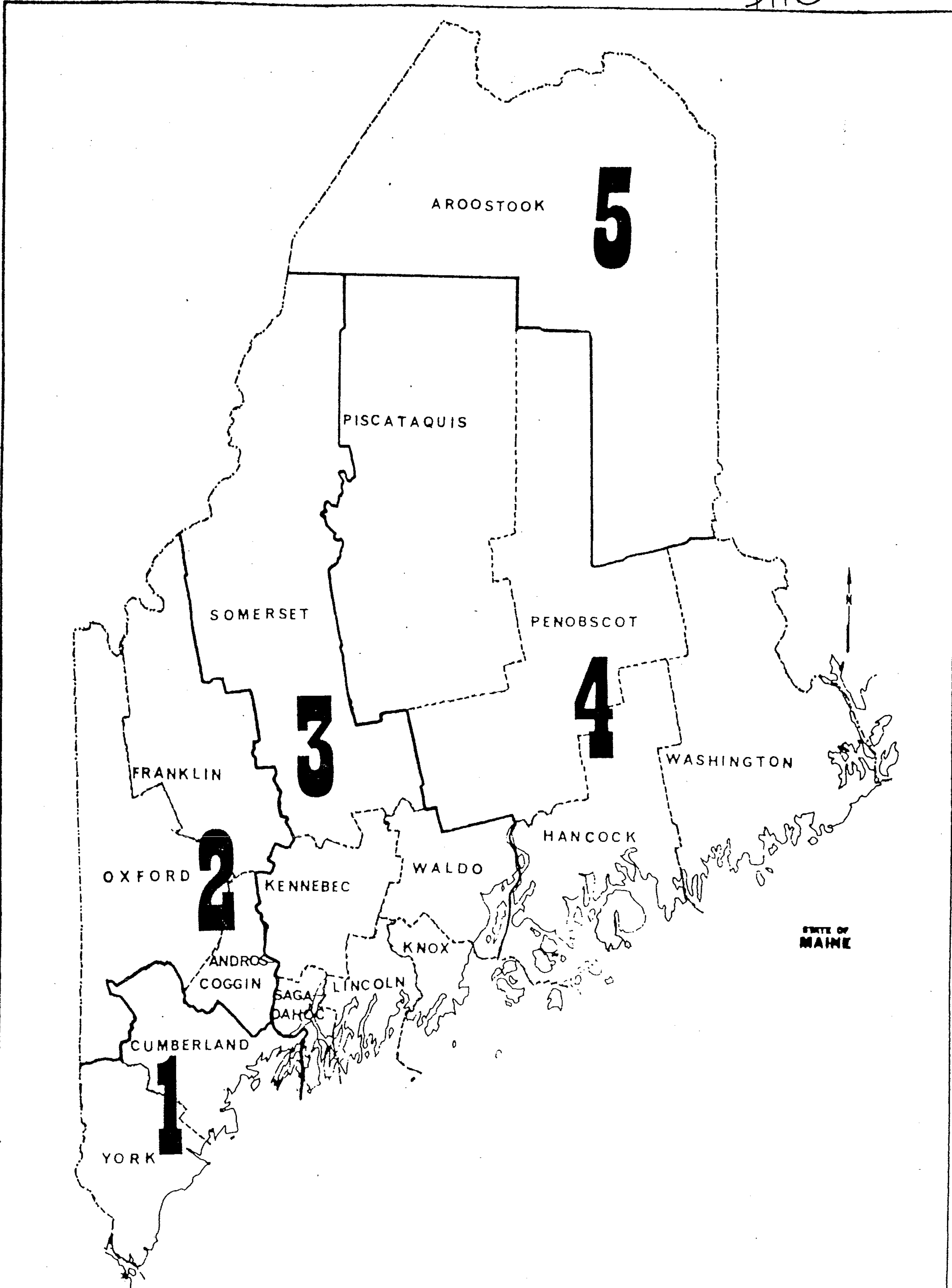
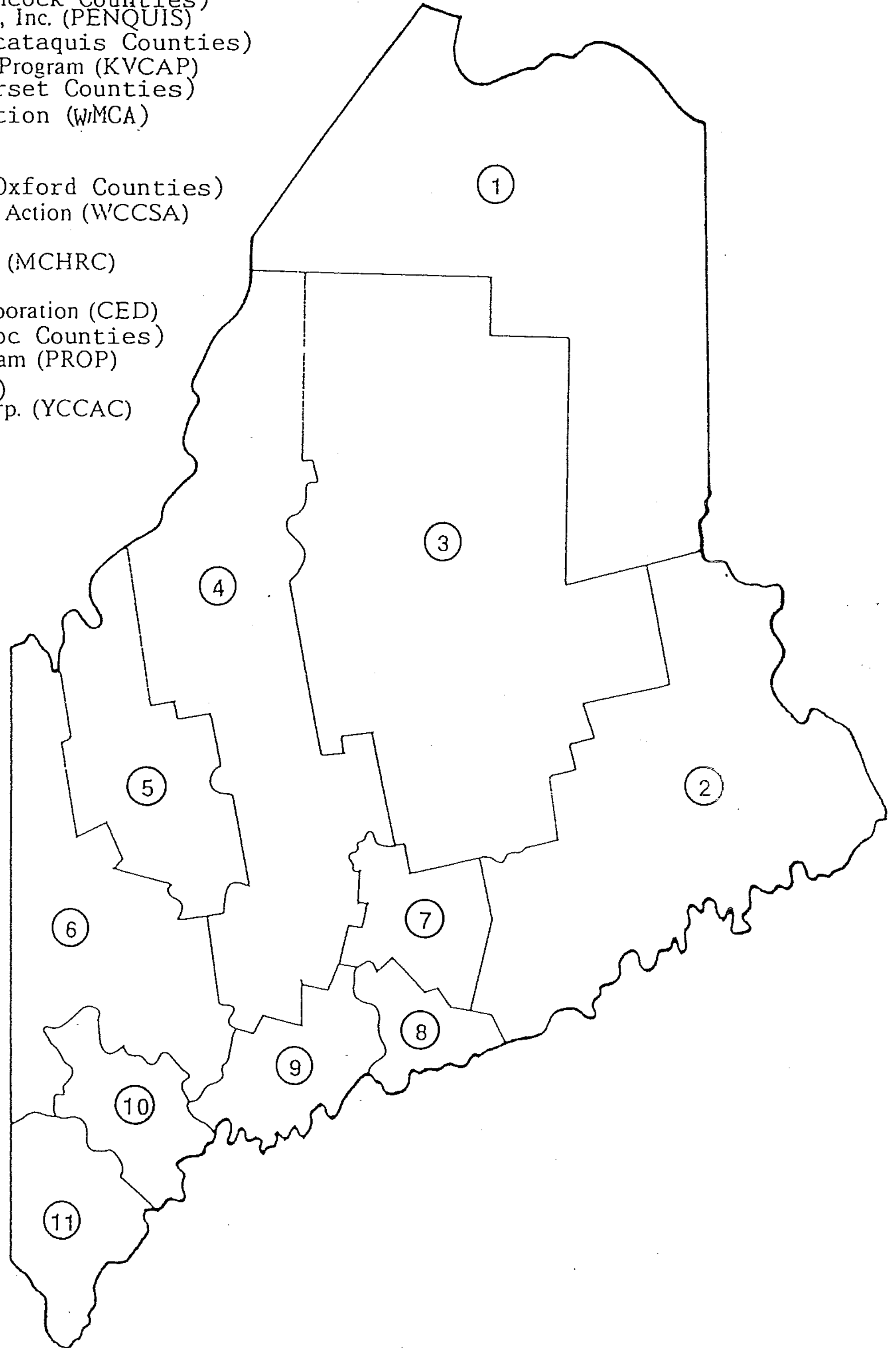


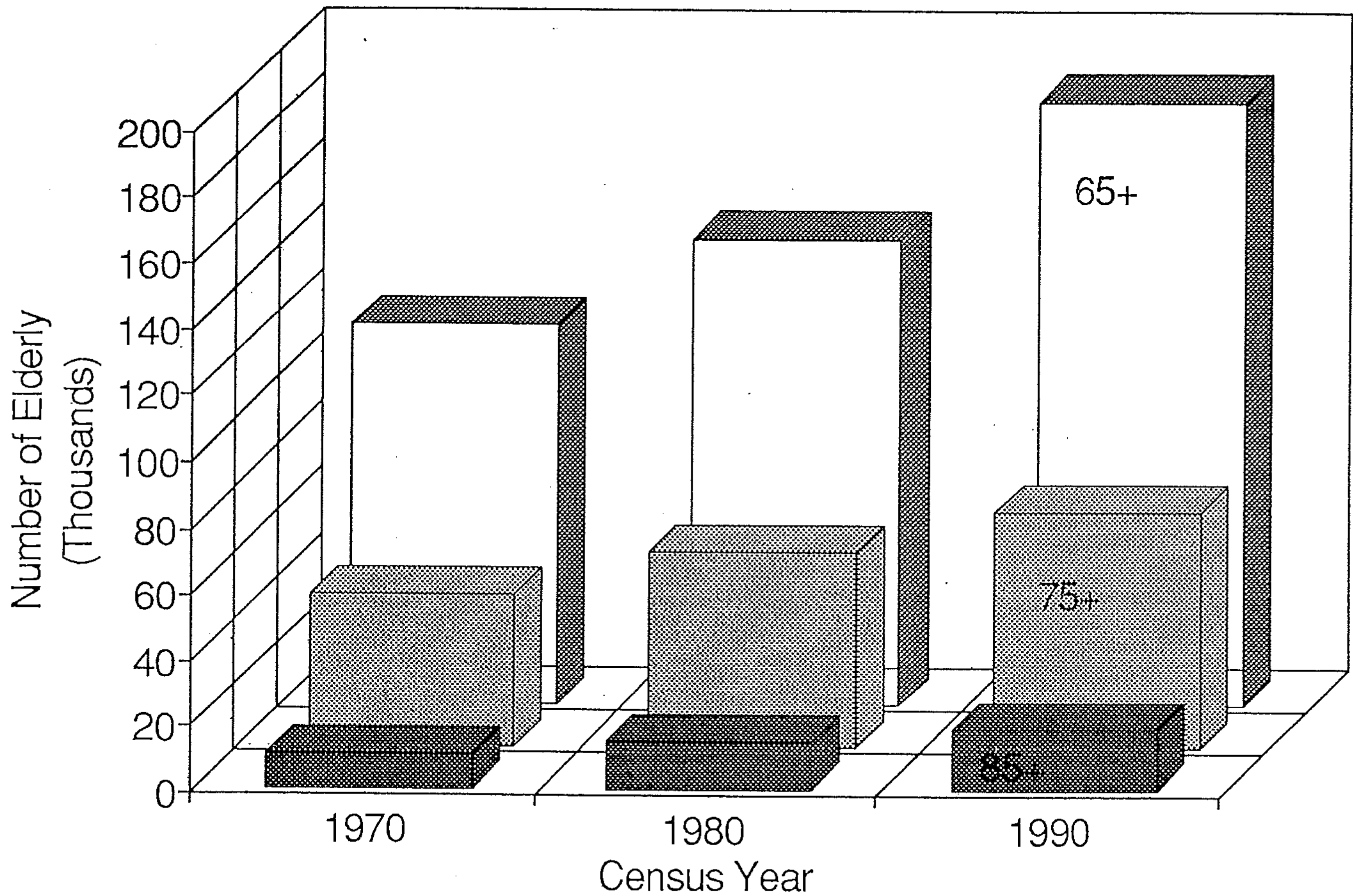
DIVISION OF COMMUNITY SERVICES

SERVICE DELIVERY AREAS

Maine Community Action Agencies

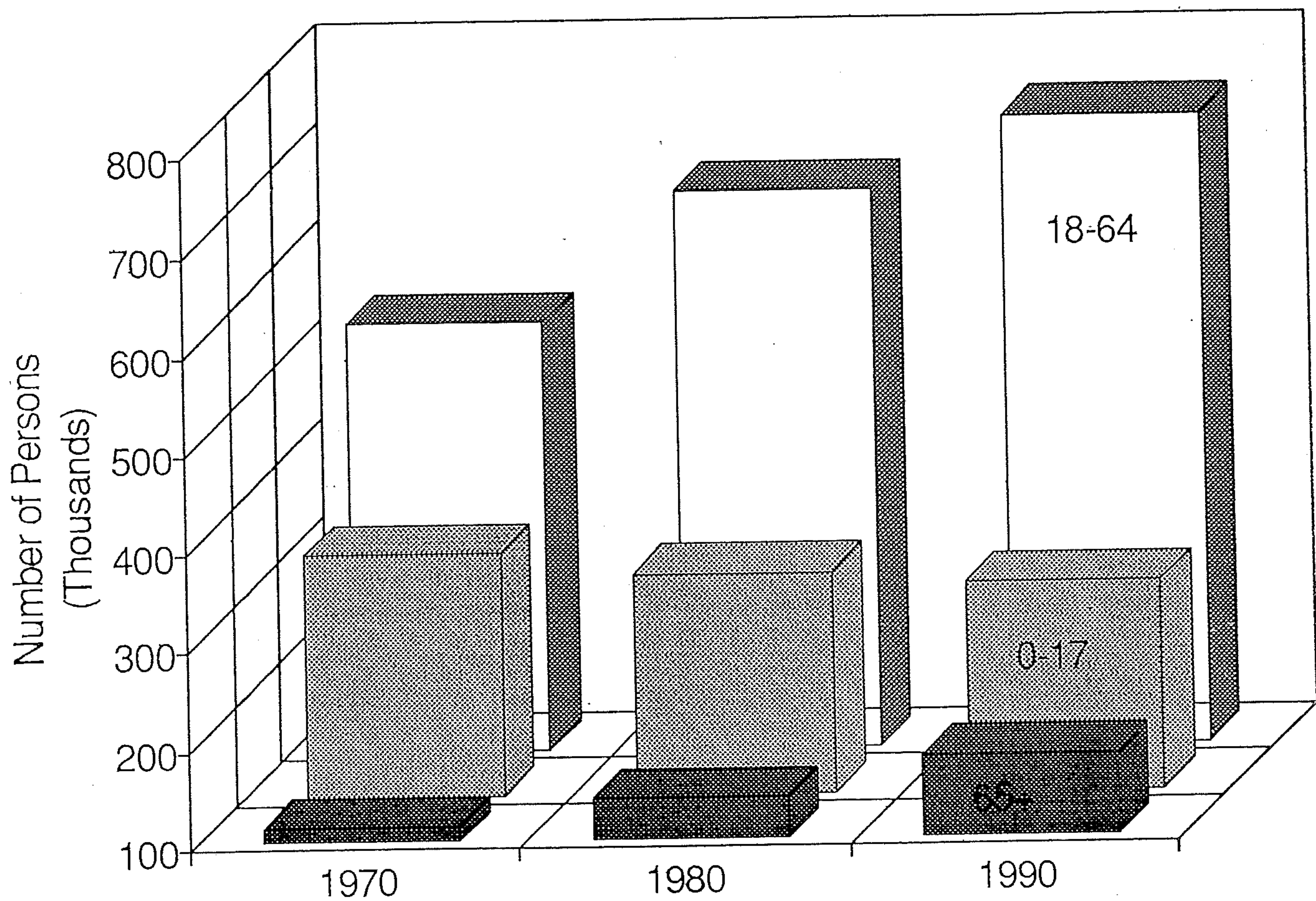
1. Aroostook County Action Program (ACAP)
   (Aroostook County)
2. Washington-Hancock Community Agency (W-HCA)
   (Washington and Hancock Counties)
3. Penquis Community Action Program, Inc. (PENQUIS)
   (Penobscot and Piscataquis Counties)
4. Kennebec Valley Community Action Program (KVCAP)
   (Kennebec and Somerset Counties)
5. Western Maine Community Action (WMCA)
   (Franklin County)
6. Community Concepts, Inc. (CCI)
   (Androscoggin and Oxford Counties)
7. Waldo County Committee for Social Action (WCCSA)
   (Waldo County)
8. Mid-Coast Human Resource Council (MCHRC)
   (Knox County)
9. Coastal Economic Development Corporation (CED)
   (Lincoln & Sagadahoc Counties)
10. People's Regional Opportunity Program (PROP)
    (Cumberland County)
11. York County Community Action Corp. (YCCAC)
    (York County)





Maine population

	1970	1980	1990
Age 65+	114617	140961	183373
Age 75+	45905	58630	71173
Age 85+	9834	14099	18218

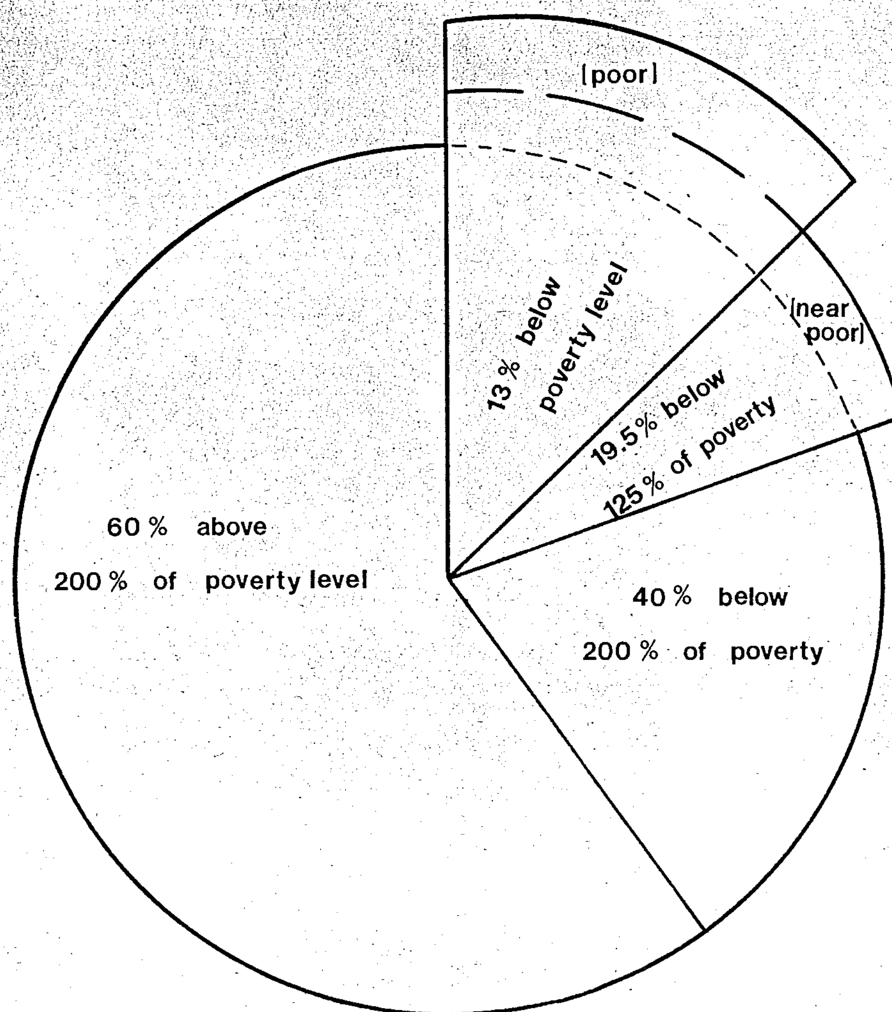


Maine Population by Age

	1970	1980	1990
Total	993722	1125030	1227928
Age 65+	114617	140961	183373
Under 18	343966	321450	309003
age 18-64	533649	662616	735552

Poverty in Maine, 1970 - 1980

Volume 1: Causes and Conditions



Executive Department
March 1985

Maine State Planning Office and
Division of Community Services

Dist 8/05 HHS

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TEL.: (207) 289-1670

August 5, 1991

To: Committee on Health, Social Services and Economic Security

From: Paul Saucier, Legislative Analyst PS

Re: Material for August 9 meeting

I have enclosed an additional article for the August 9th meeting.

PS/jlj/9110opla

LIST OF REPORTS FOR WHICH EXECUTIVE SUMMARIES WERE MAILED TO COMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY, 8/5/91

Additional Support for People in Retraining and Education Program: An Evaluation According to Legislative Requirements - February, 1990

AFDC Caseload Characteristics in January 1989

Affordable Housing in Maine, A Study of the Obstacles to - December 1, 1989

Aid to Families with Dependent Children and Medical Assistance Payment Programs, Report of the Task Force to Study the - May 15, 1991

Aid to Families with Dependent Children Need and Payment Standards, Final Report of the Commission to Evaluate the Adequacy of the - February, 1990

Aid to Families with Dependent Children, Proposal to Adequately Address the Housing Needs of Recipients of - Recommendations

Alcohol and Drug Abuse Planning Committee, Program and Audit Committee Review

Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services, First Report of the Commission to Study the - 1989

Child Support Enforcement Program, Maine Emergency Medical Services, Program and Audit Committee Review - 1990-1991

Child Welfare Services - 1986 Program and Audit Committee Review

Child Welfare Services, Maine Emergency Medical Services, Program and Audit Committee Review - 1989-1990

Children's Mental Health System, Building a: A community Based Crisis Stabilization and Diversion System - February 25, 1991

Children at the Augusta Mental Health Institute: Prevention Strategies and Ideal Discharge Plans - June, 1989 - June, 1990

Children, Youth and Families, Governor's Task Force to Improve Services for Maine's - May 22, 1991

Early Intervention System, Historical Perspectives on Maine's 0-5 Interdepartmental

Elderly Citizens, Commission to Study the Level of Services for Maine's - December, 1990

General Assistance, Final Report of the Special Select Commission on the Financing and Administration of - May, 1987

Health Care Expenditures, Blue Ribbon Commission on the Regulation of - January, 1989

Health Information Recording System, Study of the Necessity and Feasibility of Establishing a - December, 1988

Implementation Plan for Settlement Agreement to Consent Decree ***(Paul Bates, et al, v. Robert Glover, et al (Civ. 89-88))*** - January 1, 1991

Maine Health Program, Report of the Task Force to Evaluate and Revise the - Phase 2 - May 31, 1991

Medicaid Financing of Services for Maine's Citizens with Mental Retardation: A Follow-Up Report - March 15, 1991

Medicaid Report, Annual - State Fiscal Year 1990

Mental Health and a Healthy Society: Transforming Maine's Mental Health System by the Year 2000 - January 25, 1991

Mental Health Systems Reform in Selected States - November, 1990

Smoking or Health, Governor's Commission on - Final Report and Recommendations - January, 1990

#2953LHS

Book of the States 1991

Table 3.3
THE LEGISLATORS
Numbers, Terms, and Party Affiliations

State or other jurisdiction	Senate						House						Senate and House totals
	Democrats	Republicans	Other	Vacancies	Total	Term	Democrats	Republicans	Other	Vacancies	House total	Term	
All states	1,192	751	1	2	1,995		3,277	2,176	4	9	5,466		7,461
Alabama	28	6	...	1	35	4	85	17	...	3	105	4	140
Alaska	8	12	...	...	20	4	23	17	...	...	40	2	60
Arizona	13	17	...	...	30	2	26	34	...	...	60	2	90
Arkansas	31	4	...	...	35	4	88	11	1 (a)	...	100	2	135
California	24	15	1 (a)	...	40	4	46	33	...	1	80	2	120
Colorado	11	24	...	...	35	4	26	39	...	...	65	2	100
Connecticut	23	13	...	...	36	2	88	63	...	...	151	2	187
Delaware	13	8	...	...	21	4	18	23	...	...	41	2	62
Florida	23	17	...	...	40	4	73	47	...	...	120	2	160
Georgia	45	11	...	...	56	2	144	36	...	...	180	2	236
Hawaii	22	3	...	...	25	4	45	6	...	...	51	2	76
Idaho	19	23	...	...	42	2	20	64	...	...	84	2	126
Illinois	31	28	...	...	59	4 (b)	67	51	...	...	118	2	177
Indiana	24	26	...	...	50	4	50	50	...	...	100	2	150
Iowa	30	20	...	...	50	4	61	39	...	...	100	2	150
Kansas	18	22	...	...	40	4	58	67	...	...	125	2	165
Kentucky	30	8	...	...	38	4	72	28	...	...	100	2	138
Louisiana	34	5	...	...	39	4	86	17	...	2	105	4	144
Maine	20	15	...	...	35	2	97	54	...	...	151	2	186
Maryland	40	7	...	...	47	4	125	16	...	...	141	4	188
Massachusetts	32	8	...	...	40	2	128	32	...	...	160	2	200
Michigan	18	20	...	...	38	4	61	49	...	...	110	2	148
Minnesota	44 (c)	23 (d)	...	...	67	4	80 (c)	53 (d)	...	1	134	2	201
Mississippi	44	8	...	...	52	4	112	9	1 (e)	...	122	4	174
Missouri	22	12	...	...	34	4	104	58	...	1	163	2	197
Montana	23	27	...	...	50	4 (f)	52	48	...	...	100	2	150
Nebraska	Nonpartisan election				49	4	Unicameral						49
Nevada	8	13	...	...	21	4	30	12	...	...	42	2	63
New Hampshire	8	16	...	...	24	2	119	281	...	...	400	2	424
New Jersey	22	17	...	1	40	4 (g)	44	36	...	...	80	2	120
New Mexico	26	16	...	...	42	4	45	25	...	...	70	2	112
New York	27	34	...	...	61	2	92	58	...	...	150	2	211
North Carolina	37	13	...	...	50	2	74	46	...	...	120	2	170
North Dakota	32	21	...	...	53	4	45	61	...	...	106	2	159
Ohio	14	19	...	...	33	4	59	40	...	...	99	2	132
Oklahoma	33	15	...	...	48	4	68	32	...	1	101	2	149
Oregon	19	11	...	...	30	4	32	28	...	...	60	2	90
Pennsylvania	23	27	...	...	50	4	104	99	...	...	203	2	253
Rhode Island	41	9	...	...	50	2	83	17	...	...	100	2	150
South Carolina	35	11	...	...	46	4	87	37	...	...	124	2	170
South Dakota	15	20	...	...	35	2	24	46	...	...	70	2	105
Tennessee	22	11	...	...	33	4	59	40	...	...	99	2	132
Texas	23	8	...	...	31	4	93	57	...	...	150	2	181
Utah	7	22	...	...	29	4	28	47	...	...	75	2	104
Vermont	16	14	...	...	30	2	74	76	...	...	150	2	180
Virginia	30	10	...	...	40	4	59	39	2 (a)	...	100	2	140
Washington	24	25	...	...	49	4	63	35	...	...	98	2	147
West Virginia	29	5	...	...	34	4	81	19	...	...	100	2	134
Wisconsin	20	13	...	...	33	4	56	43	...	...	99	2	132
Wyoming	11	19	...	...	30	4	23	41	...	...	64	2	94
Dist. of Columbia	12	0	1 (a)	...	13	4	Unicameral						13
American Samoa	Nonpartisan selection			4	18	4	Nonpartisan election			1	21	2	39
Guam	13	8	...	...	21	2	Unicameral						21
No. Mariana Islands	2	7	...	...	9	4	8	7	...	...	15	2	24
Puerto Rico	18 (i)	8 (j)	1 (k)	...	27	4	36 (j)	14 (j)	1 (k)	...	51	4	78
U.S. Virgin Islands	159	3	3 (l)	...	15	2	Unicameral						

Note: This table reflects the legislatures as of January 1989, except for New Jersey, Virginia and the No. Mariana Islands; information for those jurisdictions is for 1990.

(a) Independent.

(b) The entire Senate is up for election every ten years, beginning in 1972. Senate districts are divided into three groups. One group elects senators for terms of 4-years, 4-years and 2-years, the second group for terms of 4-years, 2-years and 4-years, the third group for terms of 2-years, 4 years and 4-years.

(c) Democrat-Farmer-Labor.

(d) Independent-Republican.

(e) Independent-Democrat.

(f) After each decennial reapportionment, lots are drawn for half of the senators to serve an initial 2-year term. Subsequent elections are for 4-year terms.

(g) Senate terms beginning in January of second year following the U.S. decennial census are for 2 years only.

(h) Council of the District of Columbia.

(i) Popular Democratic Party.

(j) New Progressive Party.

(k) Puerto Rican Independent Party (also known as the Independent Puerto Rico Party).

(l) Independent (2); Independent Citizens Movement (1).

Dist 8/05 HHS

ISSN 0146-9002

Significant Features of Fiscal Federalism

Volume 1

Budget Processes and Tax Systems

1991

Advisory Commission
on Intergovernmental Relations
February 1991 M-176

Table 4
State Budget Stabilization Funds

State	Methods for Deposit	Methods for Withdrawal
Alaska *Budget Reserve Account*	By appropriation	By appropriation for the governor to meet a disaster
California *Special Fund for Economic Uncertainties*	Year-end surplus or by appropriation	(1) Automatic expenditure to cover revenue shortfall or other deficiency in general fund (2) executive order can allocate funds for additional fire fighting or disaster response needs
Colorado* *4% Required Reserve*	4% of total general fund appropriations plus supplementals are automatically set aside	Automatic expenditure when revenue estimates fall below targets; fund can be used only to cover appropriations already authorized
Connecticut *Budget Reserve Fund*	Year-end surplus; fund capped at 5% of net general fund appropriations for fiscal year	Automatic expenditure to cover budget deficit to the extent that funds are available
Delaware *Budget Reserve Account*	Automatic deposit from previous year's unencumbered funds; fund capped at 5% of estimated general fund revenues	By appropriation to cover budget deficit or to compensate for revenue reductions: requires 3/5 vote of each house
Florida *Working Capital Fund*	Year-end surplus; fund capped at 10% of previous year's general fund	By appropriation when revenue collections are insufficient to meet appropriations
Georgia *Revenue Shortfall Reserve*	Year-end surplus; fund capped at 3% of net revenue	Automatic expenditure to cover revenue shortfall collections
Idaho *Budget Reserve Account*	By appropriation	By appropriation
Indiana *Counter-Cyclical Revenue & Economic Stabilization Fund*	(Annual growth rate in personal income minus 2%) x (previous year general fund revenues)	Funds transferred to general fund if percentage change in adjusted personal income is less than 2%
Iowa *Economic Emergency Fund*	Year-end surplus; fund capped at 10% of funds appropriated from the state's general fund during the preceding fiscal year	By appropriation only for a purpose for which the General Assembly previously appropriated funds for that fiscal year
Kentucky* *Budget Reserve Trust Fund*	By appropriation	Allotted by governor to meet a revenue shortfall: governor must notify legislature
Maryland* *Revenue Stabilization Account*	By appropriation	Transferred by governor to general fund revenues if state unemployment rate is both greater than 6.5% and greater than the rate 12 months earlier; amount of transfer is reduced by amount of general fund budget reductions made by legislature
Massachusetts *Commonwealth Stabilization Fund*	Year-end surplus; fund capped at 5% of current fiscal year revenues	By appropriation
Michigan* *Budget and Economic Stabilization Fund*	Statutes require appropriation of an amount equal to (annual growth rate in real personal income in excess of 2%) x (general fund revenues of prior fiscal year)	If annual growth rate in real personal income is negative, withdrawal equals (deficiency) x (general fund revenues), but no more than needed to balance budget; withdrawals are allowed in year that pay-in is made if actual revenue collections fall below level on which budget was based
Minnesota *Budget Reserve Account*	By direct appropriation—$550 million; by contingent appropriation an amount to bring the reserve up to 5% of general fund appropriations for the biennium	By appropriation or transfer by commissioner of finance with approval of governor; consultation with Legislative Advisory Commission required
Mississippi *General Fund Stabilization Reserve*	Automatic transfer of 25% of annual surplus, with fund not exceed 5% of previous year's general fund revenue	Transfer by Fiscal Management Board to cover revenue shortfall
Missouri* *Budget Stabilization Fund*	By appropriation; fund is not to exceed 5% of the receipts into the general revenue fund for preceding fiscal year	By appropriation to the governor to meet budget shortfalls
New Hampshire *Revenue Stabilization Reserve Account*	Audited year-end surplus	Transfer by the comptroller with approval of the Advisory Budget Control Committee and the governor when: (1) General fund operating deficit occurred for most recently completed fiscal year, and (2) Unrestricted general fund revenues in the most recently completed fiscal year were less than budget forecast
New Jersey *Surplus Revenue Fund*	50% of revenue collections in excess of governor's certification of revenues	(1) By appropriation or (2) by the governor in event of an emergency identified by the governor, upon approval by the legislature's Joint Budget Oversight Committee

Table 4 (cont.)
State Budget Stabilization Funds

State	Methods for Deposit	Methods for Withdrawal
New Mexico *Operating Reserve Fund*	Excess revenue with balance not to exceed 8% of aggregate recurring appropriations from the general fund for the previous fiscal year	By appropriation in the event revenues are insufficient to meet the level of appropriations authorized
New York* *Tax Stabilization Reserve Fund*	Year-end surplus up to 0.2% of aggregate general fund disbursements; reserve fund cannot exceed 2% of general fund disbursements for the fiscal year	By appropriation when state is in deficit
North Dakota *Budget Stabilization Fund*	Biennium end surplus in excess of $40 million	Governor may transfer for revenue shortfall of at least 5% of the estimate made by the most recently adjourned Assembly
Ohio *Budget Stabilization Fund*	Transfer of general revenue in excess of certified revenues for biennium	Funds transferred to general fund if growth in general revenue fund is negative
Oklahoma *Constitutional Reserve Fund*	Automatic transfer of revenue in excess of official revenue projection; fund is capped at 10% of general revenue fund for the preceding fiscal year	Up to 1/2 of balance may be appropriated if: (1) forthcoming fiscal year general revenue fund is less than that of current fiscal year certification; or (2) emergency declaration by the governor with concurrence by legislature with a 2/3 vote of each house; or (3) joint emergency declaration by speaker and president pro tempore with concurrence by legislature with a 3/4 vote of each house
Pennsylvania *Tax Stabilization Reserve Fund*	By appropriation	By appropriation when governor declares an emergency or downturn in the economy; requires 2/3 vote of each house
Rhode Island *Budget Reserve and Cash Stabilization Account*	For FY87 and thereafter, 40% of lottery revenue	Automatic expenditure to cover revenue shortfall
South Carolina* *General Reserve Fund*	Revenues in excess of annual operating expenditures must be transferred to the fund; fund is capped at 3% of general fund revenue of the latest completed fiscal year	Budget and Control Board transfers to cover year-end operating deficit
Tennessee *Revenue Fluctuation Reserve*	By appropriation	By appropriation when state is in deficit
Texas* *Economic Stabilization Fund*	Transfer of 1/2 of any unencumbered general revenue fund balance at end of each biennium plus portions of oil and natural gas production tax collections	By appropriation with 2/3 vote of legislature
Utah *Budget Reserve Account*	General fund surplus up to 3%; account may not exceed 6% of the general fund appropriation for the fiscal year in which the surplus occurred	By appropriation to cover operating deficits
Vermont *Budget Stabilization Trust Fund*	Undesignated general fund surplus; fund is capped at 2% of general fund appropriations from most recently ended fiscal year	By the state treasurer to the extent necessary to offset a general fund deficit
Virginia *Revenue Reserve Fund*	By appropriation	Governor may transfer for revenue shortfall caused by economic conditions or by changes in federal tax legislation
Washington *Budget Stabilization Fund*	Pursuant to appropriation: (projected growth in real personal income minus 3%) X (previous fiscal year general state revenues)	By appropriation, with 60% vote required, when revenues fall below forecast, for labor force training, or for any purpose legislature determines would reduce unemployment caused by state's economic cycle
Wisconsin Budget Stabilization Fund	By appropriation	By appropriation
Wyoming *Budget Reserve Account*	Year-end surplus plus appropriations	By appropriation

*State Notes

Colorado — If economic conditions require expenditures from the fund, the governor must develop a plan that would maintain the reserve at no less than 2%. The plan is subject to legislative modification.

Kentucky — Conditions governing the use of the fund are attached to its appropriation every two years. At the end of the biennium, the fund lapses and has to be recreated. The state also has created in the general fund the Surplus Fund Account. No expenditures may be made from the account unless appropriated by the legislature, or unless required by the budget reduction provisions of a joint budget resolution.

State Notes *(cont.)*

Maryland — The Revenue Stabilization Account must be increased $5 million each year whenever balance is less than $100 million or 2% of general fund revenues.

Michigan — If state unemployment rate is between 8% and 11.9%, legislature may appropriate 2.5% of the fund balance for programs that will provide for increases in state employment. If rate is 12% or more, up to 5% may be so used.

Missouri — The General Assembly may appropriate to governor any portion of existing balance to cover budget shortfalls. Also, in any year in which governor finds it necessary to withhold appropriated funds, governor may order Commissioner of Administration to make transfers from fund to fulfill expenditures authorized by appropriation. However, such action must be approved by General Assembly, and hence can only occur if General Assembly is in session. Further, the General Assembly shall not appropriate moneys from the fund without authorization from the governor.

New York — Once borrowed, fund must be paid back within six years in three equal installments.

South Carolina — Funds withdrawn from the General Reserve Fund must be restored annually at a rate of not less than 1% of the general fund revenue of the latest completed fiscal year. The state also has a Capital Reserve Fund that receives money by appropriation. It is capped at 2% of general fund revenue of latest completed fiscal year. The Budget and Control Board transfers money from this fund to avoid midyear budget reductions. After May 1 of a fiscal year, money in Capital Reserve Fund can be appropriated for other specified purposes with 2/3 vote of legislature.

Texas — The constitutional amendment creating the fund mandates the following revenue transfers to it: (1) 50% of any unencumbered general revenue fund balance at the end of each fiscal biennium; (2) an amount of general revenue equal to 75% of the amount by which oil production tax collections in any future fiscal year exceed oil production tax collections in fiscal year 1987; (3) an amount of general revenue equal to 75% of the amount by which natural gas production tax collections in any future fiscal year exceed oil production tax collections in the fiscal year 1987. (For purposes of calculating the transfer, natural gas tax collections would be adjusted to reflect 12 months of collections in each fiscal year.)

Source: National Conference of State Legislatures, *State Fiscal Letter*, March/April 1990. Reprinted with permission from the National Conference of State Legislatures.

Dist 8/05

A BRIEF OVERVIEW OF THE SPECIAL INVESTIGATIONS UNIT

Prepared for the Committee on Health, Social Services and Economic Security by Committee Staff

Chronology

First established in 1972 within the Department of Audit. Mr.Jack Parrish hired as first director.

In the late 1970s, transferred to DHS Legal Division.

Upon the recommendation of the head of the Legal Division, transferred to the Bureau of Income Maintenance, where it ran as a free-standing division.

In 1989, moved under the supervision of the Child Support Enforcement division (still within the Bureau of Income Maintenance). Mr. Parrish took advantage of early retirement option offered as part of budget reductions. A Child Support Enforcement supervisior from the Bangor regional office was temporarily assigned to Mr. Parrish's position.

As part of the budget for fiscal years 92 and 93, Legislature restored Mr. Parrish's position (which was lost when he took early retirement) and asked Restructuring Commission to examine special investigations function.

Background Information

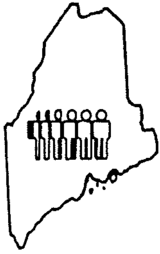
Throughout his tenure with the Unit, Mr. Parrish asserted that millions of dollars of undetected fraud could be recovered if the unit were independent, akin to the federal Inspector General's Office. Since his retirement, Mr. Parrish has been quoted extensively in the Kennebec Journal and other Maine newspapers in a series of articles alleging widespread unaddressed fraud in Maine's welfare programs.

During this year's appropriations process, the location of the Special Investigations Unit was debated, with some wanting it to remain within the Department of Human Services, some wanting it transferred to the Attorney General's Office and others advocating for a State Inspector General's office to be established.

The federal Inspector General's Office is currently reviewing Maine's welfare programs; the Department of Human Services has expressed confidence that the review will find Mr. Parrish's assertions to be false.

LHS2956

HHS



Maine Council of Community Mental Health Services

280 State Street, Augusta, Maine 04330 623-1525

September 20, 1991

Rosalyne Bernstein
Roland Caron
Members, Committee on Health, Social Services, and Economic Security

Comments on Interim Report:
Support for Principles and Findings,
Suggestions on Options

From: Frank Schiller, Executive Director

Speaking for Maine's network of community-based agencies which provide a broad range of mental health services and supports, the Maine Council applauds and welcomes your efforts to apply a clear set of strategic issues to the restructuring of our health, social services, and income maintenance programs. Your initial findings reflect and reinforce the perception that the organization and delivery of services often hinders and confuses effective efforts to respond to the multiple, wholistic needs of Maine people.

Both in terms of public accountability and in assured accessibility and availability of quality services, the principal of consumer orientation and empowerment is extremely important. Currently, services are more often organized and provided through divisions of historical bureaucracies and funding sources, rather than a more realistic and effective framework of multiple human needs.

Several years ago the mental health system initiated a plan to develop comprehensive community support systems for persons with mental illness. Over 125 federal and 50 state funding sources and programs were identified as instrumental in developing or reestablishing appropriate community supports for persons with severe mental illness and their families. The exercise of directing this gamut of resources to people's needs continues today. Consistent with your committee's initial findings and options, several changes would be beneficial to this process.

The role of government again needs to be clarified. The functions of public protection, coordination, the initiation of policy and programs which represent most effective models, and financial support are often compromised when the government itself also functions as a provider of services. Your attention to public-private partnerships, as well as to consumer orientation and technological enhancement reinforces our recommendation that much more extensive effort be made to privatize much of what is now directly carried out by state government. The state mental hospitals, which now absorb close to 80% of Maine's fiscal resources for mental health, are one example.

Your attention to gaps in the service system due to interagency responsibilities and lack of resources, as well as to barriers to access, reinforces our recommendation that regional planning and advocacy entities be organized with comprehensive authority and responsibilities, and not on the basis of narrow, categorical conditions such as age or diagnosis. As mental health service providers, we are glad to have the articulate and energetic efforts of consumers working for improved awareness of and responsiveness to the effects of mental illness. We are also aware of the range of social, vocational, educational, health, and other basic needs of consumers, and would welcome the potential for us to advocate for an improved mental health system in the context of comprehensive community support.

The current economic climate in Maine reinforces our attention to and awareness of the need for austerity and efficiency in the provision of basic services and supports for people in need. Also, the increasing growth and proliferation of governmental mandates and regulations contributes to a growing chasm between the costs and operations of services provided through private resources and those which are provided with state support. There is a growing distinction between services available for those with the resources to pay for their own, and those who must rely on public subsidies. The disincentives to public subsidy are becoming greater and greater. The licensing, contracting, reporting, auditing, planning, and quality assurance functions of publicly subsidized programs are, as your report notes, in dire need of consolidation and uniformity. We cannot afford to proliferate more costly administrative requirements.

Our experience with interdepartmental coordination reinforces the issues identified in your initial report. Often, these committees become forums for mid-level bureaucrats to generate policies and regulations which hinder as much as help a flexible and effective response to consumer needs. There is certainly a need for greater integration and coordination, but, unlike historical efforts, also a need for ongoing monitoring and direction to these efforts.

We are encouraged by the sensitive, realistic findings of your committee, and would be very happy to continue to provide input and assistance as you continue your work. Thank you.

Pag 2

STATE OF MAINE
HEALTH POLICY ADVISORY COUNCIL

Telephone (207) 582-8940

John L. Martin
Speaker of the House

Charles P. Pray
President of the Senate

John R. McKernan, Jr.
Governor

Ronald G. Thurston
Chairman

Kala E. Ladenheim
Executive Director

MEMORANDUM

To: Special Commission on Governmental Restructuring, Committee on Health, Social Services and Economic Security

From: Ronald G. Thurston, Chair, Health Policy Advisory Council

Re: HPAC Future Configuration

Date: September 19, 1991

=======================================

The Health Policy Advisory Council has been examining the structure of advisory bodies in health in order to make recommendations on ways to increase effectiveness, efficiency and citizen participation. The following is a draft of some structural/programmatic recommendations to the Commission on Governmental Restructuring, developed at the last Health Policy Advisory Council meeting.

The recommendations describe an ideal structure for developing health policy. The term "Health Policy Board" refers to a citizen body that fulfills the key policy role. While the concept is based in part on existing bodies, it does not refer to any single specific existing advisory board. This concept could be further widened to encompass social services.

Recommendations regarding a health policy body:

1. **GOALS**
   The mandates of the health policy board shall emphasize consensus building, oversight responsibility, and institutional memory. They shall be framed in the context of establishment of health system policy goals, review of progress toward goals, and making recommendations regarding systems changes necessary to meet goals.

2. **STRUCTURE**
   Create a Health Policy Board with a matrix structure to provide intellectual continuity and coordination across advisory groups and problem areas, and over time. This ongoing body would consist of
   a. a health policy board to set overall priorities and coordinate and integrate the work of the panels, and
   b. two types of groups, replacing current advisory bodies:
      i. standing panels concerned with specific substantive areas or constituencies (children and families, elderly persons, persons with mental illnesses, health) and
      ii. study panels formed to carry out time limited studies of specific issues. These studies could be initiated and

funded by the policy board or standing panels (assuming a core budget), the legislature, or the executive branch.

3. **STAFFING**
Staffing of the policy board should be independent and non-partisan, to permit impartial policy development and oversight, and to bridge the executive and legislative branches. If separate staffing is not possible, the board should be staffed by a body that does not have program implementation responsibilities, such as the State Planning Office (Executive), the Office of Policy and Legal Analysis (Legislative Council), or jointly by these two offices (to balance executive and legislative influence). Notwithstanding the need for independent staff, joint staffing of study and standing panels with staff from agencies with substantive jurisdiction or legislative and executive department staff shall also be used as appropriate to speed coordination of policy and program activities.

Executive Director shall be appointed by the board, be accountable to and report to the board, and serve at the pleasure of the board.

4. **MEMBERSHIP**
Membership should be pragmatically designed to represent a mix of specific constituency slots and at-large positions. The make-up should be designed to ensure active involvement by all key sectors in health, including providers, consumers, payors, insurers and government policy makers, through membership on the policy board and standing and study panels. Emphasis should be on high level of members and commitment to broad interests of Maine citizens. Membership should be slotted, with appointments from nominated agencies/organizations with stake in outcome, e.g., consumers/low income/ providers/ educators/ ethicists/ Legislature.

5. **REGIONAL STRUCTURE**
Develop a regional structure to coordinate activities of various regional boards, building parallel relationships at regional and state levels.

The Health Policy Advisory Council is in the process of joining with the Maine Committee on Aging, the Maine Human Development Commission, and the Maine Commission on Mental Health in order to increase administrative efficiency and performance by sharing physical overhead and some support functions, in response to budget reductions. These groups have also discussed policy coordination, but no consensus has been reached on how best to increase coordination while protecting autonomy of some fundamentally different advocacy interests.

This proposal represents the Health Policy Advisory Council's recommendation on how to develop and coordinate policy processes that cut across a range of groups or needs but that share common themes. These proposals have been recently presented to staff of the other advisory bodies, but have not been discussed by the other councils. In future discussions, we hope to further develop these proposals jointly, particularly as they apply to advocacy and administrative functions that have not been addressed in detail here.

August 8, 1991

Special Commission on Governmental Restructuring
membership & staffing

Co-Chairs: Mr. Henry and Mr. Nicoll

staff: Martha Freeman (OPLA)
Tim Glidden (OPLA)
Richard Silkman (SPO)
Carol Michel (SPO)

Committees:

I. Committee on Health, Social Services and Economic Security (HSS)

Ms. Bernstein and Mr. Caron, co-chairs
Ms. Levenson
Mr. Rosser

staff: Paul Saucier (OPLA)
Joyce Benson (SPO)

II. Committee on Education and Cultural Services (ECS)

Ms. Amero and Mr. Storer, co-chairs
Mr. Hibyan

staff: Michael Higgins (OPLA)
Richard Sherwood (SPO)

III. Committee on Protection of Public Safety and Health (PSH)

Ms. Kinnelly and Mr. Willey, co-chairs
Mr. Hare

staff: Deborah Friedman (OPLA)
Mike Montagna (SPO)

IV. Committee on Economic and Physical Infrastructure (EPI)

Mr. Flanagan and Ms. Mattimore, co-chairs
Mr. Brace

staff: Karen Hruby (OPLA)
Steve Adams (SPO)

V. Committee on Physical Resources (PYR)

Mr. McGowan and Mr. Cope, co-chairs
Mr. Anderson

staff: Patrick Norton (OPLA)
Mark Dawson (SPO)

VI. Committee on Governmental Relations and Process (GRP)

Mr. Bonney and Ms. Post, co-chairs
Mr. Higgins
Mr. John Lisnik

staff: Jon Clark (OPLA)
Carol Michel (SPO)

Note: OPLA Research Assistants are Mila Dwelley, Roy Lenardson & Bret Preston. Additional SPO and Departmental staff to be assigned.
9102opla

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Note: OPLA Research Assistants are Mila Dwelley, Roy Lenardson & Bret Preston. Additional SPO and Departmental staff to be assigned.
9102opla

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

To: Paul Saucier, Legislative Council
Joyce Benson, State Planning Office

From: Peggie Dore, Administrative Secretary

Date: September 12, 1991

It is my understanding that the Government Restructuring Committee has requested the attached information. Enclosed are copies for the Committee members.

Please call me at 289-2546 if I can be of further assistance.

State House Station 11, Augusta, Maine 04333 — *Offices Located at* 221 State Street
Telephone: (207) 289-2736

Access Commission
Adaptive Equipment Loan Fund
AFDC Advisory Council
AIDS Patient Services
Androscoggin County Child Abuse & Neglect Council
Bath/Brunswick Child Abuse & Neglect Council
Bridgton Task Force on Child Abuse & Neglect
Brunswick Scan Committee
Certificate of Need Advisory Committee
Child Development Services Board
Child Welfare Advisory Committee
Children's Residential Treatment Committee
Commission on Nursing Supply and Availability
Committee on Transition
Cumberland County Child Abuse & Neglect Council
Developmental Disabilities Council
Division for the Blind & Visually Impaired Advisory Council
Division of Deafness Advisory Committee
Down East Community Hospital Scan
Drug Utilization Committee
EMMC Scan
Franklin County Child Abuse & Neglect Council
Governor's Commission on Supported Employment
Governor's Commission on Domestic Abuse
Hancock Child Abuse and Neglect Council
Health Policy Advisory Council
Home Health Advisory Committee
Juvenile Justice Advisory Group
Kennebec County Child Abuse & Neglect Council
Knox County Child Abuse & Neglect Council
Lincoln County Child Abuse & Neglect Council
Maine Committee on Aging
Maine Health Policy Advisory Committee
Maine High Risk Organization Board
Maine Human Development Commission
Medicaid Advisory Commission
Mid Maine Medical Scan Committee
Miles Memorial Hospital Scan Team
Oxford County Child Abuse & Neglect Council
Penobscot Child Abuse and Neglect Council
Piscataquis Child Abuse and Neglect Council
Project Search CDS Local Coordinators Committee
Refugee Advisory Council
SCAN
Somerset County Child Abuse and Neglect Council
Somerset County Child Development
Southern Maine Child Development Center
State Independent Living Council
Victim's Rights Commission
Waldo County Child Abuse and Neglect Council
Waldo County Child Development Services
Washington Child Abuse and Neglect Council
York County Child Abuse & Neglect Council

Briefing Memo

To: Rollin Ives, Commissioner

Through: Deputy Commissioner - Programs [ ] Finance [ ]

From: Jamie P. Morrill, Assistant Deputy Commissioner

Subject: Time/Costs of DHS Advisory Committees

Date: February 11, 1991

Issue Activated By:

Request by Commissioner

Background:

This Department expends an enormous amount of resources, both case and staff time, to participate on, staff or fund Advisory Committees. This expenditure of resources has more recently come to light as all DHS programs are prioritized due to budget constraints. To get a more accurate picture of the resources expended, Bureau Directors were asked to list the various advisory committees in which staff are involved, and approximate the costs of that involvement. The survey results are as follows:

Highlights:

Bureau	# of Committees	DHS Cost to Staff	DHS Cost to Participate	DHS Funds	Total DHS Cost	Other Funds (Approx.)
BOR	8	$10,280	$ 6,600	$24,000	$40,880	$ 70,400
BIM	1	-0-	-0-	$21,000	$21,000	-0-
BEAS	6	-0-	$ 5,800	$66,000	$71,800	$307,200
BC&FS	115*	$24,855	$70,024	unknown	$94,879	$868,000
OPRD	7	$14,539	$ 1,674	$ 600	$16,813	$356,000
BOH	40	$33,590	$25,102	$13,254	$71,946	$ 24,000
BMS	7	$10,790	$ 6,929	$ 8,475	$26,194	$ -0-
Total	164	$94,054	$116,129	$133,329	$343,512	$2,259,000

*Approximately 20 of these Committees are already counted in other Bureaus.

Of these 164 committees, 52 are required by either state or federal statute and are as follows:

Pay 2

MAINE COMMISSION ON MENTAL HEALTH

State House Station 153 - Augusta, Maine 04333
(207) 626-3018

David Gregory, Esq.
Chair
Ruth Cumler
Vice Chair

Lelia Batten
Merrill R. Bradford, Esq.
Janice Burns
Walter Christie, M.D.
Catherine E. Cutler
Alan Elkins, M.D.
Thomas J. Kane, D.S.W.
Grace Leonard
Ronald Melendy
Marcel Morin
Marc Nadeau
Joan Pederson
Marc Plourde
Tim Rogers, Ph.D.
Martha Sevigny
Elizabeth A. Sisson
Richard J. Staples, Ph.D.
Carol Stewart
Janet Stratton, Esq.
Sallie Tarbell
Malcolm Wilson

Reid S. Scher
Executive Director

September 20, 1991

Comments of the Maine Commission on Mental Health

In Response to the Interim Report of the

Committee on Health, Social Services and Economic Security

1) The Commission believes that the committee's initial findings identify important issues and provide a good foundation for its work with one exception. Finding 6. notes that confidentiality requirements may deter system coordination. While these protections may create inconvenience, we would strongly recommend that such requirements not be weakened, given the nature of the information that is a part of the therapeutic process and the harm that can come to the client from the dissemination of the information. excepting emergencies, it should be the right of the client to control the circulation of confidential information.

2) Regarding the options under discussion, which seem to revolve around the creation of a Department of Child and Family Services and a Department of Physical and Mental Health, the Commission would make the following points:

a) There are benefits to be gained from the creation of a Department of Physical and Mental Health, which include the closer coordination of rehabilitation services with mental health services, the potential for the elimination of obstacles created in the administration of the Medicaid system to the development of the mental health system and the potent al for greater access to appropriate and needed physical health services for persons with mental illness.

b) There are great concerns that the mental health system and services will be a greatly reduced priority in a department that includes the large and extremely physical health bureaucracies. The Commission would stress the need for continuing independent oversight and advocacy as a means of maintaining needed and appropriate focus on mental health at the policy making levels of government.

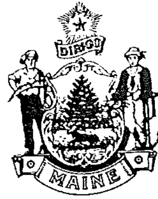
c) Option 11. calls for the grouping of overlapping and closely related services in one department or agency. Along these lines, the Commission is very concerned that, by grouping mental health with physical health, the medical model of mental health care will come to predominate, as opposed as to the psychosocial rehabilitation and other models closer to social service delivery models. There is a close relationship between services currently provided by the Department of Human Services and the mental health service system, such as alcohol and substance abuse services, protective services and a variety of benefit and economic security services. The Commission's concern is that such a configuration, with the stated principal of grouping closely related services, would ultimately drive a wider wedge between these systems by virtue of their continued separation.

d) Several members express concern that the treatment orientation of the Bureau of Children With Special Needs will be lost in the vast protective bureaucracies with which it will be combined. We would strongly urge that the integrity of children's mental health services be maintained in this reconfiguration.

3) The Commission notes that the interim report gives little consideration to the role of the private sector in the restructured departments. We would point out that the private sector already carries much of the load of service delivery through contracted services. We would urge consideration of the role of the private sector in the changing system. Regional coordination would have an impact on the private sector and create the potential for greater changes in this relationship. The Government Restructuring Commission has an opportunity to make a reasoned contribution to this changing relationship and we would urge that this be taken into consideration in your deliberations.

These comments represent the major issues identified by the Commission in consideration of the interim report. The Commission wishes to congratulate the committee for having accurately identified many of the major problems afflicting the system and for laying the groundwork for a series of positive, corrective actions. We remain available to provide whatever input you might wish.

Joyce
Roy 2



John R. McKernan, Jr.
Governor

Lynn Wachtel
Commissioner

Leonard Dow
Director of Community Development

Department of

ECONOMIC AND COMMUNITY DEVELOPMENT
OFFICE OF COMMUNITY DEVELOPMENT

MEMORANDUM:

TO: Special Commission on Governmental Restructuring
Committee on Health, Social Services and Economic Security

FROM: Margaret Marshall, Chair *Margaret Marshall*
Interagency Task Force on Homelessness & Housing Opportunities

RE: Interim Report

DATE: September 20, 1991

###

On behalf of the Interagency Task Force on Homelessness and Housing Opportunities I submit the following comments on the interim report.

<u>Section III - Initial Findings:</u>

The Task Force concurs with all findings identified in the Interim Report.

<u>Section IV - Options Under Discussion:</u>

The Task Force, at the request of the Committee, limits our comments to the following options as priorities.

<u>Option 7:</u> Develop a central information and intake system for all services.

<u>Comments:</u> This would provide the "One Stop Shopping" recommended by the Task Force in the report "By Sundown" submitted to the committee.

Option 8: Create a unified case management system for families with primary responsibility vested in a single lead agency.

Comments: Again, the focus is on the "One Stop Shopping". After the initial call the client is referred to an agency to develop a program for that person or family and take on the responsibility of assuring that the client is being served. "If you don't get help, call me back." (Page 13, By Sundown report.)

Option 11: Group overlapping, duplicating, and closely related services, and locate each group in one department or agency.

Comments: This option would eliminate the need for the client to go from one agency to another. It would eliminate the fragmentation of services.

Option 12: Regardless of the configuration of State agencies, raise the coordination and collaboration to priority status. Provide a strong interdepartmental coordinating mechanism with authority to mediate disagreements.

Comments: A Board or Commission established with a office and staff support at the Executive level to ensure that coordination and collaboration would take place.

Advocating
Self Help & Self Reliance
For Maine Citizens

MCAA

132 STATE STREET, P.O. BOX 5402, AUGUSTA, MAINE 04332-5402 (207) 622-5838 FAX (207) 622-0314

To: Committee on Health, Social Services, and Economic Security

From: Dana Totman, President

Subject: Government Restructuring

Date: September 19, 1991

The Maine Community Action system is a statewide service delivery mechanism for providing services to low income families and individuals. Our system serves 100,000 different Maine families annually. We maintain 22 full time offices, all which provide intake, information, referral and various programmatic services. Additionally, we provide these same services at over 100 itinerant sites. Collectively we have approximately 1300 personnel delivering 75 million dollars of services and programs to Maine's families. Our funding comes from nearly all state departments. We deliver education, health, energy, housing, transportation, employment, income transfer, case management, economic development, volunteer, nutrition, and advocacy related services.

Our system is comprised of eleven community based organizations. In some capacity we serve each of the eleven consumer groups identified by the committee. With this as a background I'm sure you'll agree our interest in this committee's work is very great. We could provide lengthy and detailed comments on each of the 19 options. We will, however, limit our comments to three general recommendations and one specific recommendation.

1. We suggest you approach the restructuring from the perspective of two consumer groups: people with mental or physical disabilities or problems and people with economic or social problems.

2. We suggest you promote the State's ability to plan, contract, monitor and track social service programs.

3. We recommend that you promote the abilities of community based organizations to provide programs and services which are effectively coordinated and easily accessible.

4. We offer specific recommendations related to option four should you eliminate the Division of Community Services. These comments are attached in the form of a recent letter to the governor.

Again we are very interested in the work of this commission and would be pleased to share information and ideas as you proceed. Thank you.

File
MCAA
Bo

Advocating
Self Help & Self Reliance
For Maine Citizens

132 STATE STREET, P.O. BOX 5402, AUGUSTA, MAINE 04332-5402 (207) 622-5838 FAX (207) 622-0314

August 30, 1991

The Honorable John R. McKernan, Jr.
Governor of Maine
State House Station #1
Augusta, Maine 04333

Dear Governor McKernan:

The recent resignation of Nicola Kobritz as Director of the Division of Community Services, and the legislation currently on your desk which would abolish the Division, prompt me to write on behalf of the member organizations of the Maine Community Action Association to share our thoughts. Our ten agencies serve 100,000 Maine families annually and provide the delivery mechanisms through which several Division programs reach Maine people.

I am not writing to influence your decision regarding the Division itself. Our interest is in the future of three specific programs currently administered by the Division. If you choose to sign L.D. 1768, currently on your desk, or to otherwise transfer any of these three programs to other administrative units, we would like you to be aware of our thoughts.

<u>We recommend the fuel assistance program be transferred to the Maine State Housing Authority for the following reasons:</u>

1. The weatherization program and fuel assistance are very closely aligned. One grant provides funds for both programs. One application form provides access to both programs. One plan is written that outlines both programs. The community action agencies deliver both programs. Because the Maine State Housing Authority administers weatherization, any alternate administration of fuel assistance would fragment the two programs. We feel that the LIHEAP Block Grant should be administered by one agency, should have a plan written by one agency, and should have a one stop application process.

2. The community action agencies are all currently delivering programs through contracts with MSHA. The relationship between MSHA and the agencies is excellent. This relationship will allow a smooth transition of LIHEAP as existing contracting and reporting systems can be used with minimal programmatic disruption.

3. The individual with the most expertise and experience administering the LIHEAP program, George Bates, is now the Director of Energy Programs for MSHA. With federal funding uncertainties and delays, George is the person best prepared to effectively manage LIHEAP in difficult times.

4. The LIHEAP program is consistent with other MSHA programs. Heating costs are a very significant piece of overall housing costs in Maine. Rental subsidies, housing rehab, furnace repair, low income housing are all MSHA programs with similar purposes to LIHEAP.

5. The data associated with the LIHEAP program can be invaluable information for housing research and planning. The MSHA will have information on 60,000 Maine homes including age, cost, type, occupancy level and condition. This data will assist with future MSHA planning efforts.

6. The MSHA has significant experience operating programs that have financial assistance go to third parties on behalf of low income citizens. In home loan programs the funds go to banks, in home repair programs the funds go to contractors and in rent subsidy programs funds go to landlords. Similarly the LIHEAP program requires funds to go to fuel vendors. The third party recipient concept is the same for LIHEAP as for other MSHA programs.

7. Transferring LIHEAP to MSHA will cause the least disruption. The community action agencies maintain over 100 outreach sites for LIHEAP applicants and make over 5,000 home visits to applicants. The agencies provide outreach, eligibility determination, budget counseling, benefit determination, check processing, and vendor payments to each of the 60,000 clients at a cost of only $26. The MSHA is prepared to continue this efficient and effective system.

<u>We recommend the Head Start program be transferred to the Bureau of Child and Family Services within the Department of Human Services for the following reasons:</u>

1. Head Start is a program that serves children and families like the Bureau does.

2. Head Start's nutrition and social services components are directly linked to this DHS Bureau and are directly or indirectly financially supported by DHS funding.

3. The linkage between Head Start and Day care are important elements to the program's operation and common administration of the two programs will enhance the coordination.

4. The Head Start providers all currently receive funds from this Bureau so a relationship is already in place.

<u>We recommend the Community Services Block Grant be transferred to the Department of Economic and Community Development for the following reasons:</u>

1. There are many similarities in the purposes of the Community Development Block Grant program and the Community Services Block Grant program.

2. The Community Services Block Grant (CSBG) program requires a degree of advocacy related to the responsiveness of other state delivered programs. This effort would be greatly compromised if the CSBG program were housed in a department that delivers the same programs being assessed by the CSBG program. The Department of Economic and Community Development provides the appropriate neutrality.

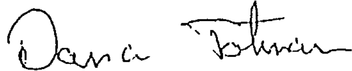
3. The flexibility of the CSBG program provides significant opportunities to develop partnerships and innovative approaches to addressing community problems. The similar flexibility of other DECD programs creates great potential to respond to unique regional needs.

4. The CSBG program and most DECD programs both are essentially coordinated at the state level with programmatic decisions made locally. This state/local relationship is critical for the CSBG program.

The Maine Community Action Agencies have a great interest in the future of these three programs. We recognize that the issues are complex and the decisions on the appropriate agencies to administer them will be far reaching. No one will feel the effect of changes in these programs more than the 100,000 Maine families served by our member agencies. We urge you to consider these recommendations as you determine what actions to take relative to the future of the Division of Community Services. If I or any of the other directors of community action agencies in Maine can be of assistance to you or your staff on these matters, feel free to call upon our services. We share your desire to serve the Maine families who rely on these programs for a better life. I can be reached at (207) 442-7963 if you wish to discuss these issues in greater detail.

Thank you for your consideration.

Sincerely,



Dana W. Totman
President

DWT:psg

MAINE ASSOCIATION OF REHABILITATION SERVICES

P.O. Box 227 - Belfast, ME 04915 - 207-338-2080

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Ken-a-Set A.R.C.
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Pathway's, Inc.
Auburn
Pottle Hill, Inc.
Mechanic Falls
Resources for the
Developmentally Disabled
Portland
Sandy River Rehabilitation Center
Dryden
Sebasticook Farms
St. Albans
Southern Aroostook A.R.C.
Houlton
Sunrise County Handicapped Programs
Machais
The Coastal Workshop
Camden
Wordford's, Inc.
Portland

September 19, 1991

Special Commission on Governmental Restructuring
Committee on Health, Social Services and Economic Security
State House Station #13
Augusta, Me 04333

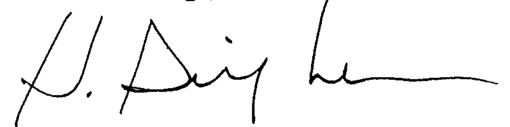
Dear Chairpersons:

I will be unable to attend the hearing on September 20, 1991. However, I am enclosing a copy of a position paper that the Maine Association of Rehabilitation Services developed earlier this year titled <u>Recommendations for Restructuring and Streamline State Government</u>.

This paper represents the position of the membership and was developed by the membership as a whole. As a result, the twenty-five member agencies fully support these recommendations.

Thank you for your consideration.

Sincerely,



Harold Siefken
President

Enc.

March 26, 1991

MAINE ASSOCIATION OF REHABILITATION SERVICES

RECOMMENDATIONS FOR RESTRUCTURING AND STREAMLINING

STATE GOVERNMENT

I. INTRODUCTION

The Maine Association of Rehabilitation Services (MARS), a statewide organization representing twenty-five private non-profit community agencies, makes the following recommendations to assist state government in meeting the needs of people with disabilities while balancing the budget. The recommendations deal with three areas: regulatory issues - cost versus benefit; privatization of services; and restructuring state government. We believe that these recommendations will result in lower cost while sacrificing no program accountability or services to people.

II. REGULATORY ISSUES - COSTS VERSUS BENEFITS

Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP)

A major benefit of MAAP was to have been its ability to improve accountability while concurrently reducing the number of audits (and therefore the cost) conducted in private agencies. It has failed on both counts.

Due to the increased expectations of MAAP, costs for private audits have increased dramatically. Multiple audits of single agencies continue to be the norm and some agencies are experiencing delays of several years until state auditors can schedule them.

MARS RECOMMENDS THAT THE JOINT STANDING COMMITTEE ON APPROPRIATIONS AND FINANCIAL AFFAIRS SOLICIT TESTIMONY ON MAAP'S EFFECTIVENESS AND, AS A RESULT, CONSIDER ITS RESTRUCTURE OR ELIMINATION.

Residential Facility Licensing, Handicapped Accessibility Regulations, ANSI Fire and Life Safety Codes, and related standards

These standards, as promulgated by the Bureau of Mental Retardation, Department of Mental Health and Mental Retardation, Bureaus of Rehabilitation and Medical Services, Department of Human Services, State Fire Marshalls Office, Department of Public Safety, have created a myriad of conflicting expectations for community agencies. Additionally, the state government agencies responsible for these standards and regulations are inconsistent in their application.

This scenario drives up both capital and administrative costs, duplicates efforts among state agencies and often does not result in significant safety or program improvements.

MARS RECOMMENDS THAT THE JOINT STANDING COMMITTEE ON HUMAN RESOURCES SOLICIT TESTIMONY FROM VARIOUS PUBLIC AND PRIVATE AGENCIES REGARDING THE OVERLAPPING AND INCONSISTENT REGULATORY REQUIREMENTS AND TAKE THE NECESSARY STEPS TO STREAMLINE THE REGULATORY PROCESS.

National Accreditation of Private Non-Profit Service Providers

The Bureaus of Mental Health, Mental Retardation and Rehabilitation mandated that all private non-profit agencies be accredited by a national accrediting body, Commission for the Accreditation of Rehabilitation Facilities (CARF) or Accreditation Council on Services for People with Developmental Disabilities (ACDD), by July, 1990 or face a withdrawal of state funding.

MARS upholds the importance of national accreditation standards since the cyclical nature of the process ensures continuous attention to standards of national merit. It is also important that these state agencies recognize that the accreditation process usually results in increased costs to private agencies.

MARS RECOMMENDS THAT:

1. NATIONAL ACCREDITATION CONTINUE TO BE A MAJOR PART OF THE FORMULA FOR ASSURING QUALITY OF SERVICES AMONG PRIVATE PROVIDERS AND AGENCIES IN THE COMMUNITY.

2. THE THREE BUREAUS INVOLVED IN MANDATING NATIONAL ACCREDITATION, IN COOPERATION WITH MARS AND THE MAINE ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES, SURVEY ALL PARTICIPATING AGENCIES TO ASSESS THE COST OF BRINGING AGENCIES INTO FULL COMPLIANCE WITH THESE NATIONAL STANDARDS BY THE END OF THE 1993 ACCREDITATION CYCLE.

3. THESE STATE AGENCIES EXERT THEIR INFLUENCE ON THE NATIONAL ACCREDITING BODIES TO MINIMIZE THEIR FEES, KEEP REALITY IN THE STANDARDS, AND THEREFORE HOLD DOWN THE COSTS TO THE PRIVATE PROVIDERS AND AGENCIES.

4. ALL PROVIDERS OF SERVICES TO ADULTS WITH DISABILITIES BE ACCREDITED BY ONE OF THE NATIONAL ACCREDITING BODIES. THIS INCLUDES PRIVATE INDIVIDUAL PROVIDERS, PRIVATE NON-PROFIT AND FOR-PROFIT AGENCY PROVIDERS.

III. PRIVATIZATION OF SERVICES

The Maine Association of Rehabilitation Services recommendations in this area deal with four service areas: case management; professional services; institutional services; and advocacy services. We believe that the privatization of these services will result in closer ties to the community in which they are offered, foster more individual choice, create healthy competition, and reduce expense to the taxpayers.

Case Management

Historically, case management has been done by state agency personnel. Given the size of the geographic regions covered, this form of case management frequently results in major decisions being made for individuals with disabilities by people who have little, if any, contact with the consumer. Service is often diluted, lacking in creativity, and expensive.

It is important to note that other states have adopted a private (as opposed to public) case management service delivery system with success.

MARS RECOMMENDS THAT:

1. THE DEPARTMENTS OF HUMAN SERVICES AND MENTAL HEALTH AND MENTAL RETARDATION WORK TOGETHER WITH PRIVATE AGENCIES TO AMEND THE STATE MEDICAID PLAN TO ALLOW THIRD PARTY BILLING FOR CASE MANAGEMENT BY PRIVATE VENDORS.

2. NATIONAL ACCREDITATION STANDARDS BE APPLIED TO THIS SERVICE AND BE A PREREQUISITE FOR MEDICAID FUNDING.

3. THESE STATE AGENCIES AND THE PRIVATE PROVIDERS AND COMMUNITY AGENCIES WORK COLLECTIVELY TO FORMULATE THE CHECKS AND BALANCES NECESSARY TO MINIMIZE "CONFLICT OF INTEREST: OR "VESTED INTEREST". IT SHOULD BE NOTED THAT NO SUCH SYSTEM OF CHECKS AND BALANCES CURRENTLY EXISTS IN THE PUBLICLY OPERATED CASE MANAGEMENT SYSTEM.

Professional services

The goal is to attract and cultivate a broader array of qualified professionals to serve persons who have severe or complex disabilities. Currently, persons with disabilities may go without service altogether as an increasing number of clinicians have significantly limited the number of Medicaid clients they serve.

MARS RECOMMENDS THAT THE DEPARTMENTS OF HUMAN SERVICES AND MENTAL HEALTH AND MENTAL RETARDATION WORK TOGETHER TO RESTRUCTURE THE MEDICAID RATES FOR THESE SERVICES TO ACHIEVE EQUALITY WITH PRIVATE SECTOR AND DEPARTMENT OF EDUCATION RATES.

Institutional Services

Except for persons with disabilities, most health care and long term services are provided in the private sector. Given the tremendous expense and questionable quality of state run services, this denial of consumer choice becomes all the more incredible. It has been repeatedly demonstrated that services provided in state institutions can be provided in a more effective, nurturing and cost effective manner in small community based facilities.

MARS RECOMMENDS THAT:

1. THE JOINT STANDING COMMITTEE ON HUMAN RESOURCES ESTABLISH A TASK FORCE SPECIFICALLY TO ORGANIZE THE INFORMATION, PROCEDURES AND RESOURCES NECESSARY TO SERVE THESE INSTITUTIONALIZED PEOPLE IN THE COMMUNITY.

2. ALL PARTICIPANTS ACKNOWLEDGE THAT BOTH SYSTEMS WILL REQUIRE FUNDING DURING THE TRANSITION PERIOD.

3. COMMUNITY RESOURCES (PRIVATE PROVIDERS, PRIVATE AGENCIES, HOSPITALS, ETC.) BE EQUIPPED WITH THE RESOURCES AND TRAINING NECESSARY TO OFFER CRISIS INTERVENTION AT THE COMMUNITY LEVEL.

Advocacy Services

Currently, advocacy services for adults and children with disabilities are provided by state government through the Office of Advocacy, Department of Mental Health and Mental Retardation and by a private agency, Maine Advocacy Services. The organizational placement of the Office of Advocacy within the Department of Mental Health and Mental Retardation creates a conflict of interest and at best results in a muted voice of advocacy. However, beyond the organizational difficulties, the presence of two agencies providing advocacy services to the same populations is a significant duplication of effort and a waste of the state's limited financial resources.

MARS RECOMMENDS THAT:

1. THE JOINT STANDING COMMITTEES ON HUMAN RESOURCES AND STATE AND LOCAL GOVERNMENT HOLD HEARINGS TO DETERMINE WHAT THE CURRENT NEED FOR ADVOCACY SERVICES ARE AND HOW THEY SHOULD BE PROVIDED.

2. BASED UPON THE TESTIMONY RECEIVED THE COMMITTEES SHOULD TAKE THE STEPS NECESSARY TO ALLOW THE ELIMINATION OF THE CONFLICT OF INTEREST AND DUPLICATION OF EFFORT BY COMBINING THE CURRENT EFFORTS OF THESE TWO ORGANIZATIONS IN A SINGLE PRIVATE AGENCY WITH THE POWERS AND RESOURCES NECESSARY TO BE AN EFFECTIVE ADVOCATE FOR ADULTS AND CHILDREN WITH DISABILITIES.

These recommendations are based on a long-term comprehensive approach to systems change, eventually resulting in cost savings including a reduction in state employees and state operated services.

IV. RESTRUCTURING STATE GOVERNMENT

While most of the comments that follow are directed toward the Bureau of Mental Retardation, MARS does not mean to imply that this is the only portion of state government that could benefit from restructuring.

MARS has identified several problem areas in the current organization structure of the Bureau of Mental Retardation: inconsistent regional operations, no apparent coordinated planning, lack of a clear mission, their authority is not commensurate with their responsibility for services to their clientele, no capability for research and development, and inadequate central office staffing.

MARS RECOMMENDS THAT:

1. THE BUREAU OF MENTAL RETARDATION ENGAGE IN A PLANNING PROCESS WITH PRIVATE SERVICES PROVIDERS TO REVISE ITS MISSION AND NARROW ITS FOCUS TO REFLECT THE CAPABILITIES OF THE CURRENT COMMUNITY SERVICE DELIVERY SYSTEM AND THE NEEDS OF ITS CLIENTS.

   MARS believes that with a revised mission and a narrowed focus, the regional office structure, as it is currently organized, can be eliminated.

2. THE RESPONSIBILITY AND AUTHORITY FOR THE ICF/MR, TITLE-XIX DAY HABILITATION AND REASONABLE COST REIMBURSED BOARDING CARE PROGRAMS BE MOVED FROM THE DEPARTMENT OF HUMAN SERVICES TO THE BUREAU OF MENTAL RETARDATION.

   This would eliminate the current problem of the Bureau of Mental Retardation having the responsibility for ensuring services to people with mental retardation without having the authority to manage a majority of the funding that pays for the services

3. THE JOINT STANDING COMMITTEE ON STATE AND LOCAL GOVERNMENT SOLICIT TESTIMONY ON THE ORGANIZATIONAL PLACEMENT OF THE BUREAU OF REHABILITATION WITHIN STATE GOVERNMENT AND THE PRIVATIZATION OF MANY OF THE SERVICES THAT THE BUREAU OF REHABILITATION NOW PROVIDES AND TAKE THE STEPS NECESSARY TO MAKE THESE CHANGES POSSIBLE.

   Currently, the Bureau of Rehabilitation, due to its relatively small size, is lost within the organizational structure of the Department of Human Services. Many of the previous statements and recommendations regarding the Bureau of Mental Retardation also apply to the Bureau of Rehabilitation since many of its direct services could be or are already being delivered by private providers.

   While we have referenced individual legislative committees in our recommendations we recognize that multiple legislative committees will have a joint role in restructuring and streamlining state government and the services it provides.

September 19, 1991

Special Commission on Governmental Restructuring
Committee on Health, Social Services and Economic Security
State House Station #13
Augusta, Me 04333

Dear Chairpersons:

I will be unable to attend the hearing on September 20, 1991.

I am a member of the Govenor's Commission to Analyze the Service Delivery System for Persons With Mental Retardation and Co-Chair of the Employment and Residential Services Subcommittee. While the Commission has not completed its work yet, I am enclosing a copy of the Report and Recommendations of the Subcommittee for your information.

Thank you for your consideration.

Sincerely,

Harold Siefken

Enc.

Final

June 5, 1991

EMPLOYMENT AND RESIDENTIAL SERVICES SUBCOMMITTEE REPORT AND RECOMMENDATIONS

Members: Ruth Benedict, DHS; Richard Estabrook, DMH&MR; Elizabeth Granthem, DHS; Charlene Kinnelly, Uplift, Inc.; Date Lowe, Green Valley Association for Retarded Citizens, Inc., Co-Chair; James Mehan, Katahdin Friends, Inc.; Betsy Rush, Foster Home Operator; Harold Siefken, Group Home Foundation, Inc., Co-Chair.

The Sub-Committee reviewed the following documents:

Maine Association of Private Residential Providers - Suggestions for a More Efficient State Government

Maine Association of Rehabilitation Services - Recommendations for Restructuring and Streamlining State Government

Medicaid Financing of Services for Maine's Citizens with Mental Retardation: A Follow-up Report

Proposed Rules to Clarify and Extend the Rights of All Persons with Mental Retardation

A Plan for People - Part II

While reviewing these documents, during several meetings, the Sub-Committee had wide ranging discussions about the current state of community service delivery, its problems, the changes in the delivery of services, the problems in delivering services that meet the needs of the entire population of people with mental retardation and how is it going to be done.

Among the many things that were discussed, some key points were raised:

1. there is little substantive disagreement among community service providers or the Sub-Committee members about community integration or the increased emphasis on individualization of service provision;

2. the population of people with mental retardation is composed of four major groups - those currently or formerly institutionalized, those who graduated from public school more than 5 or 10 years ago, those who were never institutionalized, lived at home and whose parents are no longer able to care for them, and those who are ready to or have recently graduated from public school;

3. the service delivery system must acknowledge the differing needs of these divergent population groups;

4. the Bureau of Mental Retardation must develop a research and development capability and assume a leadership role in the service delivery system;

5. if no additional resources are made available then the recommendations of the Plan for People - Part II and other similar plans can not be implemented, except in the most minimal way, while continuing to meet the differing needs of the populations groups described in paragraph 2.

All of the discussions concluded with "Where will the additional money come from to develop and implement the recommendations of the Plan for People - Part II and other similar documents?" Since there are only two ways to make income available - generate more or re-allocate existing money the Sub-Committee offers the following recommendations:

1. That a "pooled-loan" program be developed through the efforts of one or more state-wide provider associations and state government. The purpose of the program would be to offer below market rate financing for capital projects and cash flow loans. If a revolving loan fund for cash flow purposes is not possible through a program of this nature then state government and the legislature should give serious consideration to the establishment of such a fund.

2. That the Bureau of Mental Retardation develop a "research and development" capacity. The central office of the Bureau of Mental Retardation must have additional staff that can be dedicated to becoming experts on state and federal funding issues, federal legislation and regulation, new and innovative funding sources from both the private and public sectors, as well as, the availability of consultants to assist community service providers with programmatic issues and problems. This information is not generally available now and must be to insure a well designed and up to date service delivery system.

3. That a "cost analysis" of current and future rules and regulations be done to insure that the added cost of the regulation are justified and funded by the agency proposing the regulation.

4. That the Department of Mental Health and Mental Retardation should get out of the delivery of direct services - institutional, case management, advocacy, and professional services and concentrate on developing and managing the in-house system necessary to ensure that the resources necessary to deliver the desired services are available and effectively utilized.

5. That the recommendations of the Medicaid Financing of Services for Maine's Citizens with Mental Retardation - A Follow-up Report, especially those dealing with the need to increase the ability of the Department of Mental Health and Mental Retardation to manage a medicaid funded service program, the under utilization of Title - XIX at Pineland Center and the transfer of those parts of the Medicaid program that fund programs for people with mental retardation from DHS to DMH&MR be implemented.

6. That the state institutions, Pineland Center, Elizabeth Levinson Center, Aroostook Residential Center, be fully funded by Title - XIX and the General Fund money currently financing part of these state institutions be used to finance the necessary development and on-going costs of the expanded community service delivery system. The "freed-up" General Fund money (currently there is $10 million in General Fund money in Pineland Center's budget alone) could be used to "seed" Title - XIX programming but the majority should remain "pure" state funds in order to retain the required flexibility to do the innovative programming necessary to meet the needs of the many populations of people with mental retardation.

7. That the Maine Advisory Committee on Mental Retardation monitor the implementation of these recommendations and make quarterly status reports to the Governor, Legislature, and members of the Governor's Commission on the progress of implementation.

Maine Transit Association

Serving the transportation needs of Maine's people from Fort Kent to Kittery

September 18, 1991

Mr. Roland Caron, Co-Chair
Ms. Rosalyne Bernstein, Co-Chair
Special Commission on Governmenal
Restructuring Committee
State House Station 13
Maine State Legislature
Augusta, ME 04333

Dear Mr. Caron and Ms. Bernstein:

On behalf of the Maine Transit Association, I would like to take this opportunity to applaud your efforts in restructuring State Government to meet its citizens needs. The following comments are synthesized from a discussion our association held this past week. I hope the comments are helpful to you and your purpose.

1. I don't think the State of Maine realizes there are a variety of transportation programs which serve the State. There are at least seventeen transportation providers who contract with various bureaus within the Department of Human Services, Department of Mental Health and Mental Retardation and Department of Transportation. All of these contracts with all of these different bureaus are for the same thing - purchasing mobility for Maine's citizens.

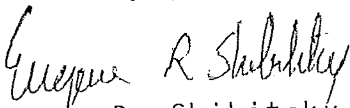
2. The problem above would be relieved by assigning one department/bureau to oversee purchased public/social service transportation contracts with the State. Not only would the operators be relieved of countless hours of bureaucratic paper pushing, but the State could channel personnel resources into areas where they are really needed. The State, by having a single agency responsible for transportation would also cut down on the amount of duplicative services it is buying simply because one agency/bureau would make sure contracts are coordinated. Because various State agencies and bureaus purchase transportation services from a number of private/public agencies the consumer is most often at a loss as to which system to ride.

Androscoggin Valley COG
Aroostook Regional Transportation
Biddeford - Saco - OOB Transit Committee
The Bus
Casco Bay Island Transit District
Community Concepts
Coastal Transportation
Downeast Transportation
Eastern Transportation
Greater Portland Council of Governments
Greater Portland Transit District
Kennebec Valley CAP
Penquis CAP
P.R.O.P.
Regional Transportation Program
Waldo County Transportation
Washington-Hancock CAP
Western Maine Transportation
YCCAC Transportation

3. Presently there is really no technical or regulatory agency responsible for all the oversight which is needed in transportation. There is no single set of transportation safety regulations or source to which operators can go for technical assistance or help in gearing up for the latest technologies.

Transportation services today operate in a vast maze of bureaucratic departments, agencies and bureaus. Some bureaus do not even know that transporation services exist. Both the state and operators are involved in too much paper work; there needs to be a streamlining of the process which can best be achieved by having one department responsible for the purchase of transportation services in the state. That agency would also provide technical assistance to the programs in the field.

Sincerely,



Eugene R. Skibitsky
President

ERS:jh

York County Community Action Corporation
11 Cottage St. / P.O. Box 72 / Sanford, ME 04073

Telephone: (207) 324-5762
324-3928
283-1446
748-1766
247-3665

September, 1991

Rosalyne Bernstein, Co-Chair
Roland Caron, Co-Chair
Special Commission on Governmental Restructuring
Committee on Health, Social Services & Economic Security
State House Station 13
Augusta, Maine 04333

Dear Ms. Bernstein and Mr. Caron,

As a Regional Transportation Agency providing a variety of transportation services under contract with the State, I would like to offer comments on the Committee's Interim Report.

Given the extremely brief time line that you have to work within, I would like to both commend you for the clarity and accuracy of the initial findings of the Committee, and support a number of the options listed in the Interim Report.

Option #9 - Elimination of multiple contracting and evaluation is a high priority for YCCAC where we not only have two fiscal years for State contracts (7/1-6/30 or 10/1-9/30), but multiple lengthy, client-specific contracts and monthly or quarterly reporting forms. (Report for our Area Agency on Aging attached.) Tracking of units of service provided requires a computer and two full time staff, for a relatively small amount of contract dollars. These administrative costs wind up reducing the contract dollars available for direct service to target groups.

Option #13 - The Bureau of Medical Services currently allows Medicaid providers to electronically submit billings via computer modem. The problem is that it requires more time expenditure (and cost) to the provider, and we are not reimbursed despite potential for major savings by the State. Since transportation providers rates have not been adjusted to reflect acknowledged service cost increases since October 1985, there is no incentive for us to use this more efficient process.

Option #15 & #18 - As a provider receiving over 20 different sources of funds, categorical funding is a major issue. Over the last several years as federal and state resources have grown more scarce, and demand for transportation (and other) services has increased, our contracts have begun to use a "triage" type approach: only those Maine residents in the most dire need,

Other Locations:

Head Start Program
P.O. Box U, Wentworth St.
Biddeford, Maine 04005
282-6290

Biddeford Community Action Center
Ross Center, Washington St.
Biddeford, Maine 04005
282-5513

Kittery Community Action Center
Community Center, Cole St.
Kittery, Maine 03904
439-2699

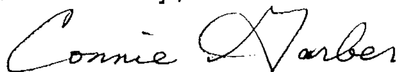
those at risk of abuse, neglect or institutionalization, are targeted for service. The concept of "an ounce of prevention " has been lost. More and more specific requirements are placed on who can be served, and what they can be provided with. Less and less emphasis has been placed on the "health maintenance organization" (HMO) approach to minimizing the seriousness of an individual's problems by early, less costly intervention.

Every year at regional, state and national meetings and Congressional hearings, the issue of lack of access to health care, training, and employment is raised. In a rural state like Maine, even if the best health care network were in place, if a person does not have a way to get to the doctor, the service is of no value. The same is true for elderly wishing to remain in their own homes, handicapped people wanting to get a job for which they have been trained, or a single parent needing to get their children to day care and be free to find employment. If there is no private automobile available, the inadequately funded public transportation system in Maine may be a poor second choice that may be unable to respond to their needs. We will never be in a position where big cities with buses and trains on every corner offer residents a variety of choices on how to get where they need to go. But the lack of a State Transportation Policy to maximize access to services and provide quality, safe transportation (not merely what a Bureau can get for the least amount of money, without regard to licensing, training or safety standards) means that Maine's citizens are looking forward to less and less mobility as dollars shrink.

As a member of the Maine Transit Association (representing public transportation providers throughout the State), I would urge the Committee to consider one fundamental question in your deliberations: If <u>any</u> service is only as valuable as a person's ability to access it, is there a better way to structure all of the services provided by the State? By providing greater mobility through the Regional Transportation Providers, and focusing on community based services in general, I believe everyone will benefit from a "HMO" approach to the growing number of serious problems facing Maine and its citizens.

I would be happy to provide any further information that you might require.

Sincerely,



Connie Garber
Transportation Director

Attachment

Southern Maine Area Agency on Aging 9/13/89

QUARTERLY SERVICE REPORT FORM

YEAR-TO-DATE TRANSPORTATION STATISTICS

SERVICE PROVIDER ______________________ REPORT PERIOD __________ to __________

YEAR-TO-DATE UNDUPLICATED PASSENGERS ______________________ RESIDENCE

Code	Number
U	______
R	______

YEAR-TO-DATE NUMBER OF PASSENGER MILES ______________

PASSENGER CHARACTERISTICS

1. AGES:

60-64 ______	70-79 ______	90-94 ______
65-69 ______	80-84 ______	95-99 ______
70-74 ______	85-89 ______	100+ ______

2. SEX: Male ________ Female ________

3. ETHNIC ORIGIN:
   a) American Indian/Aleutian ______
   b) Asian Pacific Islander ______
   c) Black, Not Hispanic Origin ______
   d) White, Not Hispanic Origin ______
   e) Hispanic ______
   f) Refused ______

   Total Minority ________

4. ENGLISH SPEAKING ______________ NON-ENGLISH SPEAKING ______________

5. PRIMARY LANGUAGE:

01 ____ French	43 ____ Micmac
02 ____ Spanish	47 ____ Passamaquoddy
04 ____ Am. Sign	54 ____ Russian
14 ____ Chinese	55 ____ Swedish
31 ____ Italian	____ Other
41 ____ Maliseet	

6. POVERTY LEVEL:

a) 100% or below ____	b) 125% or below ____
Minority ____	Minority ____
Non-Minority ____	Non-Minority ____

7. FRAIL/DISABLED: ______________

DEFINITIONS ON THE REVERSE

DEMOGRAPHIC DEFINITIONS

MINORITY ELDERLY: Persons aged 60+ who are either: American Indian/Alaskan Native; Asian/Pacific Islander; Black, not of Hispanic origin; or Hispanic.

FRAIL/DISABLED ELDERLY: Persons aged 60+ having a physical or mental disability, including having Alzheimer's disease or a neurological or organic brain disorder of the Alzheimer's type, that restricts the ability of an individual to live independently.

RURAL ELDERLY: Persons aged 60+ residing in rural areas within the PSA.

For our purpose these cities and towns of 10,000+ will be coded "U" for urban:

Auburn	Brunswick	Portland	South Portland
Augusta	Gorham	Presque Isle	Waterville
Bangor	Lewiston	Saco	Westbrook
Bath	Limestone	Sanford	Windham
Biddeford	Lisbon	Scarborough	York

All other cities, towns and places will be coded "R" for rural.

LOW-INCOME NON-MINORITY ELDERLY: All persons aged 60+ with an annual income at or below the Federally established poverty level, EXCEPT the minority elderly, as defined above.

LOW-INCOME MINORITY ELDERLY: Minority elderly, as defined above, with annual income at or below the Federally established poverty level.

These minority categories are prescribed by and defined in OMB Directive 15, "Race and Ethnic Standards for Federal Statistics and Administrative Reporting, "Statistical Policy Handbook, 1978, U.S. Department of Commerce, Office of Federal Statistics and Standards, P. 37-38.

Maine Association of Substance Abuse Programs Inc.

71 Sewall Street, P.O. Box 5067, Augusta, Maine 04330 207-622-1777

September 20, 1991

TO: Special Commission on Government Restructuring
FR: Maine Association of Substance Abuse Programs
Lynn Duby, President
RE: Partnership for Services

Enclosed please find the MASAP suggestions for creating more responsive governmental structure and policies in order to maximize resources and the provision of needed substance abuse services to Maine citizens.

Yours is an important venture for Maine that could devise improved methods of operating state government . We believe it is essential that your perspective be from the citizens viewing the services of government rather than from the perspective of the government as provider of services. Our comments are intended to reflect the experience of community based agencies in trying to live with state funding, rules and regulations and the effect of these factors on providing services to low income clients. Community agencies are very close to the citizens, and non-profits specifically are controlled locally. Non-profit Human Service Agencies must often be the bridge between state government and its citizens. This role is becoming increasingly untenable with progressively less funding and more regulations. The Partnership between local agencies and state government to the benefit of low income citizens is quickly disappearing.

Please feel free to contact any of the MASAP members for further or more specific information.

Thank you for your consideration.

Coordination of Services for Consumer Access and Cost Savings

Departments develop in response to their sphere of interest, in the process they tend to create procedures and justify their expertise and become myopic in their perspective on clients and services. If there was only one Department this would not necessarily be a problem.All would be represented fairly and evenly based on the competency and openess of the administration. In the real world there are multiple departments each with their own interest, procedures and levels of administrative capabilities. The result is duplicative administrative procedure, competing clients and programs priority and added confusion for all fostered by departmental myopia.

In 1989, the legistature recognizing the extent of this problem in the area of substance abuse , created the Office of Substance Abuse to focus planning, financing and monitoring with a single body of state govermnent. The legislation and structure exist but the administrative leadership has not been forthcoming to effect the change.

For example in 1991, one community based substance abuse agency still has funding from 3 Departments, involving 6 Bureaus (and 6 contract officers) with over 11 state and financial reportin forms and three separate state licenses (with 3 licensing specialis Furthermore, local programs are developed to meet the diretions of all of these competing interests even though the clients are essentially all the same.

The costs are enormous;funding is wasted by State Departments on unneccessary administrative cost at both the state and local levels as well as confusion and lack of services for clients.

With their mandate for action OSA could be the model for structuring state government to reduce cost and improve client services. Without the power, it will only be an example of hollow restructuring of government.

Proposed Resolution to the Problem:

A. Single State Agency for Substance Abuse

The legislature and governor need to insure the leadership to consolidate all budget, planning and contract monitoring with consistent rules and regulations within the Office of Substance Abuse.

Cost Savings:

1. Reduce state contract officer positions
2. Reduce state data processing positions
3. Reduce state administrative positions
4. Reduce local agencies administrative expenses
5. Reduce local agency staff turnover

B. Single State Licensing Bureau

The Legislature needs to consolidate all licensing functions into a single licensing bureau to insure protection of the public good and consistent regulations.

Cost Savings:
1. Reduce state licensing staff
2. Reduce local agency administrative expenses

II. Public - Private Partnership - Economic

In substance abuse services as with many other human services state funds are used to subsidize services to low income clients. These funds are usually matched with local funding sources, client fees, medicaid and donations in order to operate programs.

However, in a five year period (FY 86-87 to FY 90-91) state cost of living increases for existing substance abuse services averaged about 2% per year. This was approximately 10% less than necessary to address inflationary trends. Salaries for substance abuse counselors have, in addition, been historically low (ie, significantly less than equivalent state employee salaries).

At the same time, the various state departments have increased the administrative tasks required (ie, licensing, contracts, reporting, auditing) which have real local costs associated. Staff have to do the paperwork.

It is common in treatment agencies for clinical staff to spend 43-50% of their time on paperwork.

Proposed Resolution to the Problem:

1. Rainy Day Fund

The Legislature should create a rainy day fund to be used for the support of social services in the event of economic downturns.

2. Index Cost of Living Adjustments

Core social services provided by non-profits be automatically built in for COLAS equivalent to the inflation index. State government COLAS are close to automatic whereas community agencies are the last recipients of surplus funds.

III. Public - Private Partnership - Local Input

Although Maine is a small state, state government is too far removed from the realities of local communities to be entirely responsible for the planning services. State departments must be responsible for state wide uniformity without adequate knowledge of the particular complexity of local areas. As a result local non-profits cannot maximize local resources.

Proposed Resolution to the Problem:

1. Regional Social Services Planning Commission

The creation of regional coordination and planning bodies can increase knowledge for effective planning sensitivity to local needs, and involve the unique local resources (ie, business, municipalities, United Ways, volunteers, etc.) to maximize the impact of services.

State government officials often are unable or unwilling to identify efforts funded by non-state resources as a part of the overall continuum of care. The result fo myopically looking at only state funded activity is a distorted view of the system and/or inaccurate approach to planning for overall service delivery.

A NEW VISION: EMPOWERING PEOPLE FOR CHANGE

MAINE'S MODEL FOR UNIFYING STATE SERVICES FOR CHILDREN & FAMILIES

FINAL REPORT OF THE PRESIDENT'S & SPEAKER'S BLUE RIBBON COMMISSION ON CHILDREN & FAMILIES

AUGUST 1991

Printed under appropriation 01094A1001012

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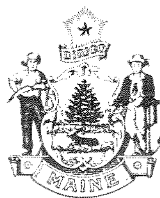

Charles P. Pray
President of the Senate

John L. Martin
Speaker of the House

114th Maine Legislature

President's and Speaker's
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This report should be seen as part of a continuing process. The Commission designed a schematic plan, not a detailed plan. We provide a foundation for an appointed Commissioner to use when moving forward into the more detailed ingredients for implementation. The end result should be a more efficient and focused approach to meeting the needs of children with problems, but more importantly, an approach which emphasizes prevention and early intervention as a means for reducing those problems.

Other states which have moved to the separate state agency approach have tended to develop agencies to serve special problem children, adolescents, and their families. The enclosed report outlines an approach which addresses children in general, with a coordinated approach to not only treating already established problems, but to reducing future problems. This is an approach which has the potential to be a national model.

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Due to the establishment of the Special Commission on Governmental Restructuring, we have made the assumption that this report will move to that body prior to any legislative action. Therefore, we have not prepared legislation as part of the content of this report. We have printed a number of the enclosed report for distribution, while the more detailed addendum which contains supporting materials will be printed in very limited quantities. It was felt that the cost of printing at this time should be reduced by proceeding in this manner.

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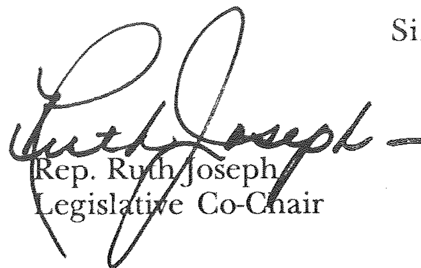

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PROLOGUE

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Throughout this report "conditions" is used to refer to any of the multiple problems affecting children and families. Because of our commitment to emphasize positive child development, healthy family functioning, and family well-being we made a conscious attempt to use language which highlights strengths rather than weaknesses. We do not wish to label youngsters or families by phrases that may inadvertently contribute to reinforcing problems, diminishing competencies, or predicting unacceptable performance. By underlining the positive, we do not want to confuse.

The conditions to which we refer include a variety of problems which can negatively affect children and families including those listed in the next paragraph. The Commission believes that the following conditions do negatively impact children and deserve the attention of the State:

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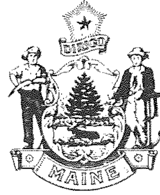

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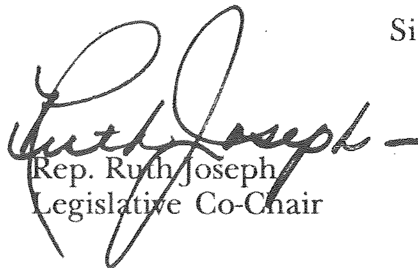

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CHAPTER 1

EXECUTIVE SUMMARY

Editor's Note: *The Blue Ribbon Commission recognizes that due to the extensive debate about the state budget and the anticipated recommendations of the Restructuring Commission, the proposed recommendations and timetables may need to be adjusted when implemented.*

MISSION OF THE BLUE RIBBON COMMISSION

The Blue Ribbon Commission on Children and Families was initiated in early May, 1990 by the Honorable Charles P. Pray, President of the Maine Senate and the Honorable John L. Martin, Speaker of the Maine House of Representatives. Its mission was to:

- Develop a plan to establish a distinct cabinet-level Department for Families and Children;
- Prepare legislation implementing a department with unified responsibilities for offering integrated services to Maine's children and families;
- Define the principles and components essential for State services to be well coordinated to fully attain a functionally integrated pattern of unified and consolidated administration and service delivery; and
- Identify methods of service delivery which are holistically oriented, child-focused, and family-focused.

BACKGROUND

During the 1980's the issue of "children and families at-risk" evolved into substantial and unresolved public policy debate. Our fellow citizens, educators, law enforcement personnel, business people, clergy, state leaders, and others became concerned. Simple questions were asked with increasing frequency.

> *"What's wrong with kids today?"*
> *"Can't that family control their kids?"*
> *"How do we sustain our society when children and families are at-risk?"*

"Are kids learning to fulfill their potential?"
"Who's raising our children?"

The Blue Ribbon Commission conducted 16 meetings from May 1990 through April 1991. We attempted to answer some of the above concerns. All meetings were open to the public and included parents and community members. The basis for the Commission's formation and deliberations was L.D. 1666, which the Legislature considered in 1989 and 1990. The legislation proposed the establishment of a Department for Families and Children.

National authorities who addressed the Commission provided information on programs and planning efforts in other states about services for children at-risk and their families. Their presentations included information about strategies developed at the national level, the laws of all states, the plans and policies of other states, and their own hands-on experience. The twenty members of the Commission deliberated major policy issues at length, using work sheets, consulting with key administrators of children's programs, and conducting research of their own. Members reached consensus on the findings and recommendations which are included in this report.

Our report, **A New Vision: Empowering People For Change — Maine's Model For Unifying State Services For Children And Families** documents the fact that children and families at-risk are matters of national and state concern. Maine and the nation are engaged in a public policy debate regarding the best methods to address problems and potential problems associated with child development and family life. There is emerging consensus on principles to encourage positive child development, positive family life, and for guiding and restructuring service delivery. There is a growing field of information about how government and communities can become more supportive of at-risk families and children. Actions taken by other states provide a sound foundation for building a positive future. The need for innovative public and private action in Maine is becoming increasingly clear.

Our report consolidates the latest knowledge and best experience. We build on the work of national authorities and other states.

SUMMARY OF FINDINGS

The Blue Ribbon Commission on Children and Families finds:

1. **THERE IS A NEED TO ASSURE THE AVAILABILITY OF SERVICES FOR MAINE'S CHILDREN AND FAMILIES.** Many Maine children do not have adequate opportunities for personal development. Families in Maine are often isolated and lack natural support networks and other ties to the community. This isolation contributes to a

diminished capacity to fully and productively participate in the public and private life and business of the community. Isolation compounds the proliferation of problematic conditions such as poverty, substance abuse, illiteracy, and other human problems which significantly limit the potential for health family life and individual development. In addition, the Commission finds that current services are overloaded and not able to meet the needs of Maine's at-risk families and children.

2. **STATE GOVERNMENT HAS RESPONSIBILITIES FOR AND ROLES TO PERFORM IN PROVIDING SERVICES FOR MAINE'S CHILDREN AND FAMILIES.** When children and families are severely affected by poverty, substance abuse, illiteracy, and other human problems that diminish their ability to fully participate in the public and private life of the community, the State has roles to fulfill. These roles involve encouraging healthy child and family development, coordinating a range of supportive services for children and families at-risk, providing financial assistance, intervening to protect children who are abused and/or neglected, and making other services available to families and children who need them.

3. **CURRENT PRACTICES FOR PROVIDING SERVICES FOR CHILDREN AND FAMILIES IN MAINE LACK COORDINATION AND PURPOSE.** There are a number of state agencies currently providing services for children and families. These agencies are not coordinated, share no unified mission, and offer no single point of entry, responsibility, or accountability. The Legislative and Executive branches of government have responsibilities for developing policy and providing services for children and families. Neither branch of government has coordinated, unified, or efficient mechanisms for carrying out its responsibilities.

4. **CURRENT STATE POLICIES RELATIVE TO FUNDING SERVICES FOR CHILDREN AND FAMILIES ARE INCOMPLETE AND INEFFECTIVE.** The State currently fails to maximize the use of federal dollars and previously has not claimed all available federal matching for both administrative and supportive service costs. We recognize recent policy and budgetary actions to claim federal funds more appropriately. It is estimated that over $40 million in federal dollars could be obtained if the state chooses to seek them.

5. **THE STATE CURRENTLY WASTES RESOURCES THROUGH PIECEMEAL POLICIES, FRAGMENTED, INEFFICIENT, AND COSTLY DUPLICATION OF SERVICES, ORGANIZATIONAL UNITS, AND ADMINISTRATIVE PRACTICES.** Over 1,000 state employees provide services for Maine's children and families at a cost of over $100 million dollars a year. Many of these employees carry out duplicative efforts, doing the same work that counterparts in separate agencies

perform. Significant savings would result from the consolidation of duplicative services, organizational units, administrative practices, service contracts, and administrative oversight and audits.

6. **A LACK OF VISION LEAVES SERVICES WITHOUT AUTHORITY OR CAPACITY.** Maine's policy of maintaining multiple state agencies, side-by-side similar state functions, and overlapping responsibilities provides at-risk children and families services which are fragmented, inefficient, costly, and lacking in well-defined authority. Because the present piecemeal state approach lacks unified vision to guide child development and comprehensive family services, the state's ability to encourage appropriate and adequate community supports and community resources for children at-risk is compromised.

SUMMARY OF RECOMMENDATIONS

The Blue Ribbon Commission on Children and Families makes the following recommendations:

1. Adopt a Unified Mission Statement

The Blue Ribbon Commission recommends that the State adopt the following mission statement to govern its roles in the provision of service to children and families:

> *The State of Maine declares that each family has primary responsibility to provide for the developmental and human needs of its members and that state government has a responsibility to help families fulfill that obligation when they are unable to do so. Children have the right to a consistent nurturing environment and to the opportunity to attain their potential for development.*
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> *The mission of government is to complement the roles of families, support networks and society in order to enhance their strengths. State government has the responsibility to intervene on behalf of children at-risk and to encourage the return to, or creation of, a nurturing family environment. The state's response should include supportive services and interventions that offer a functionally integrated continuum of appropriate and reasonable support, either directly or in concert with private organizations. Services should address the cognitive, educational, emotional, health, physical, and social needs of children and their families. The state's intervention is subject to the rights of*

families and children, their preferences, statutory authorization, and the availability of funds.

NOTE: The Commission recognizes the efforts of the Governor's Task Force to Improve Services for Maine's Children, Youth and Families in the development of the mission statement.

2. *Define the Roles of Government*

The Blue Ribbon Commission recommends that the roles of State government in providing services for children and families be more concisely defined and that the State base the services it provides in well articulated principles. These guiding principles are outlined later in this report, as are the responsibilities that the Commission believes reside with State government.

3. *Creation of Joint Select Committee for Children & Families*

The Commission recommends the establishment of a Joint Select Committee for Children and Families to be a focal point for public policy discussion of children's and families' issues and to offer oversight of state administered services. The Commission recommends that the Joint Select Committee for Children and Families be created by Joint Order during the 1991 session of the Legislature as an eventual companion to legislation enacting a Department for Families and Children.

Members of the Commission have divided opinions about the effective date for establishing the Joint Select Committee. Some recommend the effective date for the formal transition period to a unified department be the same as that for the establishment of the Joint Select Committee (i.e., October 1, 1991). Others recommend that the two occur separately, creating the Committee effective immediately upon passage of the joint order (i.e., June, 1991.)

4. *Establish a Unified Department for Families & Children*

The Commission recommends that a distinct department for children and families be established to unify responsibilities for providing integrated delivery of functionally consolidated supportive services for families and children who need them. The department should be formed by consolidating, transferring, and revitalizing existing programs, administrative practices and personnel.

The programs and agencies recommended for consolidation are currently housed in the Department of Corrections, the Department of Education, the Executive Department, the Department of Human Services, the Department of Mental Health and Mental Retardation, and the Interdepartmental Council. As part of this consolidation, the Commission also recommends initiating a unified case management

system which is holistically-based, comprehensive, designed to stress education, human development, and preparation for the job market, and organized around the needs of high-risk children and their families. Members of the Commission strongly recommend that the transition to and full operation of the new unified department take place by January 1, 1993.

5. *Consolidation of Existing Committees*

The Commission recommends the consolidation of ten existing committees into a single independent advocacy organization for children and families. (Those committees and commissions are listed fully in the body of this report.) The Maine Commission for Children and Families should be an independent group designed to advocate for children and families and to provide an additional check and balance between the public and the State.

6. *Creation of a Family Foundation*

The Commission recommends the establishment of the Maine Family Foundation. This foundation is envisioned as a public-private partnership established to develop and promote positive family life, positive child development, primary prevention, early intervention, improvements in state policy and services, effective program administration, and research relative to children.

7. *State & Local Education Coordination*

In order to assure improved educational outcomes for all school age children, particularly those served by the Department for Children and Families, the Blue Ribbon Commission recommends that significant and substantial actions be taken to define, develop, and increase the coordination and cooperation between special education services personnel at the local level and the personnel and services of the Department for Children and Families.

8. *Medicaid for Children*

The Commission recommends full exploration of the transfer of the administrative responsibilities for the Medicaid program to the Executive Department.

9. *Transition Services for Children At-Risk*

The Commission believes that all children who are receiving supportive services through the Department for Children and Families and preparing to live independently should be eligible for transition services, modeled on the Transition Committee's program. The Commission recommends that the department's transition policy and

program be designed to prepare all service recipients for independence from the Department's supportive services. This process and policy should be implemented after January 1, 1993.

10. Unified School District within the Department

The Commission recommends that during the transition process, the Department for Children and Families undertake an exploration of the establishment of a unified school district or intermediate educational unit within the Department.

11. Pineland Center

The Commission recommends that the goals, principles, and purposes that guide services for the Department for Children and Families be applied to services provided to the small number of children residing at Pineland Center.

12. Primary Prevention & Other Services

The Commission recommends that state supportive services focus on primary prevention and early intervention. Prevention and early intervention should be components of a comprehensive continuum of services and should be offered in concert with other private and public resources in the community.

Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

Declaration of Responsibility for Maine's Children

More than ever before, we, the people of Maine, must accept our responsibility to guarantee the well-being of all Maine's children. Daily we hear reports of children being abused, living in poverty, becoming homeless, and growing up illiterate and unable to earn a legitimate wage. Our private interests and public policies put our children's welfare secondary to the demands of technological change, economic uncertainty, and the needs of adults who were themselves shortchanged as children. In defiance of these conditions, we assert that our children come into the world with certain inherent rights:

- *To be cherished and accepted in their families.*
- *To be nurtured by their families in a way that meets their individual needs, so that they can grow in ability to reach their fullest potential.*
- *To receive sensitive, continuing help in understanding, accepting and developing pride and confidence in their ethnic and religious heritage.*
- *To grow in trust in themselves and others through continuing, loving care and respect as unique human beings.*
- *To grow up in freedom and dignity in a community of people who accept them with understanding, respect, and friendship.*
- *To receive help in overcoming any deprivation in their physical, emotional, intellectual, social, or spiritual growth.*
- *To be given education, training, and career guidance to prepare them for a useful and satisfying life.*
- *To receive preparation for citizenship and parenthood.*
- *To be raised in an atmosphere free from the suffering of physical and emotional abuse.*
- *To be loved.*

(Adapted, with permission, from the Bill of Rights for Maliseet Children, Houlton Band of Maliseet Indians)

By protecting these rights, communities create nurturing environments for children. Promoting such nurturing environments will bring strength to our families, our communities, our state, and our nation.

Our children's lives are at stake. Maine's future prosperity is at stake. Our own honor is at stake. We must act to leave our children a world better that the one we inherited. As we value life, prosperity, and honor, we pledge to win for Maine's future generations those ideals that we ourselves hold most dear: the expectation of well-being for all Maine families, the hope for peace, and self respect.

(Reprinted with permission of Ad Hoc Children's Committee)

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Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

CHAPTER 2

INTRODUCTION

The members and staff of the Blue Ribbon Commission on Children and Families searched for words and phrases to describe their vision for addressing the complicated, recurring, and sometimes unpleasant conditions that can and do affect families and children in Maine. The difficulty arose from trying to succinctly describe the kinds of multiple problems which face families and children and from problems associated with recognizing differing views of what constitutes appropriate remedies, a growing volume of professional jargon, and, deeply rooted ideological convictions and beliefs. The Commission has attempted to submit a final report which is clear, does not stigmatize or label, and is consistent in the language that it uses to describe the problems and concerns it has identified and the changes that it envisions.

Commission members believe that all children in Maine deserve equal access to opportunity, regardless of their socioeconomic status, cultural and racial background, or other individual histories or characteristics. The Commission members also believe that state government, families, communities, schools, health care providers, places of worship, and places of work all contribute to the lives of children and families and to the opportunities available to them.

This report is predicated upon these and several other basic beliefs: that the well being of Maine's children and families is important to the overall health of society; that each segment of society contributes to family life and the well-being of children; that society has a role to fulfill in addressing the causes of, and consequences for, families and children at-risk.

The Blue Ribbon Commission believes that a full range of resources need to be available for children and families. Members believe that all segments of society can be service delivery networks and support families and children so that they may fully participate in the opportunities that are crucial to their well-being and to the health of the community and the state. This report recommends enhancing the lives of children and families through reorganizing, revitalizing, and consolidating government programs and services and increasing the

involvement of communities and members of the general public in the development and delivery of services to children and families at-risk.

GUIDING PRINCIPLES OF THE COMMISSION

The following principles and beliefs guided the work of the Commission:

1. All segments of Maine society should be empowered to participate in serving as supportive networks for families and children with, or without the participation of State government. Voluntary, private, and joint-public-private efforts should exist.

2. Society as a whole benefits when there is a strong sense of shared community responsibilities for the well-being of children and families, respect for individual differences, and a commitment to helping all members of the community become active and productive participants in the public and private life and business of the community.

3. Improving the participation of communities and the efficiency of government programs and services will take time. Improvements will be implemented gradually through a well designed plan of action.

4. Resources and service delivery networks should exist to encourage community involvement in the well-being of its children and families and to provide direct help to children and families at-risk or in need.

5. All segments of society are interdependent and can be sources of support and service delivery for families and children. Community involvement can contribute significantly to family well-being, development, and the protection and care of children.

6. Changes in economic, social, and family patterns have a significant impact on children and families. Services for families and children should be flexible so that they can respond to and address changes as they occur.

7. Poverty, illiteracy, substance abuse, physical and sexual abuse, and other social and human ills contribute to the break-down of families and to a host of other problems for children. These problems can cross generations and are basic to many at-risk children and families experiencing significant difficulties becoming productive participants in the public and private life and business of the community. Public policies which ignore these root causes and fail to offer preventive actions may be ineffective.

8. There is a need for a concentrated and coordinated effort to increase opportunities for children and families at-risk and to empower communities and society as a whole to participate in this effort. The State has significant roles and responsibilities to fulfill in this effort.

9. Primary prevention of, and early intervention in, problematic conditions which affect children and families is crucial to the success of any government response.

10. Services for families and children should be appropriate for the age and developmental level of the child involved, holistically oriented, and child- and family-centered. Interdisciplinary teams are an effective way to deliver services.

FACTORS AFFECTING FAMILIES & CHILDREN IN MAINE

Rapid changes in the economic, social, and family patterns of our society have a significant impact on children and families in Maine.

Many families now consist of one parent, generally a mother. The numbers of women with children who enter the work force have increased dramatically and have radically altered the traditional model of family life known to us for the past thirty years. Far fewer children in the 1990s grow up in established nuclear and extended families with grandparents and other supportive family members available for help than did in the 1950s. In addition, nuclear families are increasingly disengaged not only from extended families, but also from the support of other segments of society.

Close knit neighborhoods, extended families living in close proximity, active school and community groups, a consistent work presence over a long period of time, and conditions more supportive of family life, were common twenty years ago. They are increasingly less common in 1991.

In addition to changes in social and family structure, in Maine today and across the country, growing numbers of families and children struggle with poverty, some form of abuse, poor pre-natal or newborn care, health conditions that consume family resources, difficulty with learning or completing school, and other human difficulties which limit their capacity to participate fully in their community. The cost in human potential, state and community services, and other vital resources is enormous.

According to the 1989 report of the Maine Committee on Primary Prevention:

- 10,000 juveniles are arrested each year;
- 2,100 come under the supervision of the Department of Corrections;
- 16,250 are chemically dependent or at risk of becoming chemically dependent;
- 2,600 drop out of high school;
- 25,000 are referred for child abuse or neglect;
- 15,000 experience serious emotional problems;
- 480 are seen in hospitals because of self-destructive threats or attempts; and
- 2,800 become pregnant.

These figures attest to the significance of the problems facing Maine's children and families and to the costs for society. They also point to the importance of providing help and supportive services that are effective and to the need for government to fulfill its roles.

CHAPTER 3

FINDINGS

A. A Need Exists for Services for Families & Children

There are growing numbers of children and families in Maine who are mired in poverty, substance abuse, illiteracy, and other human problems which significantly affect their ability to fully participate in the opportunities for productive participation in the public and private life and business of the community. Growing numbers of children are referred to the State for a wide range of conditions and problems. Service providers and state programs are overloaded with requests for assistance that cannot be met within existing resources. The need for services is greater than the services available.

B. Government has Roles & Responsibilities to Fulfill

The Blue Ribbon Commission on Children and Families believes that the State has roles to fulfill in:

- Encouraging healthy child development through programs such as child development services, Head Start, intervention for children with developmental disabilities, family support programs, public health nursing, and the Women, Infants, and Children's Program (WIC).
- Defining and coordinating the range of supportive services which are necessary to protect and help children and families at-risk.
- Supplementing financial and other resources for families who are unable to adequately provide for their children.
- Offering children with special needs appropriate early intervention, home-based care, family support, and other community services.
- Providing protection, residential care, and treatment for children who are abused or neglected.
- Making services available for persons with mental illness and children with emotional disabilities in, or as close as possible to, their home communities.

- Developing and assuring the availability of community corrections and corrections programs for juvenile and adult offenders which are responsive, rehabilitative and habilitative, and which provide sufficient space and programming.

C. Current State Services for Children & Families Lack Coordination & Purpose

State policies and supportive services for children are currently conducted through a wide variety of organizational fiefdoms, spread throughout an array of state bodies, agencies, and administrative committees. There is no unified mission, no coordinated well defined public policy, and no "single case manager" responsible for addressing the increasingly complex needs of children and families in Maine. There is also no single, strong, independent voice of advocacy or expertise.

The Legislative and Executive Branches of government both lack a single authority which is accountable for policy development, oversight, outcomes, and action related to State and community involvement in the lives of Maine's children and families.

The Legislative branch has at least five joint standing committees which have significant defined roles and responsibilities for selected policies affecting children. They are: Appropriations and Financial Affairs, Corrections, Education, Human Resources, and State and Local Government. No single legislative committee has unified responsibility for oversight and policy considerations affecting children and families.

The Executive Branch has at least five major departments with significant roles and responsibilities for operating selected programs affecting children and families. There is no single administrative department or commissioner with full-time responsibility for managing state programs affecting children and families. Current services are fragmented, uncoordinated, inefficient, and delivered inappropriately to children whose needs have been inadequately defined or whose needs have been defined by labels, not individual assessment. Some Commission members believe that the current fragmentation of services contributes to, rather than ameliorates, the problems of Maine's children and families.

The Commission heard from parents of at-risk children and service providers about the lack of a single state organization with authority to make decisions and to which requests for help can be addressed. Legislators expressed concern that there is no coherent policy. Rather, there are a number of divergent policies and contradictory bureaucratic voices defending individual turfs and separate priorities at appropriations and other public policy hearings. The Commission found that many state bureaucrats have limited understanding of how proposals tie

together to create a single mission or unified agenda for children and families. Children with multiple needs are served by multiple agencies with multiple workers and multiple case plans. Services are disjointed and fragmented.

The Commission believes that state supportive services should not continue to be operated by a wide array of state agencies and administrative committees. Service delivery should not continue to be coordinated by numerous inter-agency administrative committees with little authority, which are further limited by turf issues. The Commission believes that the many administrative committees are time consuming, expensive, and relatively unproductive.

D. State Funds Can Be Saved & Invested in Children's Services

The Commission found that through more efficient use of state dollars, savings can be realized. The resulting savings can be used to increase services for children and families. Eliminating administrative duplication and inefficiency will make more money available for service delivery.

In addition there are millions of dollars available in federal funds that previously have gone unclaimed.

We recognize recent policy and budgetary actions to claim federal funds more appropriately. The Commission believes that its recommendations will result in savings which are significant. Policy-makers will be called to decide how to invest the savings – return it to the general fund, redirect it to other programs, or invest it in services for children and families. The Commission strongly recommends that the savings which result from consolidation and unification be reinvested in programs for children.

E. Fiscal Policies Incomplete & Ineffective

In many programs, significant amounts of state general fund dollars have financed 100% of ***administrative*** costs even though federal matching funds could have covered as much as 50% of the cost. For every $500,000 of state general fund dollars that now pay fully for administrative costs, the Blue Ribbon Commission finds that 20% could be recouped from the federal government. In some programs, this percentage of uncollected federal money may be as high as 60%.

The Interim Plan for Development of a Medicaid Plan for Children and Families of Maine, written by The Institute for Human Services Management and C.A.R.E.S., Inc. and published in 1991, presents detailed information on the State's failure to obtain available federal revenues. This report indicates that a $2 million investment will result in additional federal funds for children totaling $46 million in the first three years, and an additional ongoing annual revenue of $20 million. One reason for these shortcomings is the fragmentation of services and the lack of coordination between agencies and departments.

There are substantial combined total savings to be gained from restructuring, unifying, reducing duplication, and making fuller use of federal funds.

Long-term savings can be attained through enhanced prevention and early intervention services for children and families. Clearly, it is feasible to reduce the future number of at-risk people who may become participants in the criminal justice, corrections, mental health or welfare systems of local and state governments at great expense to taxpayers.

With a unified Department for Families and Children, a family-focused approach, interdisciplinary teams, unified case management, and a Family Foundation, it is possible to prevent more at-risk children from becoming at-risk adults who participate in government programs. If we prevent five children from becoming adult patients at a state institution for people who are mentally ill, we will reduce future costs for taxpayers by an average of $350,000 per year.

It is better to pay a little now than to pay a lot more later. More importantly, it is better to care for children today than to treat adults who are mentally disabled tomorrow.

F. State Resources Wasted through Duplication

During the fiscal year ending June 30, 1990, more than 1,000 state employees located within five state agencies utilized over $100 million dollars a year offering supportive services for at-risk children and their families. Of those employees, 168 carried out only administrative functions. The Commission finds that these administrative costs could be significantly reduced through the creation of a unified Department and the elimination of duplicative administrative functions. For example, four of the five state agencies providing services to children and families currently contract with the same community providers for the provision of residential care and treatment. These four departments utilize four separate contracts, budget requirements, and audit procedures. In a unified department, these overlapping requirements and costs would be significantly reduced. A savings for State government and for community providers would be realized.

CHAPTER 4

RECOMMENDATIONS

The Blue Ribbon Commission on Children and Families calls for a redefinition of the roles and responsibilities of government, a redirection of resources, more use of community and other non-state support networks and resources, a consolidation of state government's children's bureaus, organizations, and administrative practices, and the functional integration of state administered services for children.

The Commission believes these steps will unify and focus state services for children and families and establish reasonable limits on the roles and responsibilities of State government. The Commission believes that adoption of these recommendations will increase the number of children in Maine who live in healthy families, who thrive, who are supported and encouraged by nurturing natural support networks, and, will reduce the numbers of children who rely on state-delivered supportive services. The Commission also believes that these changes will result in state services which are more efficiently and effectively administered, less costly, more capable of offering child- and family-centered help, and more reliant on local, family, and community-based resources.

The Commission makes the following recommendations.

I. Adopt a Unified Mission Statement

The Blue Ribbon Commission recommends that the State adopt a unified mission statement governing its roles in providing services to children and families. That mission statement is as follows:

> *The State of Maine declares that each family has primary responsibility to provide for the developmental and human needs of its members and that state government has a responsibility to help families fulfill that obligation when they are unable to do so. Children have the right to a consistent nurturing environment and to the opportunity to attain their potential for development.*

The mission of government is to complement the roles of families, support networks and society in order to enhance their strengths. State government has the responsibility to intervene on behalf of children at-risk and to encourage the return to, or creation of, a nurturing family environment. The state's response should include supportive services and interventions that offer a functionally integrated continuum of appropriate and reasonable support, either directly or in concert with private organizations. Services should address the cognitive, educational, emotional, health, physical, and social needs of children and their families. The state's intervention is subject to the rights of families and children, their preferences, statutory authorization, and the availability of funds.

II. Define the Roles of Government

The Blue Ribbon Commission recommends that the roles of state government in providing services for children and families be more concisely defined and that the State base the services it provides in well defined principles. These guiding principles, outlined on pages 14 and 15 of this report, guided the work of the Commission and should be adopted by the State to serve as the principles that guide its programs and services.

The Commission also recommends that the roles of government be clearly defined to include the following: (1) encouraging child development through a variety of programs and services, (2) increasing opportunities for children with developmental disabilities, (3) providing family support services, (4) providing public health nursing, (5) defining and coordinating the range of supportive services which are necessary for children and families at-risk, (6) providing financial and other resources to families who are unable to adequately provide for their children, (7) offering children with special needs appropriate early intervention, home based care, family support, and other community services, (8) providing protection, residential care and treatment for children who are abused or neglected, (9) making services available for persons with mental illness and children with emotional disabilities in, or as close as possible to, their home communities, and (10) developing and assuring the availability of community corrections and corrections programs for juvenile and adult offenders which are responsive, rehabilitative and habilitative, and which provide sufficient space and programming.

III. Establish a Unified Department for Children & Families

The Commission recommends that a distinct department for children and families be established with unified responsibilities for

providing integrated delivery of functionally consolidated supportive services for children and families in need. The Commission has identified programs within five state agencies that form parts of Maine's response to the needs of children and families. The Commission strongly believes that the fragmented pieces can be revised and integrated as the functional heart of a unified Department for Families and Children. The Commission recommends that the following programs be transferred out of their existing agencies and into a unified Department for Families and Children:

CORRECTIONS: Juvenile correctional services including youth detention, the Maine Youth Center, juvenile probation and parole, juvenile community corrections services.

EDUCATION: Child development services including the Interdepartmental Coordinating Committee for Pre-school Handicapped Children, 0-5 programs, and PL 99-457 programs.

EXECUTIVE DEPARTMENT: Head Start, children's substance abuse programs funded by the Office of Substance Abuse.

HUMAN SERVICES: Bureau of Child and Family Services including child care and purchased social services, Bureau of Health including the Public Health Nursing Program, Maternal and Child Health Program, Adolescent Pregnancy & Parenting, Family Planning Program, Genetic Disease Program, Handicapped Children's Program, Women, Infant & Children Program, Pre-natal Program, and the Family Preservation Program of the Bureau of Income Maintenance.

MENTAL HEALTH AND MENTAL RETARDATION: Bureau of Children with Special Needs including the Elizabeth Levinson Center, Military & Naval Children's Home, Infant Development Center, and community services for children, Bureau of Mental Health's AMHI adolescent Unit or its successor(s), Bureau of Mental Retardation children's programs except those provided at Pineland Center.

SERVICES HOSTED IN SEVERAL AGENCIES: Committee on Transition and Interdepartmental Council.

ADDITIONAL RECOMMENDATIONS FOR THE UNIFIED DEPARTMENT INCLUDE:

Creation of a Unified Case Management System

The Blue Ribbon Commission places great emphasis on functionally integrating and improving the delivery of state administered services. The Commission believes strongly that developing a unified case

management system which is holistically based, comprehensive, designed to stress education, human development, and preparation for the job market, is necessary to appropriately address the needs of children and families at-risk.

One case manager per child/family is recommended as part of the consolidation of service practices including case management focused on primary prevention, early intervention, and other help designed to improve family well-being. In addition, the Commission recommends extensive utilization of interdisciplinary teams capable of offering a comprehensive range of integrated supports and resources which address the needs of children and families.

Employee Preparation

Employee preparation and retraining for all affected state employees and non-state agency employees is strongly recommended. This training should take place well in advance of November 30, 1992. The Commission also believes that extensive employee participation in planning and implementing the consolidation of administrative and service delivery functions is crucial to a successful outcome.

Transition Process & Timetable Recommended

The Commission strongly recommends the transition to the unified department include the following key actions and preparations in the sequence and of the duration suggested below. *(Editor's Note: The Blue Ribbon Commission recognizes that due to the extensive debate about the state budget and the anticipated recommendations of the Restructuring Commission, the dates outlined in this timetable will need to be adjusted)*

- Legislation authorizing transition enacted – June 1991
- Joint Select Committee authorized – June 1991
- Commissioner and other key leaders appointed – October 1, 1991
- Enabling legislation enacted including transfer of funds and statutory change – April 1992
- Administrative plan completed – September 30, 1992
- Employee preparation and training complete – November 30, 1992
- Department operational (all programs and staff transferred – January 1, 1993.

The Commission recommends that key leaders be appointed by October 1, 1991 and that the administrative plan for the Department be complete by September 30, 1992, with four Interdepartmental Council positions transferred to work with the Commissioner to complete the administrative plan and facilitate the transition. Existing bureau directors, division directors, program managers, and regional managers should participate as members of a senior workgroup for administrative

planning. The responsibility for funds, program management, and service delivery should be transferred and operational simultaneously, unifying the department no later than January 1, 1993.

To functionally consolidate services, the Commission recommends the integration of 0-5, child development services, 3-5, Headstart, 0-18 health programs, 0-18 children's mental health and mental retardation programs, the integration of child welfare, juvenile justice, and juvenile substance abuse, and increased coordination with special education programs and the development of a unified school district plan.

Guidelines for Department Implementation & Operation

The Commission believes that implementing a unified Department for Children and Families will require a transition plan and implementing legislation. The plan should be consistent with the unified mission statement recommended earlier and should include:

- Direction to offer educational, developmental, health, medical, mental, social, and correctional services for children and families. The Department should be authorized to address issues related to family functioning, child development, and conditions affecting children including, but not limited to, adult or child abuse and neglect, drug or alcohol abuse, preschool education, early childhood development, low aspirations, family problems, family violence, juvenile delinquency, medical problems, mental health problems, emotional disturbance, mental retardation, poverty, school dropouts, special education, spousal abuse, truancy, teen pregnancy, suicide, and other conditions which place children and families at-risk.

- Authorization for the Commissioner to develop a plan which is consistent with the Blue Ribbon Commission on Children and Families' recommendations and recommendations of the Joint Legislative Committee for Children and Families. Subject to the availability of funds, the plan must include services which are family-and child-focused, which focus on strengthening natural and community support networks, which are holistic in nature and designed to restore the capability of the nuclear family. The plan should create a one-case manager-one-family approach, consolidate the administrative and service functions of government which help children and families, eliminate unnecessary layers of bureaucracy, and offer a comprehensive continuum of care with unified access points, application process, assessment practices and casefile, strong accountability and quality assurance, a procedure for evaluating outcomes, pilot programs and model projects, and a service delivery model which integrates the administrative and service functions of government at the regional and central office levels. The plan should identify cost savings.

Organization & Staffing

More than 1,000 existing state employees will be involved in the transition to a unified Department for Children and Families. The Commission recommends that the first step for the Commissioner of the new department is to prepare an organization and staffing plan, well defined lines of communication and responsibility, a reliable inventory of resources, and an assessment of the target populations to be served.

The Commission's review of the current staffing and financial resources highlighted the need for flexibility and the necessity for restructuring government in the immediate future. In November of 1989, it was estimated that by June 30, 1990, the five major state agencies offering help for children had 7,338 staff positions and funds totalling $1,681,000,000. By April of 1990, the same five agencies, as part of their fiscal year 1991 funding, had 7,265 staff positions and $1,792,000,000.

By March 14, 1991, the total general fund resources available for fiscal year 1991 dropped by $43 million in some accounts and rose by $65 million in others. Federal allocations dropped by $7.3 million in some accounts and increased by $37 million in others. Also, several hundred staff positions were abolished or vacant and all staff were required to take five days off during the final three months of the fiscal year. The March 1991 changes had an enormous impact on agencies providing services for families and children. The budgets for 1992 and 1993 are still undecided at the time this report was prepared.

This changing fiscal picture makes it difficult for the five child-serving agencies to estimate their actual costs or resources or to document the number of unduplicated children and families which they serve. Each agency, and frequently each program within an agency, maintains separate data not readily comparable or compatible. It is also difficult to determine if, for what purpose, how frequently, or how well one child or one family is served by these five agencies.

Because of the changing nature of funding and staffing patterns in government, the Commission makes the following additional recommendations relative to the establishment of the unified Department:

- One Commissioner should be designated to the Department for Children and Families. This individual should work in cooperation with the other affected Commissioners to secure resources for the effective and efficient management of the unified Department. Funds for indirect administrative allocations for the unified Department should be based upon the present average percent of indirect administrative costs across the transferred agencies and services. This percent should be applied to define the funds to be transferred from the Department of Human Services,

the Department of Mental Health and Mental Retardation, the Department of Corrections, the Department of Education, and other agencies to the unified department.

- The Department should include at a minimum one Commissioner, two deputy commissioners – one for finance and one for program, secretarial and support staff, an appropriate number of assistant attorney generals, purchase of service staff, financial support staff, quality assurance staff, and others.

- The bureaus, units, regional staff, space allocations, support budgets and program budgets presently assigned to those units designated for transfer should be transferred in total to the unified department.

- Personnel costs, all other dollars, and capital funds for the new department should come via a direct transfer from existing agencies and programs targeted for consolidation. When administrative costs for a program are now located in undifferentiated accounts, a percentage share should be determined and transferred.

- For all transferred programs and services, the transfer of administrative and support resources should apply to all organizational levels: departmental, central office, bureaus, regions, itinerant locations, and indirect costs such as the state-wide cost allocation plan.

- The Commissioner should be appointed prior to the formal transition process and should, at a minimum, prepare a transition plan which includes: A financial package and the transfer of resources; organizational charts and proposed staffing, plans for reducing duplication of programs and staff, utilization of staff to be transferred during the transition period for the preparation of plans, transition costs and cost savings, a five year plan for enhancing the services and programs for children and families, and a break down of service types, needs, geographical areas, costs, and community participation.

IV. Creation of Joint Select Committee for Children & Families

The Commission recommends the establishment of a Joint Select Committee for Children and Families to be a focal point for public policy discussion of children's and families' issues and to offer oversight of state administered services. The Commission recommends that the Joint Select Committee for Children and Families be created by Joint Order during the 1991 session of the Legislature as a companion to eventual legislation enacting a Department for Families and Children.

The Committee should consist of 13 members of the Legislature, including 3 members of the Senate appointed by the President of the Senate and 10 members of the House of Representatives appointed by the Speaker of the House of Representatives as follows: 2 members of the Joint Standing Committee on Appropriations and Financial Affairs, 2 members of the Joint Standing Committee on Education, 2 members of the Joint Standing Committee on Human Resources, 2 members of the Joint Select Committee on Corrections, 2 members of the Joint Standing Committee on State and Local Government, and 3 additional members of the Legislature. Members should be compensated in accordance with Title 3, M.R.S.A., section 2 and the Legislative Council should provide staffing for the Committee within existing resources.

V. Creation of a Family Foundation

The Commission recommends the establishment of the Maine Family Foundation. This foundation is envisioned as a public-private partnership established to develop, encourage, enhance, and promote positive family life and positive child development. This will be accomplished through the development of primary prevention and early intervention proposals, support for applied research in the fields of family life, child development, program administration, information collection and dissemination, evaluation, training and coordination, and policy and program recommendations. The Foundation should also conduct, commission and/or publish studies, and participate in local, state, and national research efforts designed to benefit children and families.

The Foundation should make recommendations relative to the management and delivery of family and children's programs and assure a continuing commitment to positive family development and the well-being of Maine's children and families. The Foundation should be funded by public dollars and private contributions.

VI. Consolidation of Existing Committees

The Commission recommends the consolidation of ten existing committees into a single independent advocacy organization for children and families.

The Advisory Committee on Children with Special Needs, the Child Welfare Advisory Committee, the Child Care Advisory Committee, the Committee on Primary Prevention, the Juvenile Justice Advisory Group, the Maine Advisory Committee on Mental Retardation (transferring adult mental retardation functions to the Developmental Disabilities Council), the Residential Treatment Centers Advisory Group, the Task Force on Children's Mental Health, the Task Force on Early Intervention, and the Task Force on Family Support should be merged

together into the Maine Commission for Children and Families. This consolidation will, the Commission believes, bring more effective, efficient, and accountable family and children's participation in oversight and planning.

The Maine Commission for Children and Families should be an independent group designed to advocate for children and families and to offer an additional check and balance for the public and the State.

The Commission believes that approximately $250,000 is spent each year administering and maintaining eight of the ten identified committees. Members recommend that $175,000 of this amount be used to fund the Maine Commission on Children and Families and $75,000 be returned to programs and services provided by the unified department. It is recommended that the Commission be authorized to hire three staff persons: an executive director, analyst, and secretary.

VII. State & Local Education Coordination

In order to assure improved educational outcomes for all school age children, particularly those served by the Department for Children and Families, the Blue Ribbon Commission recommends that significant and substantial actions be taken to define, develop, and increase the coordination and cooperation between special education services personnel at the local level and the personnel and services of the Department for Children and Families.

"Child find", needs identification, and referral activities should be increased and, where appropriate, case management services should become available in cooperation with the Department for school children who are at-risk. In addition, pupil evaluation practices and polices should be evaluated and revised, advocacy and assistance for children and parents should be improved prior to, and during, the pupil evaluation process, and a comprehensive range of services should be cooperatively developed based on the needs identified through the pupil evaluation process.

VIII. Medicaid for Children

Access to basic health care is crucial to the well-being of our children. The Commission recommends full exploration of transferring administrative responsibilities for the Medicaid program to the Executive Department. This proposal extends beyond the mission of the Blue Ribbon Commission thus the concept was not discussed in depth. However, the Commission recommends further consideration be given to this idea, particularly as the discussion of restructuring government continues.

IX. Transition Services for Children At-Risk

Children at-risk who have special needs are eligible for educational supportive services through State government until they reach the age of 20. The State Committee on Transition coordinates services for selected children who "age out" of eligibility by preparing them and their families for the world after school. The Commission believes that all children at-risk who are receiving supportive services through the Department for Children and Families and preparing to live independently should be eligible for transition services, modeled on the Transition Committee's program. That program includes preparation and follow-up utilizing an interdisciplinary support network of community resources and specialists. The Commission recommends that the inclusion of all at-risk children who are preparing to live independently from Department services take place following the January 1, 1993 start-up of the Department for Children and Families.

X. Unified School District within the Department

The Commission recommends that the Department for Children and Families undertake during the transition process, an exploration of the establishment of a unified school district or intermediate educational unit within the Department. This district should enable local education units and the Department to meet legal mandates appropriately and to fully access available and appropriate funding, particularly federal resources. A unified school district should ensure that students who are in the care of the Department for Children and Families receive educational services in a consistent and equitable manner and assure continuing educational growth while within the jurisdiction of a local educational unit, regardless of whether or not students reside in a facility directly administered or funded by the Department.

XI. Pineland Center

The Commission recommends that the goals, principles, and purposes that guide services for the Department for Children and Families be applied to services provided to the small number of children residing at Pineland Center.

XII. Primary Prevention & Other Services

The Commission strongly supports primary prevention programs and early intervention as components of a comprehensive continuum of supportive services. Primary prevention and early intervention should be offered in concert with private and public resources, involve all

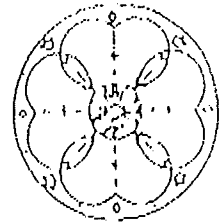
segments of society, and include networks of private and public service providers.

Closing Summary

The Blue Ribbon Commission believes that the creation of a unified Department, a Family Foundation, an independent advocacy and oversight commission, a unified case management approach, and closer coordination with school systems will contribute to preventing the development of significant, life-long problems and difficulties that negatively affect the well-being of many Maine children and families.

The Commission also believes functional integration and consolidation of state administration and services within a unified Department for Families and Children will result in services which will help at-risk people more efficiently and be delivered more cost effectively.

Central Maine Indian Association, Inc.



Sharing Resources and Ideas

FAX No. # 942-2927

FACSIMILE TRANSMITTAL SHEET

SENDING PARTY

FROM: Claire Bolduc - Terry Polchies

DATE: 20 September 1991

RECEIVING PARTY

TO: Paul Saucier

ORGANIZATION OR FIRM: Comm. Gov't Restructuring

FACSIMILE NUMBER 289-1275

NUMBER OF PAGES, W/O COVER 2

SPECIAL INSTRUCTIONS: Bonjour et Merci

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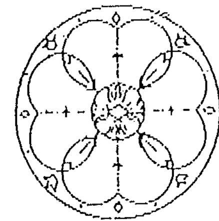
Thank you Claire Bolduc

(207) 942-2926 or (207) 942-2927

Central Maine Indian Association, Inc.



TESTIMONY BEFORE THE
SPECIAL COMMISSION ON GOVERNMENTAL RESTRUCTURING
COMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY
BY
TERRY POLCHIES, EXECUTIVE DIRECTOR
CENTRAL MAINE INDIAN ASSOCIATION, INC.
20 SEPTEMBER 1991

Thank you for this opportunity to present some thoughts from the members and staff of Central Maine Indian Association. This Commission has an enormous task - and a rich opportunity to positively affect the lives of our constituency. We have read the Interim report, and are appreciative of the work already done, and assure you of our gratitude for your commitment and hard work to date.

We were particularly interested in the Function Statement, which, to us, is missing a most important statement about the State's absolute and inexorable commitment to the common weal, to the flowering of each citizen's personal potential, and to sustainable family and community life. These commitments would reassure our community about the future of their families, their children and their communities. We urge the committee to consider this suggestion.
We support the notion that the delivery of services is indeed a State responsibility.

We searched also for a commitment to the provision of free health and social services, and did not find it. Such a commitment would reassure all citizens - since any of us might be in the position of needing continuing health/social services, and few of us have employer-provided insurance coverage.

The Initial Findings are a satisfactory description of problems we would have identified from our work loads. Yet, we would add one. The State and its Agencies does not have a clear, concise, inclusive goal for the common weal and for the development of its most important resource: people. We would ask you to include such a goal in the Options. A Goal could unify the efforts of the dedicated professionals in all the state agencies, and serve as a benchmark for the beginning of this new effort to restructure and optimize State services.

We have considered the gaps and problems identified and have the following suggestions:

1. Services ought to be decentralized - particularly in rural settings, so that no citizen is further than 25 miles from a social service provider. This may mean one social worker, and a meeting room in West Athens, but that one person with continuing training could be

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the point of entry for the residents of that 25 mile catchment area. The meeting room can provide space for residents to meet service providers, meet each other, provide a place to "get away from the house". In larger communities, the meeting space could easily be used to provide day care services for mental health consumers, for example.

Decentralization can also be served by paying for professionals to circuit ride through a district. This would certainly provide the profession with new and important information about the consumer in his/her natural setting.

Single points of entry to the systems of health and social services could be a phone system, staffed by highly trained ombudsmen.

2. The question of shortage of trained professionals is worth extra attention, as the findings do not address the lack of indigenous health and allied health professionals. For example, there are no Native American physicians... There are no recruitment initiatives in the functionally bilingual and bicultural communities - despite the fact that these communities have a higher than average need for prevention and treatment services. We urge the committee to add culture and language to their understanding of our communities.

We also observe that the State agencies do not make optimum use of their highly trained personnel: in effect MSW's are often taken up by tasks that can be accomplished by clerical support persons, and they could be allowed to do the "social work" that clients so desperately need.

3. We believe that Prevention and Early Intervention are still difficult concepts for planners and policy makers, and unwieldy for service providers like ourselves. We believe that Prevention merits extra attention and development from a wide group of consumers, providers, and natural community leaders. Our work loads indicate that Prevention is a misnomer, that in our prevention work, we are "breaking cycles". Framing the question in this way yields new insight about the real work of prevention and intervention, and the tasks are easier to outline and plan. Goals are easier to set. We suggest that the issues of Prevention and Early Intervention be revisited by another Commission before final reports and recommendations are presented to the Governor and Legislature.

4. The other options in the Report seem most reasonable, and with the addition of culture, language, decentralization, and clear State goals for the development and support of all citizens, we can imagine that the implementation of these options could be os service to our members/clients.

Thank you for your invitation to participate, and we would be happy to answer any questions you might have about our work or our suggestions.

Maine Foster Parent Association

Aspen Ridge
11 Liberty Drive
Bangor, Maine 04401
848-7537 or 1-800-367-3900

September 19, 1991

To Members of the Committee on Health, Social Services and Economic Security:

The Maine Foster Parent Association feels strongly that the formation of a Department of Child and Family Services is in the best interest of children, families and the State of Maine. We urge that prevention and early intervention be the goal and that this be reflected in the mission of this new Department by the directive to screen families into the system upon referral rather than out as is presently the case.

Regarding items seven and eight from "options under discussion", it seems ideal to us that a family be assigned one worker, responsible for assessment of that family's needs who would also continue to function as broker and advocate for that family. This family caseworker would design, coordinate and oversee an individualized plan which would neither neglect nor overlap services essential to that family's well being. This would be of benefit, not only to the family which would have an ongoing relationship with one person but for social workers whose present compartmentalized view of his or her client limits intervention options.

Given the large percentage of state wards who are adjudicated we would also urge that existing information from the Department of Corrections be incorporated into a central information and intake system and the formation of a family court be considered.

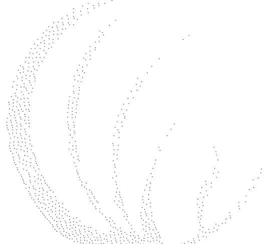
As the largest single provider group to state wards, Maine Foster Parent Association expects to work closely with the committee charged with the development of regional boards which would plan and implement appropriate services for Maine's children.

We thank you for this opportunity to express our opinions and concerns and look forward to an interactive relationship with this and future committees.

Sincerely,

Debbie Goss
President

Alliance for the Mentally Ill of Maine



MEMORANDUM

TO: *Special Commission on Governmental Restructuring, Committee on Health, Social Services and Economic Security.*
FROM: *Michael J. Fitzpatrick, Alliance for the Mentally Ill of Maine*
DATE: *September 20, 1991*
RE: *Brief Comments on Committee's Interim Report*

The Alliance for the Mentally Ill of Maine which has twenty-one (21) affiliates throughout Maine has a membership of over 1,000 families.

We are excited by your reorganization efforts. They hold promise to create a more accessible and balanced system of care. The following are brief comments on four (4) key areas:

1. *REGIONAL BOARDS TO PLAN AND IMPLEMENT COMMUNITY MENTAL HEALTH SERVICES.*

   Maine's mental health system remains fractured with uneven resource distribution. This option has the potential of creating a coordinated and accountable system of care for persons with mental illnesses that truly respond to local needs. It should promote healthy competition and require services to be more readily accessible to the persons they serve.

   We welcome this change.

2. *THE CREATION OF A DEPARTMENT OF PHYSICAL AND MENTAL HEALTH THAT WOULD INCLUDE THE BUREAUS OF PUBLIC HEALTH, MENTAL HEALTH, MENTAL RETARDATION, REHABILITATION SERVICES AND MEDICAID SERVICES.*

   Access to effective community based inpatient and outpatient services is the highest priority of families with a loved one with mental illness. Mental illness thrusts a person into many service systems. Service provider turf and communication issues complicate an already confusing, ill funded system.

   An example of these problems is the inability of the Bureaus of Mental Health and Rehabilitation to philosophically and practically combine their resources. This has served to create a system that is fraught with delays and regulations which effectively discourage many persons with mental illness who wish to go to work.

Box 222, Augusta, ME 04332
(207) 622-5767 / 1-800-464-5767

Mental illness is Maine's number one health problem. History and stigma continue to separate mental illness from other health problems. A Department of Physical and Mental Health would seem to be a natural match and meaningful start toward combining and coordinating those services that are so crucial to the needs of persons with mental illness and their families.

The two (2) shortcomings that concern us are that the medicalization of care for those with mental illness may too narrowly focus the scope of the system of care and that within a larger department of health, mental illness may lose the focus it now, at long last, has achieved.

3. *DEPARTMENT OF CHILD AND FAMILY SERVICES.*

We are continuing to work with families who have children with mental illness. They have to transition the mental health, education, social service and, at times, youth correctional systems. Much of the pain and frustration that these families feel is directly related in the incomprehensible maze this service system presents. A Department of Child and Family Services may be a critical step toward creating a responsive and understandable system of care. The time is now to create systems that are flexible, accessible and responsive to the needs of those who use them.

While AMI-ME has some concerns that moving the service boxes around will not be as effective as we hope, we feel strongly that your reorganization efforts are worthwhile and a long time coming.

4. *CONFIDENTIALITY.*

Finally, confidentially requirements within the mental illness service system continue to interfere with families becoming part of their loved ones treatment team. In most circumstances, the families involvement is essential to assure the best possible treatment.

Thanks for the opportunity to respond to your efforts.

Dist 8/23 HHS

John R. McKernan, Jr.
Governor

DEPARTMENT OF LABOR
Telephone (207) 289-3788
FAX (207) 289-5292

Charles A. Morrison
Commissioner

August 23, 1991

SUBCOMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY

DOL SERVICES TO UNEMPLOYED/UNDEREMPLOYED

INTRODUCTION:

* DOL is a human resource development agency committed to providing services and programs to people and businesses to ensure the security and skills of Maine's work force, both today and in the future.

* We provide:

-- Labor exchange and job training services;

-- Income protection via unemployment insurance benefits;

-- Health and safety protection for the public and workplaces;

-- Regulation of working conditions;

-- Career education and labor market information; and

-- Labor-management relations services.

* For our "Unemployed/Underemployed" clients, 97% of the DOL effort (about $200 million) is devoted to this population.

* Services are nearly all federally funded, and are delivered through a decentralized network reaching all parts of the state.

* Because our programs are mostly federally-funded, we are geared to meeting federal performance standards. Our programs have been nationally recognized; we received the NAB award for excellence.

* Delivery of our services is coordinated through MHRDC to avoid duplication and overlap of programs.

P.O. Box 309, Augusta, Maine 04332-0309 — *Offices Located at* 20 Union Street

* RETI is an example of how we maximize services and avoid duplication/overlap with other organizations.

* DOL is unique in that many of our services require or are encouraged to have private sector involvement and oversight (PICs, BES and JS Advisory Committees, JMG, LMI Affiliates, and various boards -- Health & Safety, Boilers, Elevators).

* Our use of technology to improve productivity and to enhance our ability to deliver services is one of our strongest attributes:

-- Voice activated computers are used to collect information from clients;

-- We are expanding this to include a voice response system to enable clients to obtain information regarding eligibility status;

-- All offices are highly automated from on-line terminals to stand-alone systems;

-- Our systems are data-based and networked;

-- We have in place artificial intelligence systems to automatically and uniformly process routine functions;

-- We utilize portable terminals to access data bases from on the road remote locations; and

-- We are looking at placing user-friendly touch screens in our offices and other public places to widen service delivery.

* All target groups are treated the same so that all available resources are applied to clients based on individual needs.

* I emphasize this because we play a role in serving the "Physically Disabled," which I will address briefly here rather than later in the day as indicated in your agenda.

DISABLED

* We coordinate our services to clients with disabilities, whether physical or mental, with other agencies (Voc. Rehab, Mental Health, Goodwill, Voc. Tech. Centers).

* Our unique role is to provide "Try Out Employment" or paid work experience to see if the person can actually succeed on the job.

* Perhaps what is most needed to improve services to the disabled is better case management.

DUPLICATION/OVERLAP OF SERVICES TO THE UNEMPLOYED/UNDEREMPLOYED

* DOL is the federally-recognized designated agency for delivery of job training, labor exchange, unemployment benefits and labor market information, although some overlap exists with other agencies and in the private sector (private employment agencies, supplemental unemployment benefits from unions, testing and training by other agencies).

* AFDC recipients are a target group for both DHS & DOL because of federal legislation. (ASPIRE-JOBS).

* New legislation does not always consider existing resources and responsibilities when creating new demands (e.g., family medical leave and whistleblower protection are assigned to MHRC for enforcement, but these are of an employment standards nature).

EMERGING ISSUES

* Workforce trends indicate an immense need for skills training and upgrading because most of the labor force for the year 2000 is already working, but yet about half of the new jobs created between now and then will be phased out or restructured.

* Workplace literacy and competency based education and training must be made more relevant to the workplace and world of work. (SCANS report)

* Business, together with government and community based organizations, must assume greater responsibility for improving productivity and meeting the employment and training challenges to the year 2000.

* To meet the increasing needs of all of government's customers, unified, multi-agency, cooperative approaches to human resource development must be established.

* Dwindling resources and increasing complexity require that information and data bases be shared and integrated among all agencies.

* The rural nature of the state and lack of adequate public transportation are becoming larger issues since it is more difficult to deliver services to some remote areas.

NUMBER 1 CHANGE -

* Improving service to all customers by:

-- Providing meaningful coordination of program planning and delivery (strengthen MHRDC);

-- Breaking down the artificial and self-imposed barriers to inter-agency cooperation;

-- Increasing the funding capabilities of our systems (e.g., STAR funding via UI tax offset);

-- Increasing our funding flexibility and stability (use of federal-state-local funds, removal of UI-JS funds from federal budget);

-- Improving communication to the public of what services are provided and who provides them; and

-- Integrating (not necessarily combining) services so that programs are interrelated when customers have more than one need (one-stop shopping).

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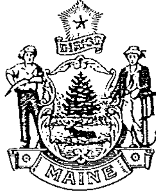
Dist 8/23 HHS



John R. McKernan, Jr.
Governor

Charles A. Morrison
Commissioner

James F. Nimon
Executive Director

DEPARTMENT OF LABOR
BUREAU OF EMPLOYMENT AND TRAINING PROGRAMS

August 23, 1991

SUBCOMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY

DOL SERVICES TO UNEMPLOYED/UNDEREMPLOYED

THE HEALTH OCCUPATIONS TRAINING (HOT) PROGRAM

INTRODUCTION

The HOT program has three separate parts that provide for: (1) increased training of Job Training System (JTS) participants for Certified Nurses Aide (CNA), Home Health Aide (HHA), and Licensed Practical Nurse (LPN) occupations; (2) training JTS participants for technical health occupations; and (3) reducing the shortage of Registered Nurses (RNs) by providing a loan payback program for employed RNs in Maine.

Following is a brief summary of each part:

Part One:

The Maine Department of Labor's (DOL) JTS provides outreach, recruitment, orientation, selection, preoccupational training, supportive services and needs-based stipends to HOT trainees who are generally selected from the JTS's applicant pool.

Maine's Technical Colleges provide the vocational training.

Since upgrading is such an important element of this program, all CNAs trained are contacted within a year of job placement to determine if they want to participate in training in order to be upgraded to LPN. LPNs trained during the first year are also contacted to determine if they are in a position to participate in training to be upgraded to RN.

Hospital Street, State House Station #55, Augusta, Maine 04333
Telephone (207) 289-3375

All training costs are met by the JTS providers using existing DOL and Department of Human Services (DHS) funds.

Part Two:

The State's JTS provides outreach, recruitment, orientation, selection, preoccupational training, supportive services, and needs-based stipends for participants who are usually selected from the JTS's applicant pool.

Skill training is accomplished through the participating hospitals who either deliver the training in-house or through sub-grants to other training entities such as a Technical College. The participating hospitals bear the cost of occupational training.

Funding for this program comes from existing job training funds held by the JTS, State general revenue funds, and from funds provided by the participating health care facilities. The State appropriation is being provided to help defray the costs of training materials. The participating hospitals bear the rest of the occupational training costs.

Part Three:

Legislation has been passed making it an allowable cost under the Maine Health Care Finance Commission for hospitals to repay the Government Student Loans of RNs employed at that institution. The Department of Human Services has amended its rules of reimbursement so that the State's other health care facilities (nursing homes, home health agencies, and rural health centers) can also charge loan payback as a reimbursable cost.

OVERLAP WITH OTHER AGENCIES

There is no overlap in the delivery of services or administration of this program. In fact, HOT is an example of a program where close collaboration exists between the DOL JTS, the DHS, Maine's Technical College System, and Maine's health care system network.

EMERGING ISSUES

The issues identified by Commissioner Morrison regarding the need to retrain the work force apply. Small health care facilities continue to need multi-skilled and multi-certified employees. There is a need for continued support for increased vocational training programs to respond to the critical shortage of trained and certified health care professionals.

Finally, there is a need to continue to explore ways to leverage Federal or private funds to match State general revenue funds. It is estimated that the JTS leveraged $850,000 of Federal funds to supplement the $250,000 contribution from State general revenue funds.

#1 RECOMMENDATION FOR IMPROVEMENT

Rural hospitals and other small health care facilities need to make full use of all the retention tools at their disposal. Any decrease in funding for health provider training is bound to affect the ability of these facilities to retain qualified staff. This is a human resource issue that needs to be collectively addressed and funded by the JTS and post-secondary systems.

Department: DOL - BETP

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Eligible job training clients interested in health occupations training	Health Occupations Training (HOT)	Eligible for any job training program	Health occupations training (Same as JTPA II-A)	369	$249,294

(use as many pages as needed to list all services provided to each client group)

Department: DOL - BETP

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Economically disadvantaged Adults & Youth with identified barriers to employment.	JTPA Title II-A	Economically disadvantaged	Assessment, basic/remedial education, occupatioal skills training, supportive services, job counselling, search and placement.	3,467	$5,389,500
Economically disadvantaged youth	JTPA Title II-B	Economically disadvantaged age 14-21	Exposure to work, basic/remedial education, school retention	1,030	$2,143,858
Dislocated workers	JTPA Title III	Dislocated due to mass layoff or plant closing	Readjustment and retraining services (Same as JTPA II-A)	1,738	$2,332,767
UI Claimants	STAR	Eligible UI claimants	Occupational skills training (Same as JTPA II-A)	1,280	$1,668,799
Economically disadvantaged above Title II-A threshold	MTI	Eligible under State MTI guidelines	Occupational skills training (Same as JTPA II-A)	1,476	$ 730,419
Eligible job training clients interested in health occupations training	HOT	Eligible for any job training program	Health occupations training (Same as JTPA II-A)	369	$ 249,294
Displaced Homemakers	DH	Eligible Displaced Homemakers	Assessment job counseling, referral support services	561	$ 519,883

(use as many pages as needed to list all services provided to each client group)

Department: DOL - BETP

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
UNDUPLICATED COUNT OF JOB TRAINING SYSTEM PARTICIPANTS - PY '90 TOTAL PARTICIPANTS				5,716	
Youth (age 14-21)				1,423	
Women				3,451	
Handicapped				866	
High School Dropouts				915	
Economically Disadvantaged				3,838	
Older Workers (Age 55+)				330	

(use as many pages as needed to list all services provided to each client group)

TOTAL P.07

Department: Labor
Bureau of Employment Security
Job Service Div.

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
All people seeking employment.	Employment Service	Unemployed, Underemployed, New Entries, Re-entries	Work registration, Veteran Service, Employment Counseling, Job Referral/Placement, Job Bank, Computer Job Matching, Labor Market Information, National Job Bank, TJTC, TAA, STAR	147,000	5.3 m Admin. 1.0 m Training 6.3 m Total
* SUB-GROUPS					
Female 42%	" "	" "	All Services	61,740	No
Male 58%	" "	" "	All Services	85,260	breakout
Youth 24%	" "	" "	All Services	35,280	of
Veterans 14%	" "	" "	All Services	20,580	funds
Disabled 2%	" "	" "	All Services	2,940	
Minority 2%	" "	" "	All Services	2,940	
Eligible Claimants 9%	" "	" "	All Services	13,230	

(use as many pages as needed to list all services provided to each client group)

* 5 year average percentage applied to June 1991 year end figures.

Department: LABOR 7/1/90 - 6/30/91

Bur. of Employment Security

Unemployment Comp. Div.

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of ~~Clients~~ Payments	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Total/Partially Unemployed Workers	Unemployment Insurance Regular Program	Total or Partially Unemployed	Cash Benefit Payments	1,043,641	$160.9 M
" " " " "	UCX Unemployment Comp. for Exservice Personnel	" " "	" " " " " "	2,789	$ 0.5 M
" " " " "	UCFE Unemployment Comp. for Federal Employees	" " "	" " " " " "	9,939	$ 1.7 M
" " " " "	TRA Trade Readjustment Allowance	Unemployed Due To Foreign Imports	" " " " " "	8,346	$ 1.1 M
" " " " "	DWB Dislocated Worker Benefits	Unemployed Benefits To Dislocated Workers	" " " " " "	11,677	$ 1.8 M
" " " " "	DUA Disaster Unemployment Assistance	Unemployed Due To A Major Disaster	" " " " " "	0	0.0
" " " " "	Unemployment Insurance Extended Benefits	Total or Partial Unemployed	" " " " " "	104,875	$ 15.7 M
" " " " "	Unemployment Comp. for Federal Employees Extended Benefits	" " " "	" " " " " "	1,234	$ 0.2 M

(use as many pages as needed to list all services provided to each client group)

Department: Education

Division of Alcohol and Drug Education Services

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
Maine school children and the teachers, administrators, counselors, etc., who work with them	Alcohol and drug prevention and education programs and services	To prevent problems related to alcohol and other drug use, abuse, and dependency	The division carries out a strategy of statewide leadership, guidance, and direct on-site services to schools for the establishment and maintenance of developmentally oriented, age-appropriate alcohol and other drug prevention and education programs and services.	210,200 children, 16,500 administrators and teachers, 525 guidance counselors, and 219 school nurses	$1,177,362

(use as many pages as needed to list all services provided to each client group)

TEA TALKS

A series of morning discussions with national experts on issues related to reimbursement of integrated treatment for individuals with the dual disorders of mental illness and substance abuse. Each talk will consist of approximately a one and one half hour presentation followed by a half hour discussion.

ECONOMIC ASPECTS IN PROVIDING INTEGRATED TREATMENT

August 27, 1991
9 - 11
Alfred's Restaurant
Kennebec Room
Civic Center Drive
Augusta

Thomas G. Mcguire, Ph.D. **Economist**
Dr. Maguire is a professor of economics at Boston University and a 1991 recipient of the Carl A. Taube Award for leadership in mental health services research from the American Public Health Association. He has played a key role nationally in assisting with mental health services financing within the public and private sector. Dr. Mcquire is an NIMH Senior Research Fellow.

QUALITY MANAGED CARE

September 10, 1991
9 - 11
Alfred's Restaurant
Kennebec Room
Civic Center Drive
Augusta

Maureen T. Hennessey, Ph.D. **Psychologist**
Dr. Hennessey is currently an Executive Director with CIGNA and manages the mental health and chemical dependency healthcare of the Missouri CIGNA Healthplan and the local employee assistance program for their national EAP network. She has also managed mental health and chemical dependency care for Connecticut General Insurance Company and Heritage Healthplan. Dr. Hennessey has served as a national consultant with government agencies and with the private sector in the area of managed care.

CLINICAL INSIGHTS AND RESEARCH FINDING

October 2, 1991
9 - 11
Day's Inn
390 Western Avenue
Augusta

Robert E. Drake, M.D., Ph.D. **Psychiatrist**
Dr. Drake is director of the New Hampshire-Dartmouth Psychiatric Research Center and associate professor of psychiatry at Dartmouth Medical School. He is widely regarded as the leading researcher in the area of dual diagnosis within the nation and consults with numerous government and private agencies on this topic. Dr. Drake is an NIMH Senior Research Fellow.

Individuals are asked to pre-register for each of these sessions by mailing $3 for each talk to Pam Boucher at MH&MR, Station #40, Augusta, Maine 04333 (289-4203) along with your name, address, phone #, and date requested. On-site registration will take place from 8:30 - 9 a.m.

The work of the Dual Disorders Reimbursement Task Group is funded, in part, with grants from the federal Office for Treatment Improvement, National Institute on Drug Abuse, National Institute of Mental Health and by the Bingham Consortium for Health Research.

STEPS OF COMPREHENSIVE ALCOHOL AND OTHER DRUG IMPLEMENTATION

SCHOOL/COMMUNITY TEAM DEVELOPMENT

SCHOOL/COMMUNITY TEAM

TWO-DAY STAFF INSERVICE EDUCATION AND AWARENESS

POLICY AND PROCEDURE

STUDENT ASSISTANCE TEAM TRAINING/IMPLEMENTATION

CLIMATE

PROJECT GRADUATION
PROJECT HOLIDAY
SAFE HOMES
NON-SCHOOL STUDENT FUNCTION POLICY
PRO-ACTIVE POLICE RESPONSE

SUPPORT GROUPS

STUDENT AWARENESS

CURRICULUM

STAFF DEVELOPMENT

MODELING

MISSION STATEMENT

THE DIVISION OF ALCOHOL AND DRUG EDUCATION SERVICES

MAINE DEPARTMENT OF EDUCATION

The Division of Alcohol and Drug Education Services of Maine's Department of Education is responsible for carrying out state government's core strategies in alcohol and other drug prevention and education for local schools in coordination with the Office of Substance Abuse. It creates school and community teams whose function is to provide leadership for locally controlled comprehensive alcohol and other drug prevention and education programs. It provides direct services to teams and schools as they develop, implement, maintain, and evaluate their programs. It conducts training activities for school personnel to help ensure that all Maine school children have a developmentally oriented, age-appropriate, up-to-date, and accurate curriculum for alcohol and other drug education in Kindergarten through grade 12. It further supports local efforts through administration of the Federal Drug-Free Schools and Communities Act and provision of technical assistance and audiovisual resources. It assists the Division of Special Education in developing school building level Student Assistance Teams whose purpose is to help high risk youth. Together these strategies help ensure that all Maine children have the benefits of high quality prevention and education programming now and in their future.

Dist 8/23 HHS

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

SUBSTANCE ABUSE SERVICES

The focus of substance abuse efforts within the Department of Mental Health and Mental Retardation is on improving the quality of services available to it's constituency: individuals with mental illness, children with special needs, and people with mental retardation.

As a group, this constituency has historically been poorly served when in need of treatment for a substance use/abuse problem in addition to their emotional or intellectual disability. Consequently, duplication of services to this consumer group has not been an issue, rather, lack of access and unavailability of appropriate services have been the norm. The existance of two, quite separate systems, (mental health and substance abuse), has contributed to the tendency to address only one part of an individual's needs which, all too often has resulted in relapse.

The Department continues to work closely with the Office of Substance Abuse (OSA) for the purpose of assuring greater systems integration at the state level. Joint contracts, mutual participation in a variety of working committees, regular informational meetings, data sharing, and joint planning and budgeting are all utilized as means for realizing a more uniform and wholistic system of service delivery for consumers.

Development and maintenance of positive working relationships with substance abuse and mental health providers, family members and consumers is an additional area of emphasis. This goal of developing partnerships which build on mutual interests and foster respect for diversity is currently being addressed through a series of working committees:

- fetal alcohol and drug effects (FADE Prevention Team)
- adolescents with substance abuse and mental health disorders (Adolescent Dual Disorders Documentation Advisory Committee)
- reimbursement for treatment of individuals with co-existing mental illness and substance abuse disorders (Dual Disorders Reimbursement Task Group)

Training and consultation for mental health and substance abuse providers on the interrelationship between mental illness and substance abuse disorders has been, and continues to be, a major thrust of this Department. Aimed at breaking down the professional barriers that exist between substance abuse and mental health professionals, these trainings are designed to build on the strengths which each discipline has to offer while at the same time broadening the capacity of the professional to more ably serve individuals with multiple needs.

The need for community based, person centered, integrated (mental health and substance abuse) treatment by the year 2000 is an area of critical need.

Two reports published in the past year, the Final Report of the State of Maine Systems Assessment Commission and the Maine Dual Disorders Monograph Volume VI call for greater unification and integration of mental health and substance abuse systems and services. This is an overall goal that is shared between the Department and OSA.

Substance abuse services within state government have experienced considerable change as a result of legislation passed in the last two sessions (P.L. 934 and P.L. 601). Many of these changes are still in the process of being implemented and, as such, it is too early to tell what, if any, additional structural changes may be needed.

At this point in time it would be helpful to have a clear structural linkage or requirement between institutes of higher education which train MSW's, psychologists, nurses, substance abuse counselors, rehabilitation counselors, physicians, etc. and the state mental health and substance abuse entities. The purpose of this linkage would be to assure that current teaching within academia is aligned with current thinking as to best practices and consumer needs in the community.

#1438i

Department: of Mental Health and Mental Retardation

Special Commission on Governmental Restructuring

Social Services Provided by Maine State Government

Client Group	Sub Category	Criteria	Services Provided	Number of Clients	Funding Level
example: Children/Youth at risk	Child Protective	abuse/neglect cases	foster care, ...	7000	$23m
Early Intervention/ Prevention (FADE)		Referral request	intake and assessment training and consultation	60 1980	51,664
MR Alcohol		MR/substance abuse	developmental tutors, psychoeducation	23	59,835
County Jails		incarcerated, non OUI	presentence planning, substance abuse assessment, evaluation group	800	130,665
Dual Diagnosis Inpatient		institutionalized at BMHI, AMHI or diversion	substance abuse assessment and evaluation individual and group treatment	250	352,136
Dual Diagnosis Community		mi/sa	assessment and evaluation, individual and group treatment/education	380	354,405
Elderly Services		elderly	information/education for elderly health, mental health and substance abuse	12,000	5,000
Intervention/ Prevention Youth		at risk of being removed from home	homebased care (time limited, family intervention and treatment)	80	132,100

(use as many pages as needed to list all services provided to each client group)

UNMET SUBSTANCE ABUSE SERVICE NEE[illegible] IN MAINE

TREATMENT SERVICES FOR ADOLESCENTS

Brief Description of Need:

Twelve-percent of the adolescent population in Maine abuses alcohol or other drugs. Between 25% and 33% of Maine's school children come from families where the parents are abusing alcohol or drugs. Unfortunately, however, the existing treatment system is inadequate to respond to this need. Part of the inadequacy is lack of sufficient service capacity to respond to the demand for service. Part, however, is lack of sensitivity of the existing service system to the needs of adolescents as a special population. That is, while some adolescents do get into the existing service system, they are not generally treated by clinicians who are sensitive to adolescent development, and how to motivate young people to become chemically free. In other words, those who get into treatment programs do not always get the best service (except in those few areas where the programs have been specifically designed to serve kids).

Proposed Response:

A series of initiatives is needed to establish a separate service system that can respond to the growing demand for service:

1. Expanded outpatient and aftercare services.

   Basic outpatient and aftercare services, tied to local school systems wherever feasible, need to be established in most areas of the state. A total of 53 full-time equivalent counselors for the indigent is needed across the state to supplement existing counselors. These people would treat 2,900 adolescents per year (74 x 55).

2. Day treatment.

   This service component needs to be established in seven locations, and serve adolescents who require a more intense treatment service, but who have stable family situations. Funds could be used to pay for 21 slots for indigent clients at a rate of $125/day. Approximately 350 clients could be served.

3. 28-day Residential Rehabilitation.

   Specific access to 28-day rehabilitation is needed for indigent adolescents, who are not eligible for Medicaid. Twenty-one slots are needed for indigents; some now get into care under the "bad debt" category. Funds identified could be used to purchase care for the approximately 120 adolescents who demand this service but never get admitted.

4. 6-Month Rehab[illegible]tation.

   An additiona[illegible]0-bed p[illegible] is needed to compliment [illegible] existing services in the Portland [illegible] Bangor areas. This program [illegible]ould serve an estimated 20-25 kids per year.

PREVENTION/INTERVENTION SERVICES FOR ADOLESCENTS

Brief Description of Need

Substantial work is being done in Maine's school systems in the area of education and training of both students and teachers regarding substance abuse. In addition, a few school systems are beginning to develop intervention mechanisms -- Student Assistance Programs, designed to identify and intervene with students at high risk of substance abuse, as well as other problems. Included as the target population here, are both the 12% of the population that is chemically dependent, and the 25-33% which come from homes where the parents are abusing. Obviously, there is some overlap between these two groups.

Unfortunately, school systems are not responsible for providing many of the special services needed by this at-risk population -- including such things as self esteem building, building skills of refusal, provision of alternative recreational and other activities, to encourage positive activity as opposed to drug use for escape.

Outside the school system, many professionals also work with kids. These professionals, and their organizations, have not had the benefit of the kind of training that the Department of Education has offered school systems. For example, child welfare organizations, Probation and Parole, and group home staffs which serve troubled kids often lack the expertise that school systems have developed in their understanding of substance abuse, and their ability to recognize it in the children they work with.

Proposed Response

Given the problem, two different types of efforts are needed to encourage the delayed use of drugs by high risk adolescents:

1. Supports to Student Assistance Programs.

   Building on OSA efforts, additional funds are proposed to purchase services needed by high risk youth. In particular, skill building training, self esteem building experiences, and establishment of peer leader programs would be supported. Grants of $35,000 could be made available to a total of 10 school systems. Funds could be spent on services purchased from the community, thereby encouraging a partnership between community-based service agencies and the school system.

Training and consultation for systems ng out-of-school youth.

Funds could be used to provide intensive training to groups of professionals which currently work with the kids at the highest risk of substance abuse -- those who have dropped out of school, and become known to the state social service system. Emphasis would be on understanding chemical dependency, identifying its effects on the kids served by the trainees, and the development of a multi-year action plan to respond to those needs. Systems targeted for initial training would include community-based providers, such as the residential treatment centers and group homes which now house many adolescents; as well as the state employees who serve difficult adolescents -- Probation and Parole, Maine Youth Center staff, and the Department of Human Services Child Welfare.

TREATMENT SERVICES FOR CORRECTIONS CLIENTS

Brief Description of Need

On any given day, Maine currently has approximately 2,000 adults in State correctional institutions, including 1,400 in State prisons, and 600 in the Count jails. In addition, 225 are housed at the Youth Center. It has been estimated that 75% of these inmates have a substance abuse problem. Unfortunately, treatment resources both inside the institutions, and upon release, are largely inadequate. The current demand for services by this population will be increased as the Bush drug law enforcement strategies are implemented in Maine and as we add more prison beds.

Correctional clients do not always do well in generic outpatient programs designed for motivated individuals. Expansion of specialized services, both inside and outside the prison walls, is needed. The programs need to be tailored to the particularly resistant client. National models that are successful are available and can be replicated in Maine.

Proposed Response

Expansion of services needs to occur both inside and outside of the institutions, as follows.

For Adults

1. Expansion of treatment in the County jails.

   Some County jails currently have substance abuse counselors, including Androscoggin, Oxford, Franklin, and Kennebec Counties. This item would allow for expansion of treatment services to four other Count jails. It would also support the development of "alternative site programs," particularly for OUI offenders who can be safely housed outside the County jail. This powerful combination of alternate housing, education, and treatment inside the jails would replicate successful activities now being undertaken specifically in Kennebec County.

2. Staff positions w[illegible]n the correctional facilities.

   Only one institution, the Maine Correctional Center, has a State employee responsible for coordinating and overseeing the substance abuse service needs of prison inmates. An additional 7 positions, one for each of the major correctional programs, are needed to manage the substance abuse treatment problems of existing inmates.

3. Follow-up Outpatient Counseling Upon Discharge.

   Additional outpatient services specifically tailored to the needs of Corrections' clients are also needed. Funds should be made available to support services to 500 inmates upon release, in 10 separate locations.

Subtotal for adults

For Adolescents

1. Residential options for substance abusers leaving the Youth Center.

   Follow-up residential care is needed for residents who have completed the substance abuse programs on the Youth Center campus. This would provide for a 10-bed halfway house for residents leaving the institution, and for the establishment of two pilot 8-10 beds transition homes, one in Lewiston-Auburn, and one in Bangor. The transition homes would provide for follow-up placement for residents leaving the halfway house. In these facilities, residents could be taught continued sobriety skills, as well as independent living skills. On an annual basis, approximately 40 youth would be served by this system of residential placements.

DEMONSTRATION HALFWAY HOUSE FOR PREGNANT WOMEN AND MOTHERS OF YOUNG CHILDREN

Proposed Response

An estimated 40,000 Maine women have severe problems with substance abuse. It is estimated that as many as 1,000 drug and alcohol affected infants are born in Maine annually. Approximately 10% of all admissions to State funded agencies receive child support and/or AFDC. About 26% of all State funded admissions to substance abuse treatment facilities are women. State and National Junior League studies have identified child care as the key factor in prohibiting women from seeking/receiving appropriate substance abuse treatment.

Funding would provide services aimed directly at treating pregnant women and mothers with young children. These women have stayed away from or not completed treatment in the past because traditional programs lack the means to adequately meet the concerns of the population - child care and prenatal care. Funds for this program would be directed to meeting the needs of this population which would enhance the program's ability to work on substance abuse issues and behavioral changes aimed at parenting skills. Networking to existing programs would be emphasized to meet follow-up and aftercare needs. Without additional funding, substance abusing pregnant women and mothers with young children will continue a pattern of substance abuse, physical abuse and a continued burden to the State welfare system. And women will remain limited in receiving the most appropriate treatment component.

A priority is a halfway house for pregnant women and mothers of young children. The total budget for a halfway house (1 10-bed facility) would be very similar to that of Evodia House or Crossroads. These programs are in the greater Portland area. The average annual operational cost for these two facilities is approximately $315,000.

To provide therapeutic day care services, at least two additional staff persons would need to be added to the program (a Master's level person and a non-Master's level person). Separate staff are required for the following reasons:

(a) Day care licensing requirements do not allow the sharing of staff across program areas;

(b) Operating a child care facility is as demanding a job as administering a substance abuse program. This is especially true since children of substance abusing parents often have needs of their own and, therefore, special skills are required of staff;

EQUITABILITY OF SUBSTANCE ABUSE COUNSELORS' SALARIES TO REDUCE HIGH TURNOVER RATES IN PUBLICLY FUNDED TREATMENT PROGRAMS

Proposed Response

Intense competition for qualified substance abuse staff exists within the service system between programs that serve predominately poor clients and those which serve private paying clients. Due to this, public programs have and are experiencing high turnover rates as most qualified clinicians move on to higher salaries elsewhere.

Of the clients served in publicly funded programs, 64% have no medical coverage, nearly half enter treatment unemployed, and 38% are widowed, separated or divorced. The continuing exodus of qualified clinicians leaves these public programs with less qualified staff and longer vacancies. Some agencies have experienced a rate of reduction in clients served as high as 25% due to long vacancies in positions.

COLA FOR COMMUNITY SUBSTANCE ABUSE AGENCIES

Proposed Response

Community substance abuse agencies serve 13,000+ clients with substance abuse issues in Maine yearly. Over half (54%) of those admitted have no insurance coverage. Twenty-five percent of the household income is retirement, AFDC, SSI, disability, town welfare or social security. The average monthly income is $720. There is a need for substance abuse services in Maine, particularly those who serve the client with a difficulty to pay. Agencies have already reduced services because of their inability to attract and retain qualified staff. Remaining staff experience overloading to handle demands. A local study revealed entry level substance abuse counselors found their salaries near the income guidelines qualifying recipients for food stamps.

REPLACEMENT OF LOSS FEDERAL FUNDS TO SUSTAIN A MODEL COMMUNITY YOUTH ACTIVITY PREVENTION PROGRAM IN PORTLAND'S PUBLIC HOUSING PROJECTS.

Proposed Response

This nationally recognized program develops and supports a positive peer leadership network to prevent alcohol and drug abuse, teen pregnancy and other social problems in Portland's public housing projects. The project's goal is to break the cycle of chronic dependence and failure to create a more positive, success oriented environment. With funding, the program could annually maintain peer leadership support for 75 youth, purchase health, social and support services for 100 housing project residents and maintain a variety of alternative community activities for 400 housing project residents.

TEEN PREGNANCY AND SUBSTANCE ABUSE INTERVENTION/TREATMENT

Proposed Response

In Maine, one of every 15 teens becomes pregnant each year. Thirty-five percent of all births to teens have been to teens under age 18. On thousand teens are receiving AFDC at any one time. It is estimated that 2/3 of pregnant teens under age 15 and nearly 1/2 of 15 to 17 year olds do not receive prenatal care in their first trimester. Maine's AFDC expenditures per year for children born to teen parents is about $50 million. Approximately 1,000 drug and alcohol affected infants are born in Maine annually, and 12% of Maine's adolescent population experience problems as a result of substance abuse.

Funds should be targeted at the pregnant and at-risk teen population. Programmatic focus would be directed to educating staff of agencies dealing with teens/pregnancy/substance abuse - rising awareness of the factors common to all (i.e., dysfunctional families, low self esteem, low school performance, etc.). Funds could provide specifically trained counselors to provide services to this population who may be recognized at-risk for substance abuse, pregnancy, for sexually transmitted disease, etc.

ALTERNATIVE TREATMENT SERVICES FOR DUAL-DIAGNOSED CLIENTS

Brief Description of Need

Individuals are admitted to AMHI as a result of chemical dependency. These individuals are admitted, not as a result of a need for mental health services per se, but because they knew the right things to say ("I'm going to kill myself; do something"), and sue to a lack of appropriate community-based substance abuse services (detox, shelter, rehabilitation, intermediate and extended care).

In addition, 50% of all people admitted to AMHI have a diagnosis of substance abuse in addition to their mental health diagnosis. Supports and services that could prevent reinstitutalization of this group are not usually available.

Proposed Response

1. Crisis response.

   Existing crisis intervention programs in four Department of Mental Health regions should receive expanded resources to provide clinical intervention, assessment, and evaluation. In addition, the ability to purchase shelter, detoxification, and transportation assistance for selected clients is needed.

2. Short-term residential rehabilitation.

   Two 10-bed community-based facilities are needed to provide intensive intervention and treatment for dual-diagnosed individuals. This service would begin the recovery process, and should be connected to other, follow-up services. Admission to this service would be limited to patients without substantial previous substance abuse treatment history -- i.e., good candidates for recovery.

3. Long-term rehabilitation.

   Fifty-percent of those people entering shelter and detoxification services would ultimately be willing to take the next step into treatment. This proposal would establish four extended care programs of 10-12 beds each. These programs would stabilize the housing needs of these later-stage substance abusers, and would provide them with a safe environment in which to establish and maintain a pattern of sobriety. Placement in this type of facility would prevent relapse, and potential readmission to AMHI.

4. Supportive living environments.

   In addition to the long-term rehabilitation referred to above, permanent supportive living arrangements are needed for an estimated 64 people per year. This item includes money for group home placement, and consultation and group counseling by Licensed Substance Abuse Counselors for the individuals in the group home.

5. Training.

   A number of training needs should be addressed, in conjunction with the expansion of services. Individuals requiring training include AMHI staff, community mental and substance abuse treatment professionals, and referral sources to both the mental health and substance abuse systems (e.g., physicians, caseworkers, etc.).

JERLD1210

OFFICE OF SUBSTANCE ABUSE (OSA)
SIGNIFICANT ACCOMPLISHMENTS
(First Seven Months of FY'91)

1. Office staff conducted 45 licensing visits; issued 15 new/renewable program licenses or certificates; conducted 9 follow-up visits to assure corrective action was taken; and conducted 20 technical assistance visits.

2. The Office initiated activity to develop uniform contracting policy, standards, and procedures. Noteworthy is the development of uniform policy that assures greater fiscal accountability at the program level. The new policy clearly outlines when programs' year-end financial reports are due, program action required in returning funds due back to the State, and action that OSA will take if programs are out of compliance.

3. The Office established a interdisciplinary committee to:

   Determine the components of performance-based contracts.
   Determine appropriate performance indicators by type of service.
   Determine appropriate minimal standards for each performance indicator.
   Determine appropriate consequences, procedures, and policies.

4. The Office, working with the Department of Human Services and local treatment providers, developed uniform unit cost definitions and criteria for calculating the cost of purchased service units.

5. Work continued on the development of the new statewide management information system. Office staff redesigned data collection forms to include the federal required data set, revised the training manual, and conducted regional training of local agency staff. The Office continued the development of data reports and submitted the first data tape for federal review. Most important is the development of a data report that allows the Office to collect baseline program performance data and monitor performance by service setting.

6. The Office has implemented a system to monitor treatment capacity by service setting. This effort is essential in assuring program efficiency.

7. The Office prepared the first comprehensive state plan for alcohol and other drug abuse services in Maine in accordance with 5 M.R.S.A., Part 24, Chapter 521.

8. Action was taken to transfer licensing regulations and authority from OADAP to OSA.

9. OSA continues to work with OADAP/DEEP staff to assure continuity of DEEP licensing requirements.

10. OSA has and will continue to work with the Department of Mental Health to develop uniform licensing standards and procedures. This effort will significantly reduce duplication of effort.

11. OSA is in the process of revising licensing regulations to include services delivered in correctional settings. This action will standardize services in jails and correctional institutions.

12. OSA is in the process of developing licensing regulations specific to the dual-diagnosis population.

13. OSA worked with the Bureau of Medical Services to streamline Medicaid regulations and the application process. As a result, treatment services will increase to persons Medicaid eligible. This action also reduces OSA staff time and costs associated in reviewing required program applications.

14. Office staff worked jointly with three independent service providers and one consortium of providers to prepare and submit applications for OTI funds. All agencies were provided with technical assistance including editorial review of draft applications. The consortium was provided with several days of time, facilitating the development of program and interagency working relationships. Three applications were submitted for waiting list reductions. One was submitted for the criminal justice system population. This application was approved but not funded.

15. The Office applied for and won its share of the new Community Youth Activity Program Prevention Block Grant. As a result, new student assistance programs were established in Maine School Administrative District No. 17 ($34,255), Maine School Administrative District No. 56 ($34,254), and Maine School Administration District No. 64 ($21,914).

16. The Office applied for the competitive Community Youth Activity Program Demonstration Grant and was awarded $321,425. A total of $221,796 was awarded to the People's Regional Opportunity Program in Portland. This nationally recognized program develops and supports a positive peer leadership network to prevent alcohol and drug abuse, teen pregnancy, and other social problems in Portland's public housing projects. The project's major goal is to break the cycle of chronic dependence and failure to create a more positive, success-oriented environment. Annually these funds maintain peer leadership support for 75 youth, purchase health, social, and support services for 100 housing project residents, and maintain a variety of alternative community activities. To assure adequate treatment services, the Office allocated an additional $94,500 for adolescent outpatient services, nonresidential services, house-based family counseling, and evaluation/referral services.

17. The Office conducted the most comprehensive study to date to assess the statewide treatment and prevention delivery system. This detailed analysis has been valuable in guiding Office policy and activity.

18. The Office conducted a two-day Governor's conference on employee assistance programs.

19. The Office participated in and partially funded Maine's Red Ribbon campaign this year. Ribbon orders increased over 30 percent to over 120,000 ribbons. The quality and variety of local events showed a commensurate increase.

20. The Office has collected and is compiling budget information from Departments to determine the amount of funding available in FY 92/93 and the projected negative impact due to a potential fiscal shortfall.

21. The Office is working closely with the Department of Mental Health and Mental Retardation in formulating a workplan to fulfill the mandates of the consent decree which impact upon the substance abuse field and dual-diagnosis clients.

SPECIAL COMMISSION ON GOVERNMENTAL RESTRUCTURING,

SUBCOMMITTEE ON HEALTH, SOCIAL SERVICES, AND ECONOMIC SECURITY

GOOD MORNING: MY NAME IS JEREAL HOLLEY. I AM THE FISCAL MANAGER OF THE OFFICE OF SUBSTANCE ABUSE AND HAVE BEEN IN THIS CAPACITY SINCE THE FORMATION OF THE OFFICE LAST JULY, 1990. THE DIRECTOR, RON SPECKMANN IS UNABLE TO BE HERE TODAY BECAUSE OF A PRIOR COMMITMENT.

THE OFFICE OF SUBSTANCE ABUSE WAS ESTABLISHED AS THE SINGLE ADMINISTRATION UNIT WITHIN STATE GOVERNMENT, ACCOUNTABLE DIRECTLY TO THE GOVERNOR, WITH RESPONSIBILITY FOR STATEWIDE PLANNING, PROGRAM DEVELOPMENT, IMPLEMENTATION AND COORDINATION OF ALL THE STATE'S SUBSTANCE ABUSE PREVENTION AND TREATMENT ACTIVITIES AND SERVICES. EFFECTIVE OCTOBER 15, 1991, OSA WILL ALSO BE RESPONSIBLE FOR A STATEWIDE INFORMATION AND CLEARINGHOUSE, STATEWIDE SUBSTANCE ABUSE TRAINING, AND THE DRIVER EDUCATION EVALUATION PROGRAM.

OSA HAS A BUDGET OF APPROXIMATELY 9 MILLION. APPROXIMATELY 12,000 PERSONS ARE SERVED ANNUALLY IN A CONTINUUM OF CARE THAT INCLUDES PREVENTION, EARLY INTERVENTION, OUTPATIENT AND RESIDENTIAL SERVICES.

I AM PLEASED TO REPORT THAT THE OFFICE HAS ACHIEVED A NUMBER OF ACCOMPLISHMENTS SINCE LAST JULY. OUTSTANDING ACCOMPLISHMENTS INCLUDE:

1. THE OFFICE PREPARED THE FIRST COMPREHENSIVE STATE PLAN FOR ALCOHOL AND OTHER DRUG ABUSE SERVICES IN MAINE

2. THE OFFICE HAS CONDUCTED A COMPREHENSIVE FISCAL ANALYSIS TO ASSESS THE CURRENT STATEWIDE DELIVERY SYSTEM.

3. THE OFFICE HAS IMPLEMENTED A STATEWIDE MANAGEMENT INFORMATION SYSTEM.

4. THE OFFICE WORKING WITH A BROAD-BASED COMMUNITY COMMITTEE HAS DEVELOPED AND IMPLEMENTED A PERFORMANCE BASED CONTRACTING MECHANISM.

I HAVE PREPARED A MORE DETAILED LIST OF ACHIEVEMENTS THAT I WILL LEAVE YOU TODAY.

I AM ALSO PLEASED TO REPORT THAT THE RECENT PASSAGE OF L.D. 175, AN ACT RELATED TO THE OFFICE OF SUBSTANCE ABUSE, STRENGTHENS THE OFFICE AND GIVES IT THE FLEXIBILITY TO BETTER ADDRESS THE FIVE BROAD ISSUES IDENTIFIED BY THE SUBCOMMITTEE.

THE OFFICE IS WORKING VERY COOPERATIVELY WITH THE DEPARTMENTS OF HUMAN SERVICES, MENTAL HEALTH, EDUCATION, CORRECTIONS, AND PUBLIC SAFETY. EXAMPLES INCLUDE:

1. MEMORANDUM OF AGREEMENTS WITH THE DEPARTMENT OF HUMAN SERVICES, MENTAL HEALTH AND EDUCATION

2, THE OFFICE HAS WORKED CLOSELY WITH THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TO DEVELOP UNIFORM LICENSING STANDARDS AND PROCEDURES.

3. THE OFFICE IS WORKING CLOSELY WITH THE DEPARTMENT OF EDUCATION IN THE DEVELOPMENT OF ITS STATEWIDE PREVENTION PLAN.

4. THE OFFICE HAS JOINT CONTRACTS WITH THE DEPARTMENT OF CORRECTIONS.

OSA DOES NOT BELIEVE THAT THERE IS A MAJOR PROBLEM WITH DUPLICATION AND/OR OVERLAPPING SERVICES. THE PROBLEM IS THAT THERE ARE NOT ENOUGH SERVICES AVAILABLE. DUE TO THE CURRENT ECONOMIC SITUATION, SERVICES WERE REDUCED BY APPROXIMATELY $1.3 MILLION.

EMERGING ~~SURVEYING~~ ISSUES/NEEDS INCLUDE SERVICES TO THE ADOLESCENT POPULATION, PERSONS INVOLVED WITH THE CORRECTIONAL SYSTEM, WOMEN AND MOTHERS OF YOUNG CHILDREN, AND INDIVIDUALS WITH A DUAL DISORDER. THE OFFICE HAS PREPARED FOR YOUR INFORMATION A LIST OF UNMET SUBSTANCE ABUSE SERVICE NEEDS IN MAINE.

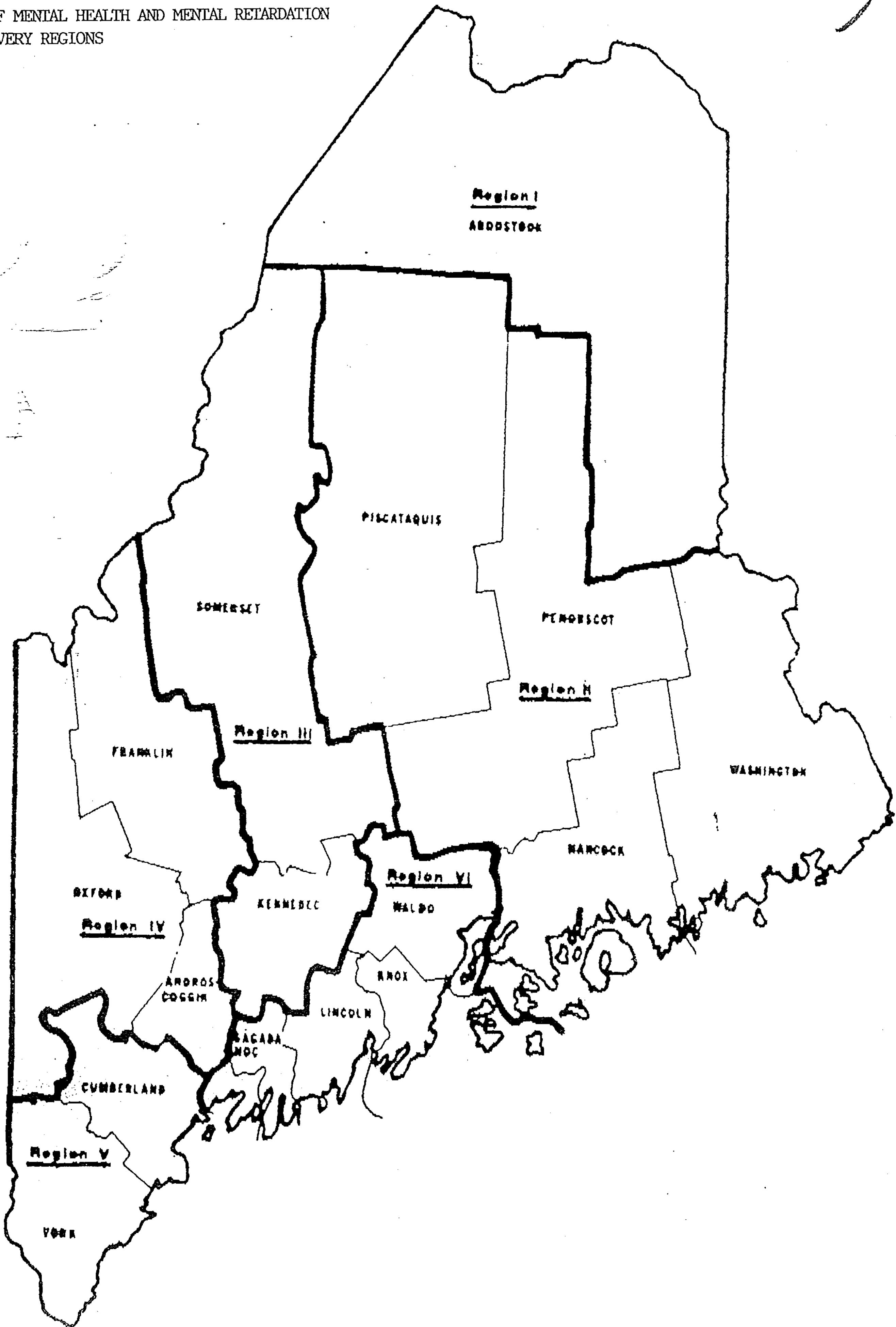
WHAT IS THE NUMBER ONE THING WE WOULD CHANGE? THE MAJOR CHANGE THAT NEEDS TO TAKE PLACE IS ASSURANCE THAT THE CURRENT PREVENTION AND TREATMENT SYSTEM IS EFFICIENT AND EFFECTIVE. MAJOR STEPS HAVE ALREADY BEEN TAKEN WITH THE IMPLEMENTATION OF THE STATEWIDE MANAGEMENT INFORMATION SYSTEM AND PERFORMANCE CONTRACTING. ADDITIONAL ACTIVITIES ARE UNDERWAY WHICH INCLUDE A STATEWIDE NEEDS ASSESSMENT, MONITORING OF TREATMENT UTILIZATION, AND AN AUTOMATED SYSTEM TO ROUTINELY MONITOR PROGRAM PERFORMANCE.

IN CLOSING, I THANK YOU FOR THIS OPPORTUNITY AND I WILL TRY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE NOW.

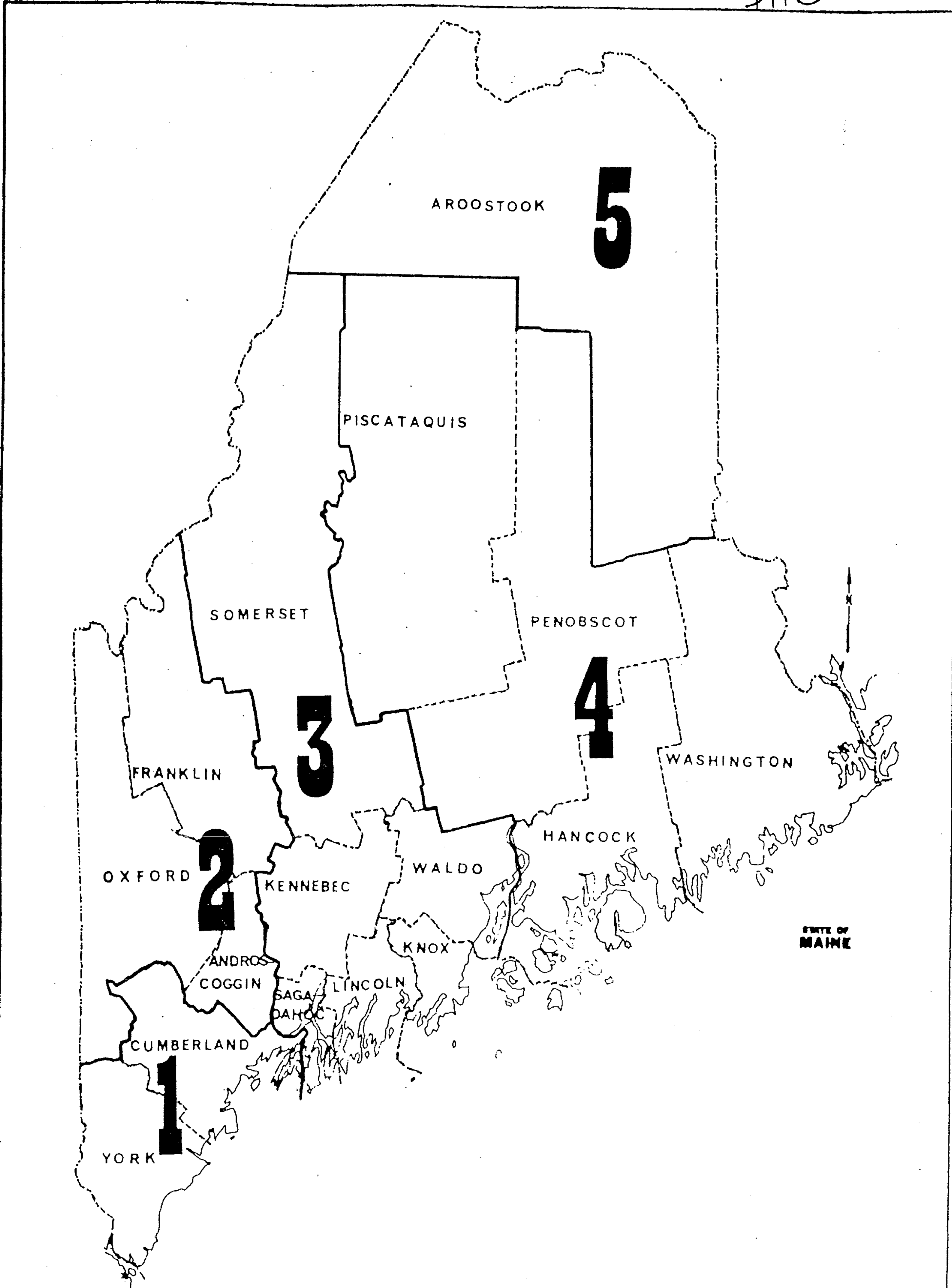
THANK YOU.

Dist 8/09 HHS

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
SERVICE DELIVERY REGIONS



DHS

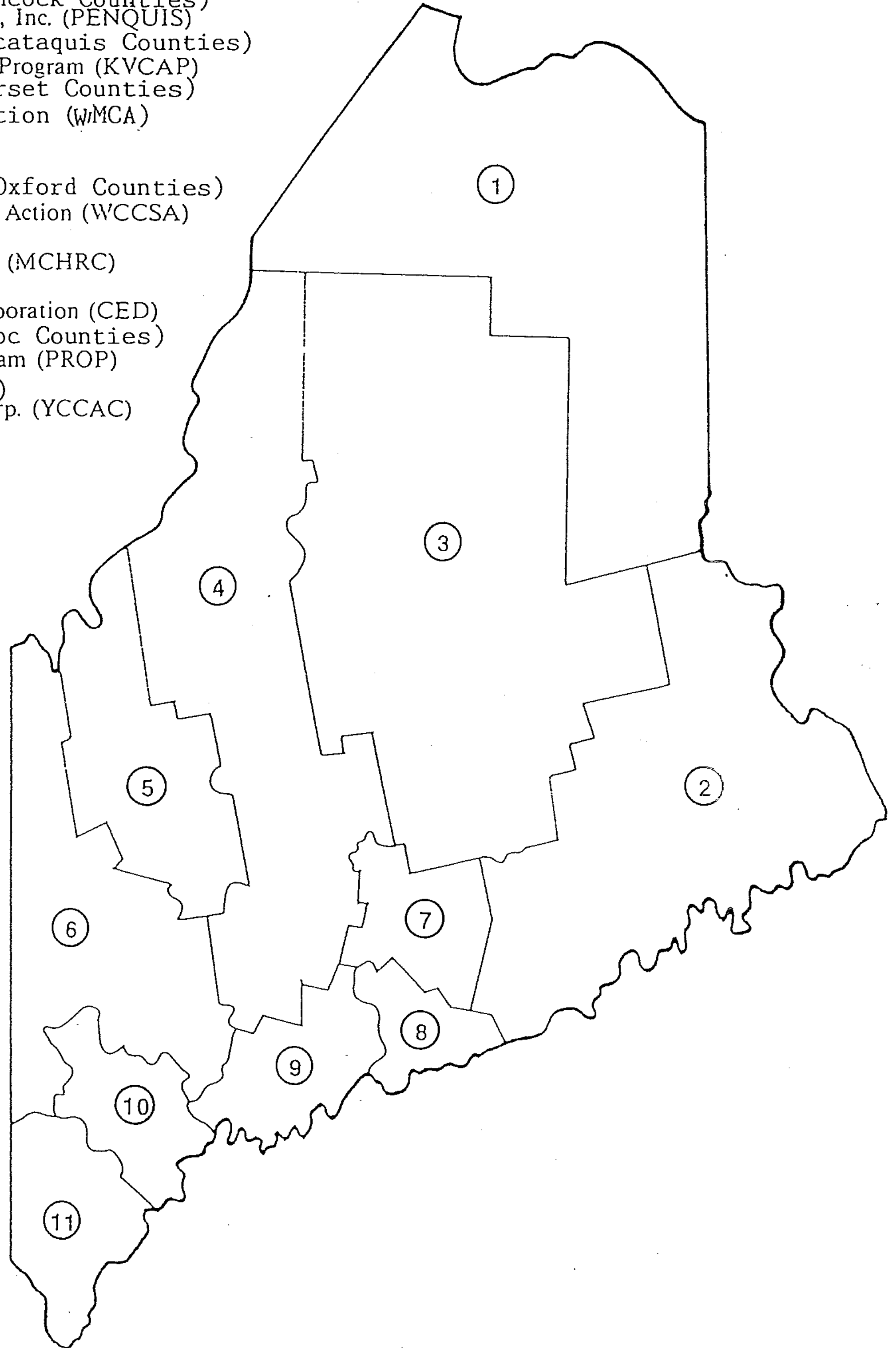


Maine Community Action Agencies

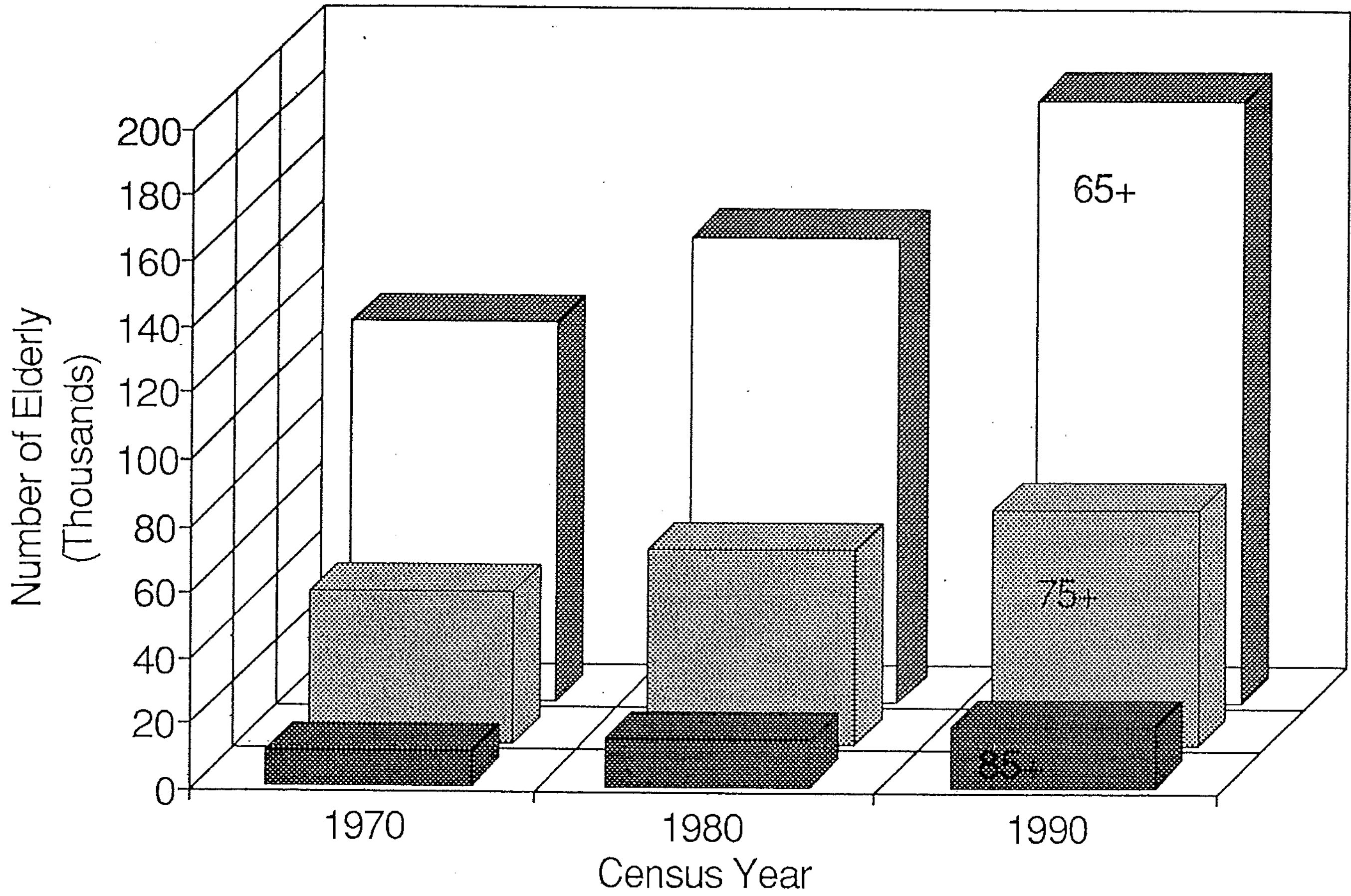
DIVISION OF COMMUNITY SERVICES

SERVICE DELIVERY AREAS

1. Aroostook County Action Program (ACAP)
   (Aroostook County)
2. Washington-Hancock Community Agency (W-HCA)
   (Washington and Hancock Counties)
3. Penquis Community Action Program, Inc. (PENQUIS)
   (Penobscot and Piscataquis Counties)
4. Kennebec Valley Community Action Program (KVCAP)
   (Kennebec and Somerset Counties)
5. Western Maine Community Action (WMCA)
   (Franklin County)
6. Community Concepts, Inc. (CCI)
   (Androscoggin and Oxford Counties)
7. Waldo County Committee for Social Action (WCCSA)
   (Waldo County)
8. Mid-Coast Human Resource Council (MCHRC)
   (Knox County)
9. Coastal Economic Development Corporation (CED)
   (Lincoln & Sagadahoc Counties)
10. People's Regional Opportunity Program (PROP)
    (Cumberland County)
11. York County Community Action Corp. (YCCAC)
    (York County)



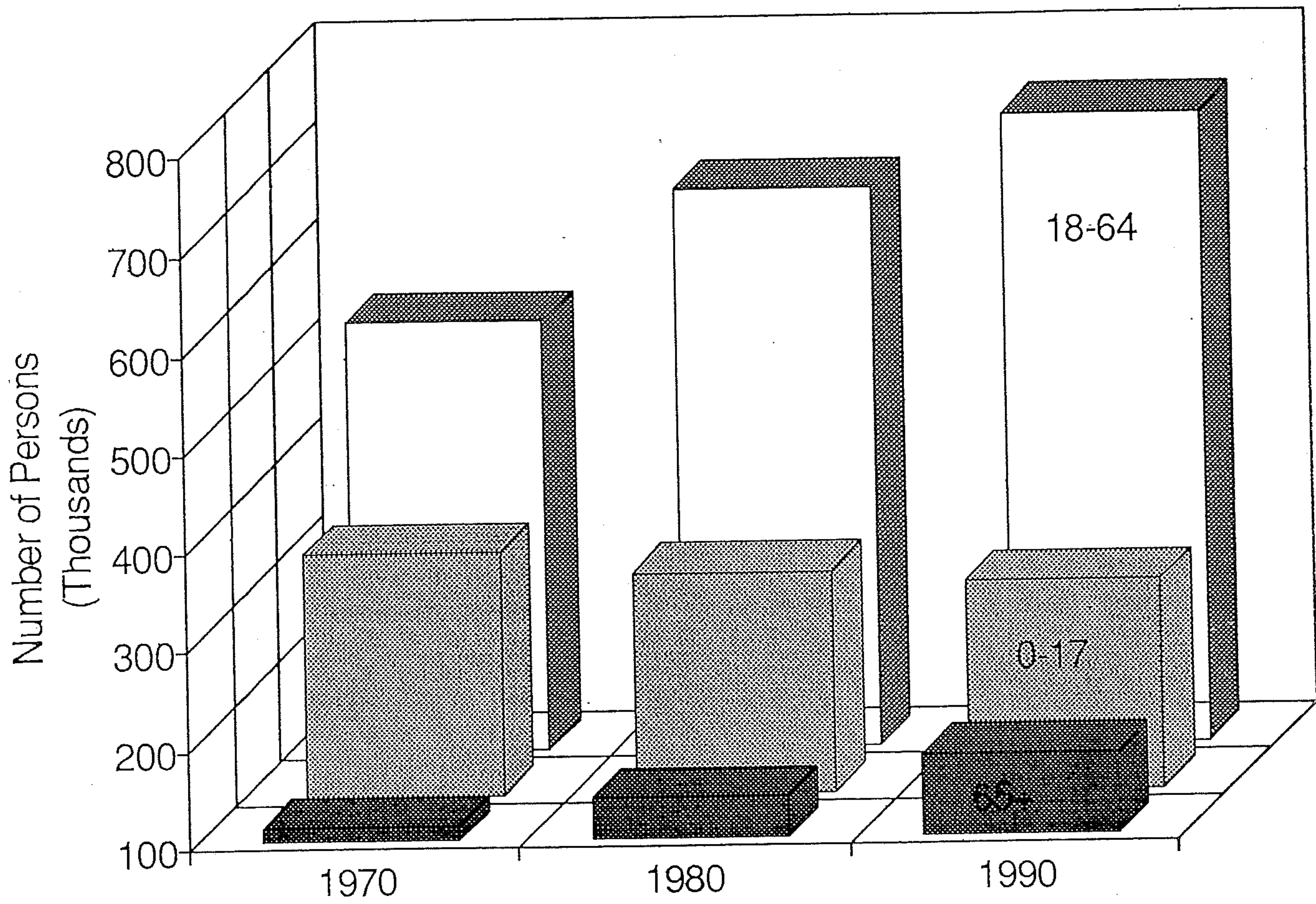
Maine's Elderly Population



Maine population

	1970	1980	1990
Age 65+	114617	140961	183373
Age 75+	45905	58630	71173
Age 85+	9834	14099	18218

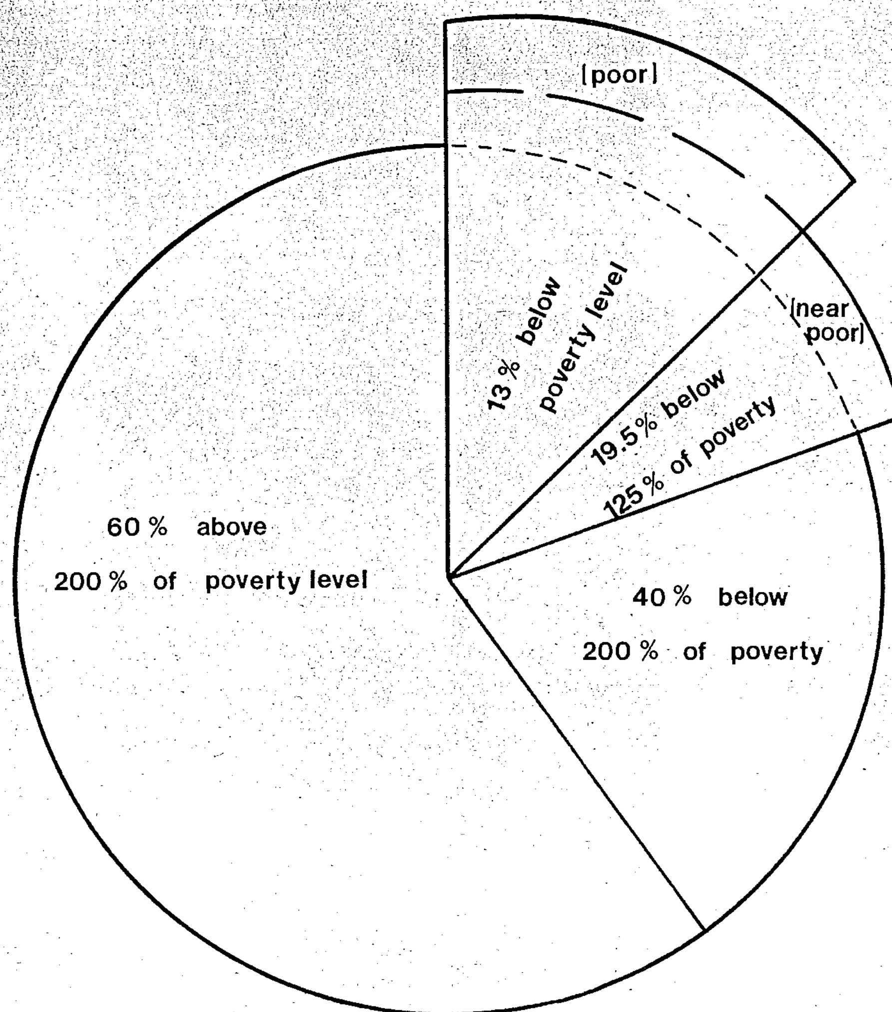
Maine Population by Age



Maine Population by Age

	1970	1980	1990
Total	993722	1125030	1227928
Age 65+	114617	140961	183373
Under 18	343966	321450	309003
age 18-64	533649	662616	735552

Poverty in Maine, 1970 - 1980
Volume 1: Causes and Conditions



Executive Department
March 1985

Maine State Planning Office and
Division of Community Services

Dist 8/05 HHS

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August 5, 1991

To: Committee on Health, Social Services and Economic Security

From: Paul Saucier, Legislative Analyst PS

Re: Material for August 9 meeting

I have enclosed an additional article for the August 9th meeting.

PS/jlj/9110opla

LIST OF REPORTS FOR WHICH EXECUTIVE SUMMARIES WERE MAILED TO COMMITTEE ON HEALTH, SOCIAL SERVICES AND ECONOMIC SECURITY, 8/5/91

Additional Support for People in Retraining and Education Program: An Evaluation According to Legislative Requirements - February, 1990

AFDC Caseload Characteristics in January 1989

Affordable Housing in Maine, A Study of the Obstacles to - December 1, 1989

Aid to Families with Dependent Children and Medical Assistance Payment Programs, Report of the Task Force to Study the - May 15, 1991

Aid to Families with Dependent Children Need and Payment Standards, Final Report of the Commission to Evaluate the Adequacy of the - February, 1990

Aid to Families with Dependent Children, Proposal to Adequately Address the Housing Needs of Recipients of - Recommendations

Alcohol and Drug Abuse Planning Committee, Program and Audit Committee Review

Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services, First Report of the Commission to Study the - 1989

Child Support Enforcement Program, Maine Emergency Medical Services, Program and Audit Committee Review - 1990-1991

Child Welfare Services - 1986 Program and Audit Committee Review

Child Welfare Services, Maine Emergency Medical Services, Program and Audit Committee Review - 1989-1990

Children's Mental Health System, Building a: A community Based Crisis Stabilization and Diversion System - February 25, 1991

Children at the Augusta Mental Health Institute: Prevention Strategies and Ideal Discharge Plans - June, 1989 - June, 1990

Children, Youth and Families, Governor's Task Force to Improve Services for Maine's - May 22, 1991

Early Intervention System, Historical Perspectives on Maine's 0-5 Interdepartmental

Elderly Citizens, Commission to Study the Level of Services for Maine's - December, 1990

General Assistance, Final Report of the Special Select Commission on the Financing and Administration of - May, 1987

Health Care Expenditures, Blue Ribbon Commission on the Regulation of - January, 1989

Health Information Recording System, Study of the Necessity and Feasibility of Establishing a - December, 1988

Implementation Plan for Settlement Agreement to Consent Decree ***(Paul Bates, et al, v. Robert Glover, et al (Civ. 89-88))*** - January 1, 1991

Maine Health Program, Report of the Task Force to Evaluate and Revise the - Phase 2 - May 31, 1991

Medicaid Financing of Services for Maine's Citizens with Mental Retardation: A Follow-Up Report - March 15, 1991

Medicaid Report, Annual - State Fiscal Year 1990

Mental Health and a Healthy Society: Transforming Maine's Mental Health System by the Year 2000 - January 25, 1991

Mental Health Systems Reform in Selected States - November, 1990

Smoking or Health, Governor's Commission on - Final Report and Recommendations - January, 1990

#2953LHS

Book of the States 1991

Table 3.3
THE LEGISLATORS
Numbers, Terms, and Party Affiliations

State or other jurisdiction	Senate: Democrats	Senate: Republicans	Senate: Other	Senate: Vacancies	Senate: Total	Senate: Term	House: Democrats	House: Republicans	House: Other	House: Vacancies	House: Total	House: Term	Senate and House totals
All states	1,192	751	1	2	1,995		3,277	2,176	4	9	5,466		7,461
Alabama	28	6	...	1	35	4	85	17	...	3	105	4	140
Alaska	8	12	...	...	20	4	23	17	...	...	40	2	60
Arizona	13	17	...	...	30	2	26	34	...	...	60	2	90
Arkansas	31	4	...	...	35	4	88	11	1 (a)	...	100	2	135
California	24	15	1 (a)	...	40	4	46	33	...	1	80	2	120
Colorado	11	24	...	...	35	4	26	39	...	...	65	2	100
Connecticut	23	13	...	...	36	2	88	63	...	...	151	2	187
Delaware	13	8	...	...	21	4	18	23	...	...	41	2	62
Florida	23	17	...	...	40	4	73	47	...	...	120	2	160
Georgia	45	11	...	...	56	2	144	36	...	...	180	2	236
Hawaii	22	3	...	...	25	4	45	6	...	...	51	2	76
Idaho	19	23	...	...	42	2	20	64	...	...	84	2	126
Illinois	31	28	...	...	59	4 (b)	67	51	...	...	118	2	177
Indiana	24	26	...	...	50	4	50	50	...	...	100	2	150
Iowa	30	20	...	...	50	4	61	39	...	...	100	2	150
Kansas	18	22	...	...	40	4	58	67	...	...	125	2	165
Kentucky	30	8	...	...	38	4	72	28	...	...	100	2	138
Louisiana	34	5	...	...	39	4	86	17	...	2	105	4	144
Maine	20	15	...	...	35	2	97	54	...	...	151	2	186
Maryland	40	7	...	...	47	4	125	16	...	...	141	4	188
Massachusetts	32	8	...	...	40	2	128	32	...	...	160	2	200
Michigan	18	20	...	...	38	4	61	49	...	...	110	2	148
Minnesota	44 (c)	23 (d)	...	...	67	4	80 (c)	53 (d)	...	1	134	2	201
Mississippi	44	8	...	...	52	4	112	9	1 (e)	...	122	4	174
Missouri	22	12	...	...	34	4	104	58	...	1	163	2	197
Montana	23	27	...	...	50	4 (f)	52	48	...	...	100	2	150
Nebraska	Nonpartisan election				49	4	Unicameral						49
Nevada	8	13	...	...	21	4	30	12	...	...	42	2	63
New Hampshire	8	16	...	...	24	2	119	281	...	...	400	2	424
New Jersey	22	17	...	1	40	4 (g)	44	36	...	...	80	2	120
New Mexico	26	16	...	...	42	4	45	25	...	...	70	2	112
New York	27	34	...	...	61	2	92	58	...	...	150	2	211
North Carolina	37	13	...	...	50	2	74	46	...	...	120	2	170
North Dakota	32	21	...	...	53	4	45	61	...	...	106	2	159
Ohio	14	19	...	...	33	4	59	40	...	...	99	2	132
Oklahoma	33	15	...	...	48	4	68	32	...	1	101	2	149
Oregon	19	11	...	...	30	4	32	28	...	...	60	2	90
Pennsylvania	23	27	...	...	50	4	104	99	...	...	203	2	253
Rhode Island	41	9	...	...	50	2	83	17	...	...	100	2	150
South Carolina	35	11	...	...	46	4	87	37	...	...	124	2	170
South Dakota	15	20	...	...	35	2	24	46	...	...	70	2	105
Tennessee	22	11	...	...	33	4	59	40	...	...	99	2	132
Texas	23	8	...	...	31	4	93	57	...	...	150	2	181
Utah	7	22	...	...	29	4	28	47	...	...	75	2	104
Vermont	16	14	...	...	30	2	74	76	...	...	150	2	180
Virginia	30	10	...	...	40	4	59	39	2 (a)	...	100	2	140
Washington	24	25	...	...	49	4	63	35	...	...	98	2	147
West Virginia	29	5	...	...	34	4	81	19	...	...	100	2	134
Wisconsin	20	13	...	...	33	4	56	43	...	...	99	2	132
Wyoming	11	19	...	...	30	4	23	41	...	...	64	2	94
Dist. of Columbia	12	0	1 (a)	...	13	4	Unicameral						13
American Samoa	Nonpartisan selection			4	18	4	Nonpartisan election			1	21	2	39
Guam	13	8	...	...	21	2	Unicameral						21
No. Mariana Islands	2	7	...	...	9	4	8	7	...	...	15	2	24
Puerto Rico	18 (i)	8 (j)	1 (k)	...	27	4	36 (j)	14 (j)	1 (k)	...	51	4	78
U.S. Virgin Islands	159	3	3 (l)	...	15	2	Unicameral						

Note: This table reflects the legislatures as of January 1989, except for New Jersey, Virginia and the No. Mariana Islands; information for those jurisdictions is for 1990.

(a) Independent.

(b) The entire Senate is up for election every ten years, beginning in 1972. Senate districts are divided into three groups. One group elects senators for terms of 4-years, 4-years and 2-years, the second group for terms of 4-years, 2-years and 4-years, the third group for terms of 2-years, 4 years and 4-years.

(c) Democrat-Farmer-Labor.

(d) Independent-Republican.

(e) Independent-Democrat.

(f) After each decennial reapportionment, lots are drawn for half of the senators to serve an initial 2-year term. Subsequent elections are for 4-year terms.

(g) Senate terms beginning in January of second year following the U.S. decennial census are for 2 years only.

(h) Council of the District of Columbia.

(i) Popular Democratic Party.

(j) New Progressive Party.

(k) Puerto Rican Independent Party (also known as the Independent Puerto Rico Party).

(l) Independent (2); Independent Citizens Movement (1).

Dist 8/05 HHS

ISSN 0146-9002

Significant Features of Fiscal Federalism

Volume 1

Budget Processes and Tax Systems

1991

Advisory Commission
on Intergovernmental Relations
February 1991 M-176

Table 4
State Budget Stabilization Funds

State	Methods for Deposit	Methods for Withdrawal
Alaska *Budget Reserve Account*	By appropriation	By appropriation for the governor to meet a disaster
California *Special Fund for Economic Uncertainties*	Year-end surplus or by appropriation	(1) Automatic expenditure to cover revenue shortfall or other deficiency in general fund (2) executive order can allocate funds for additional fire fighting or disaster response needs
Colorado* *4% Required Reserve*	4% of total general fund appropriations plus supplementals are automatically set aside	Automatic expenditure when revenue estimates fall below targets; fund can be used only to cover appropriations already authorized
Connecticut *Budget Reserve Fund*	Year-end surplus; fund capped at 5% of net general fund appropriations for fiscal year	Automatic expenditure to cover budget deficit to the extent that funds are available
Delaware *Budget Reserve Account*	Automatic deposit from previous year's unencumbered funds; fund capped at 5% of estimated general fund revenues	By appropriation to cover budget deficit or to compensate for revenue reductions: requires 3/5 vote of each house
Florida *Working Capital Fund*	Year-end surplus; fund capped at 10% of previous year's general fund	By appropriation when revenue collections are insufficient to meet appropriations
Georgia *Revenue Shortfall Reserve*	Year-end surplus; fund capped at 3% of net revenue	Automatic expenditure to cover revenue shortfall collections
Idaho *Budget Reserve Account*	By appropriation	By appropriation
Indiana *Counter-Cyclical Revenue & Economic Stabilization Fund*	(Annual growth rate in personal income minus 2%) x (previous year general fund revenues)	Funds transferred to general fund if percentage change in adjusted personal income is less than 2%
Iowa *Economic Emergency Fund*	Year-end surplus; fund capped at 10% of funds appropriated from the state's general fund during the preceding fiscal year	By appropriation only for a purpose for which the General Assembly previously appropriated funds for that fiscal year
Kentucky* *Budget Reserve Trust Fund*	By appropriation	Allotted by governor to meet a revenue shortfall: governor must notify legislature
Maryland* *Revenue Stabilization Account*	By appropriation	Transferred by governor to general fund revenues if state unemployment rate is both greater than 6.5% and greater than the rate 12 months earlier; amount of transfer is reduced by amount of general fund budget reductions made by legislature
Massachusetts *Commonwealth Stabilization Fund*	Year-end surplus; fund capped at 5% of current fiscal year revenues	By appropriation
Michigan* *Budget and Economic Stabilization Fund*	Statutes require appropriation of an amount equal to (annual growth rate in real personal income in excess of 2%) x (general fund revenues of prior fiscal year)	If annual growth rate in real personal income is negative, withdrawal equals (deficiency) x (general fund revenues), but no more than needed to balance budget; withdrawals are allowed in year that pay-in is made if actual revenue collections fall below level on which budget was based
Minnesota *Budget Reserve Account*	By direct appropriation—$550 million; by contingent appropriation an amount to bring the reserve up to 5% of general fund appropriations for the biennium	By appropriation or transfer by commissioner of finance with approval of governor; consultation with Legislative Advisory Commission required
Mississippi *General Fund Stabilization Reserve*	Automatic transfer of 25% of annual surplus, with fund not exceed 5% of previous year's general fund revenue	Transfer by Fiscal Management Board to cover revenue shortfall
Missouri* *Budget Stabilization Fund*	By appropriation; fund is not to exceed 5% of the receipts into the general revenue fund for preceding fiscal year	By appropriation to the governor to meet budget shortfalls
New Hampshire *Revenue Stabilization Reserve Account*	Audited year-end surplus	Transfer by the comptroller with approval of the Advisory Budget Control Committee and the governor when: (1) General fund operating deficit occurred for most recently completed fiscal year, and (2) Unrestricted general fund revenues in the most recently completed fiscal year were less than budget forecast
New Jersey *Surplus Revenue Fund*	50% of revenue collections in excess of governor's certification of revenues	(1) By appropriation or (2) by the governor in event of an emergency identified by the governor, upon approval by the legislature's Joint Budget Oversight Committee

Table 4 (cont.)
State Budget Stabilization Funds

State	Methods for Deposit	Methods for Withdrawal
New Mexico *Operating Reserve Fund*	Excess revenue with balance not to exceed 8% of aggregate recurring appropriations from the general fund for the previous fiscal year	By appropriation in the event revenues are insufficient to meet the level of appropriations authorized
New York* *Tax Stabilization Reserve Fund*	Year-end surplus up to 0.2% of aggregate general fund disbursements; reserve fund cannot exceed 2% of general fund disbursements for the fiscal year	By appropriation when state is in deficit
North Dakota *Budget Stabilization Fund*	Biennium end surplus in excess of $40 million	Governor may transfer for revenue shortfall of at least 5% of the estimate made by the most recently adjourned Assembly
Ohio *Budget Stabilization Fund*	Transfer of general revenue in excess of certified revenues for biennium	Funds transferred to general fund if growth in general revenue fund is negative
Oklahoma *Constitutional Reserve Fund*	Automatic transfer of revenue in excess of official revenue projection; fund is capped at 10% of general revenue fund for the preceding fiscal year	Up to 1/2 of balance may be appropriated if: (1) forthcoming fiscal year general revenue fund is less than that of current fiscal year certification; or (2) emergency declaration by the governor with concurrence by legislature with a 2/3 vote of each house; or (3) joint emergency declaration by speaker and president pro tempore with concurrence by legislature with a 3/4 vote of each house
Pennsylvania *Tax Stabilization Reserve Fund*	By appropriation	By appropriation when governor declares an emergency or downturn in the economy; requires 2/3 vote of each house
Rhode Island *Budget Reserve and Cash Stabilization Account*	For FY87 and thereafter, 40% of lottery revenue	Automatic expenditure to cover revenue shortfall
South Carolina* *General Reserve Fund*	Revenues in excess of annual operating expenditures must be transferred to the fund; fund is capped at 3% of general fund revenue of the latest completed fiscal year	Budget and Control Board transfers to cover year-end operating deficit
Tennessee *Revenue Fluctuation Reserve*	By appropriation	By appropriation when state is in deficit
Texas* *Economic Stabilization Fund*	Transfer of 1/2 of any unencumbered general revenue fund balance at end of each biennium plus portions of oil and natural gas production tax collections	By appropriation with 2/3 vote of legislature
Utah *Budget Reserve Account*	General fund surplus up to 3%; account may not exceed 6% of the general fund appropriation for the fiscal year in which the surplus occurred	By appropriation to cover operating deficits
Vermont *Budget Stabilization Trust Fund*	Undesignated general fund surplus; fund is capped at 2% of general fund appropriations from most recently ended fiscal year	By the state treasurer to the extent necessary to offset a general fund deficit
Virginia *Revenue Reserve Fund*	By appropriation	Governor may transfer for revenue shortfall caused by economic conditions or by changes in federal tax legislation
Washington *Budget Stabilization Fund*	Pursuant to appropriation: (projected growth in real personal income minus 3%) X (previous fiscal year general state revenues)	By appropriation, with 60% vote required, when revenues fall below forecast, for labor force training, or for any purpose legislature determines would reduce unemployment caused by state's economic cycle
Wisconsin Budget Stabilization Fund	By appropriation	By appropriation
Wyoming *Budget Reserve Account*	Year-end surplus plus appropriations	By appropriation

*State Notes

Colorado — If economic conditions require expenditures from the fund, the governor must develop a plan that would maintain the reserve at no less than 2%. The plan is subject to legislative modification.

Kentucky — Conditions governing the use of the fund are attached to its appropriation every two years. At the end of the biennium, the fund lapses and has to be recreated. The state also has created in the general fund the Surplus Fund Account. No expenditures may be made from the account unless appropriated by the legislature, or unless required by the budget reduction provisions of a joint budget resolution.

Table 4 (cont.)
State Budget Stabilization Funds

State Notes *(cont.)*

Maryland	The Revenue Stabilization Account must be increased $5 million each year whenever balance is less than $100 million or 2% of general fund revenues.
Michigan	If state unemployment rate is between 8% and 11.9%, legislature may appropriate 2.5% of the fund balance for programs that will provide for increases in state employment. If rate is 12% or more, up to 5% may be so used.
Missouri	The General Assembly may appropriate to governor any portion of existing balance to cover budget shortfalls. Also, in any year in which governor finds it necessary to withhold appropriated funds, governor may order Commissioner of Administration to make transfers from fund to fulfill expenditures authorized by appropriation. However, such action must be approved by General Assembly, and hence can only occur if General Assembly is in session. Further, the General Assembly shall not appropriate moneys from the fund without authorization from the governor.
New York	Once borrowed, fund must be paid back within six years in three equal installments.
South Carolina	Funds withdrawn from the General Reserve Fund must be restored annually at a rate of not less than 1% of the general fund revenue of the latest completed fiscal year. The state also has a Capital Reserve Fund that receives money by appropriation. It is capped at 2% of general fund revenue of latest completed fiscal year. The Budget and Control Board transfers money from this fund to avoid mid-year budget reductions. After May 1 of a fiscal year, money in Capital Reserve Fund can be appropriated for other specified purposes with 2/3 vote of legislature.
Texas	The constitutional amendment creating the fund mandates the following revenue transfers to it: (1) 50% of any unencumbered general revenue fund balance at the end of each fiscal biennium; (2) an amount of general revenue equal to 75% of the amount by which oil production tax collections in any future fiscal year exceed oil production tax collections in fiscal year 1987; (3) an amount of general revenue equal to 75% of the amount by which natural gas production tax collections in any future fiscal year exceed oil production tax collections in the fiscal year 1987. (For purposes of calculating the transfer, natural gas tax collections would be adjusted to reflect 12 months of collections in each fiscal year.)

Source: National Conference of State Legislatures, *State Fiscal Letter,* March/April 1990. Reprinted with permission from the National Conference of State Legislatures.

Dist 8/05

A BRIEF OVERVIEW OF THE SPECIAL INVESTIGATIONS UNIT

Prepared for the Committee on Health, Social Services and Economic Security by Committee Staff

Chronology

First established in 1972 within the Department of Audit. Mr.Jack Parrish hired as first director.

In the late 1970s, transferred to DHS Legal Division.

Upon the recommendation of the head of the Legal Division, transferred to the Bureau of Income Maintenance, where it ran as a free-standing division.

In 1989, moved under the supervision of the Child Support Enforcement division (still within the Bureau of Income Maintenance). Mr. Parrish took advantage of early retirement option offered as part of budget reductions. A Child Support Enforcement supervisior from the Bangor regional office was temporarily assigned to Mr. Parrish's position.

As part of the budget for fiscal years 92 and 93, Legislature restored Mr. Parrish's position (which was lost when he took early retirement) and asked Restructuring Commission to examine special investigations function.

Background Information

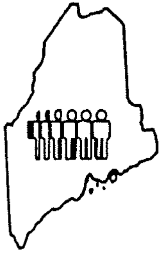
Throughout his tenure with the Unit, Mr. Parrish asserted that millions of dollars of undetected fraud could be recovered if the unit were independent, akin to the federal Inspector General's Office. Since his retirement, Mr. Parrish has been quoted extensively in the Kennebec Journal and other Maine newspapers in a series of articles alleging widespread unaddressed fraud in Maine's welfare programs.

During this year's appropriations process, the location of the Special Investigations Unit was debated, with some wanting it to remain within the Department of Human Services, some wanting it transferred to the Attorney General's Office and others advocating for a State Inspector General's office to be established.

The federal Inspector General's Office is currently reviewing Maine's welfare programs; the Department of Human Services has expressed confidence that the review will find Mr. Parrish's assertions to be false.

LHS2956

HHS



Maine Council of Community Mental Health Services

280 State Street, Augusta, Maine 04330 623-1525

September 20, 1991

Rosalyne Bernstein
Roland Caron
Members, Committee on Health, Social Services, and Economic Security

Comments on Interim Report:
Support for Principles and Findings,
Suggestions on Options

From: Frank Schiller, Executive Director

Speaking for Maine's network of community-based agencies which provide a broad range of mental health services and supports, the Maine Council applauds and welcomes your efforts to apply a clear set of strategic issues to the restructuring of our health, social services, and income maintenance programs. Your initial findings reflect and reinforce the perception that the organization and delivery of services often hinders and confuses effective efforts to respond to the multiple, wholistic needs of Maine people.

Both in terms of public accountability and in assured accessibility and availability of quality services, the principal of consumer orientation and empowerment is extremely important. Currently, services are more often organized and provided through divisions of historical bureaucracies and funding sources, rather than a more realistic and effective framework of multiple human needs.

Several years ago the mental health system initiated a plan to develop comprehensive community support systems for persons with mental illness. Over 125 federal and 50 state funding sources and programs were identified as instrumental in developing or reestablishing appropriate community supports for persons with severe mental illness and their families. The exercise of directing this gamut of resources to people's needs continues today. Consistent with your committee's initial findings and options, several changes would be beneficial to this process.

The role of government again needs to be clarified. The functions of public protection, coordination, the initiation of policy and programs which represent most effective models, and financial support are often compromised when the government itself also functions as a provider of services. Your attention to public-private partnerships, as well as to consumer orientation and technological enhancement reinforces our recommendation that much more extensive effort be made to privatize much of what is now directly carried out by state government. The state mental hospitals, which now absorb close to 80% of Maine's fiscal resources for mental health, are one example.

Your attention to gaps in the service system due to interagency responsibilities and lack of resources, as well as to barriers to access, reinforces our recommendation that regional planning and advocacy entities be organized with comprehensive authority and responsibilities, and not on the basis of narrow, categorical conditions such as age or diagnosis. As mental health service providers, we are glad to have the articulate and energetic efforts of consumers working for improved awareness of and responsiveness to the effects of mental illness. We are also aware of the range of social, vocational, educational, health, and other basic needs of consumers, and would welcome the potential for us to advocate for an improved mental health system in the context of comprehensive community support.

The current economic climate in Maine reinforces our attention to and awareness of the need for austerity and efficiency in the provision of basic services and supports for people in need. Also, the increasing growth and proliferation of governmental mandates and regulations contributes to a growing chasm between the costs and operations of services provided through private resources and those which are provided with state support. There is a growing distinction between services available for those with the resources to pay for their own, and those who must rely on public subsidies. The disincentives to public subsidy are becoming greater and greater. The licensing, contracting, reporting, auditing, planning, and quality assurance functions of publicly subsidized programs are, as your report notes, in dire need of consolidation and uniformity. We cannot afford to proliferate more costly administrative requirements.

Our experience with interdepartmental coordination reinforces the issues identified in your initial report. Often, these committees become forums for mid-level bureaucrats to generate policies and regulations which hinder as much as help a flexible and effective response to consumer needs. There is certainly a need for greater integration and coordination, but, unlike historical efforts, also a need for ongoing monitoring and direction to these efforts.

We are encouraged by the sensitive, realistic findings of your committee, and would be very happy to continue to provide input and assistance as you continue your work. Thank you.

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STATE OF MAINE
HEALTH POLICY ADVISORY COUNCIL

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Executive Director

MEMORANDUM

To: Special Commission on Governmental Restructuring, Committee on Health, Social Services and Economic Security

From: Ronald G. Thurston, Chair, Health Policy Advisory Council

Re: HPAC Future Configuration

Date: September 19, 1991

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The Health Policy Advisory Council has been examining the structure of advisory bodies in health in order to make recommendations on ways to increase effectiveness, efficiency and citizen participation. The following is a draft of some structural/programmatic recommendations to the Commission on Governmental Restructuring, developed at the last Health Policy Advisory Council meeting.

The recommendations describe an ideal structure for developing health policy. The term "Health Policy Board" refers to a citizen body that fulfills the key policy role. While the concept is based in part on existing bodies, it does not refer to any single specific existing advisory board. This concept could be further widened to encompass social services.

Recommendations regarding a health policy body:

1. **GOALS**
   The mandates of the health policy board shall emphasize consensus building, oversight responsibility, and institutional memory. They shall be framed in the context of establishment of health system policy goals, review of progress toward goals, and making recommendations regarding systems changes necessary to meet goals.

2. **STRUCTURE**
   Create a Health Policy Board with a matrix structure to provide intellectual continuity and coordination across advisory groups and problem areas, and over time. This ongoing body would consist of
   a. a <u>health policy board</u> to set overall priorities and coordinate and integrate the work of the panels, and
   b. two types of groups, replacing current advisory bodies:
      i. <u>standing panels</u> concerned with specific substantive areas or constituencies (children and families, elderly persons, persons with mental illnesses, health) and
      ii. <u>study panels</u> formed to carry out time limited studies of specific issues. These studies could be initiated and

funded by the policy board or standing panels (assuming a core budget), the legislature, or the executive branch.

3. **STAFFING**

Staffing of the policy board should be independent and non-partisan, to permit impartial policy development and oversight, and to bridge the executive and legislative branches. If separate staffing is not possible, the board should be staffed by a body that does not have program implementation responsibilities, such as the State Planning Office (Executive), the Office of Policy and Legal Analysis (Legislative Council), or jointly by these two offices (to balance executive and legislative influence). Notwithstanding the need for independent staff, joint staffing of study and standing panels with staff from agencies with substantive jurisdiction or legislative and executive department staff shall also be used as appropriate to speed coordination of policy and program activities.

Executive Director shall be appointed by the board, be accountable to and report to the board, and serve at the pleasure of the board.

4. **MEMBERSHIP**

Membership should be pragmatically designed to represent a mix of specific constituency slots and at-large positions. The make-up should be designed to ensure active involvement by all key sectors in health, including providers, consumers, payors, insurers and government policy makers, through membership on the policy board and standing and study panels. Emphasis should be on high level of members and commitment to broad interests of Maine citizens. Membership should be slotted, with appointments from nominated agencies/organizations with stake in outcome, e.g., consumers/low income/ providers/ educators/ ethicists/ Legislature.

5. **REGIONAL STRUCTURE**

Develop a regional structure to coordinate activities of various regional boards, building parallel relationships at regional and state levels.

The Health Policy Advisory Council is in the process of joining with the Maine Committee on Aging, the Maine Human Development Commission, and the Maine Commission on Mental Health in order to increase administrative efficiency and performance by sharing physical overhead and some support functions, in response to budget reductions. These groups have also discussed policy coordination, but no consensus has been reached on how best to increase coordination while protecting autonomy of some fundamentally different advocacy interests.

This proposal represents the Health Policy Advisory Council's recommendation on how to develop and coordinate policy processes that cut across a range of groups or needs but that share common themes. These proposals have been recently presented to staff of the other advisory bodies, but have not been discussed by the other councils. In future discussions, we hope to further develop these proposals jointly, particularly as they apply to advocacy and administrative functions that have not been addressed in detail here.