MAINE STATE LEGISLATURE

The following document is provided by the

LAW AND LEGISLATIVE DIGITAL LIBRARY

at the Maine State Law and Legislative Reference Library

http://legislature.maine.gov/lawlib

Reproduced from scanned originals with text recognition applied

(searchable text may contain some errors and/or omissions)

MAINE PUBLIC DOCUMENTS

1950-51

(in three volumes)

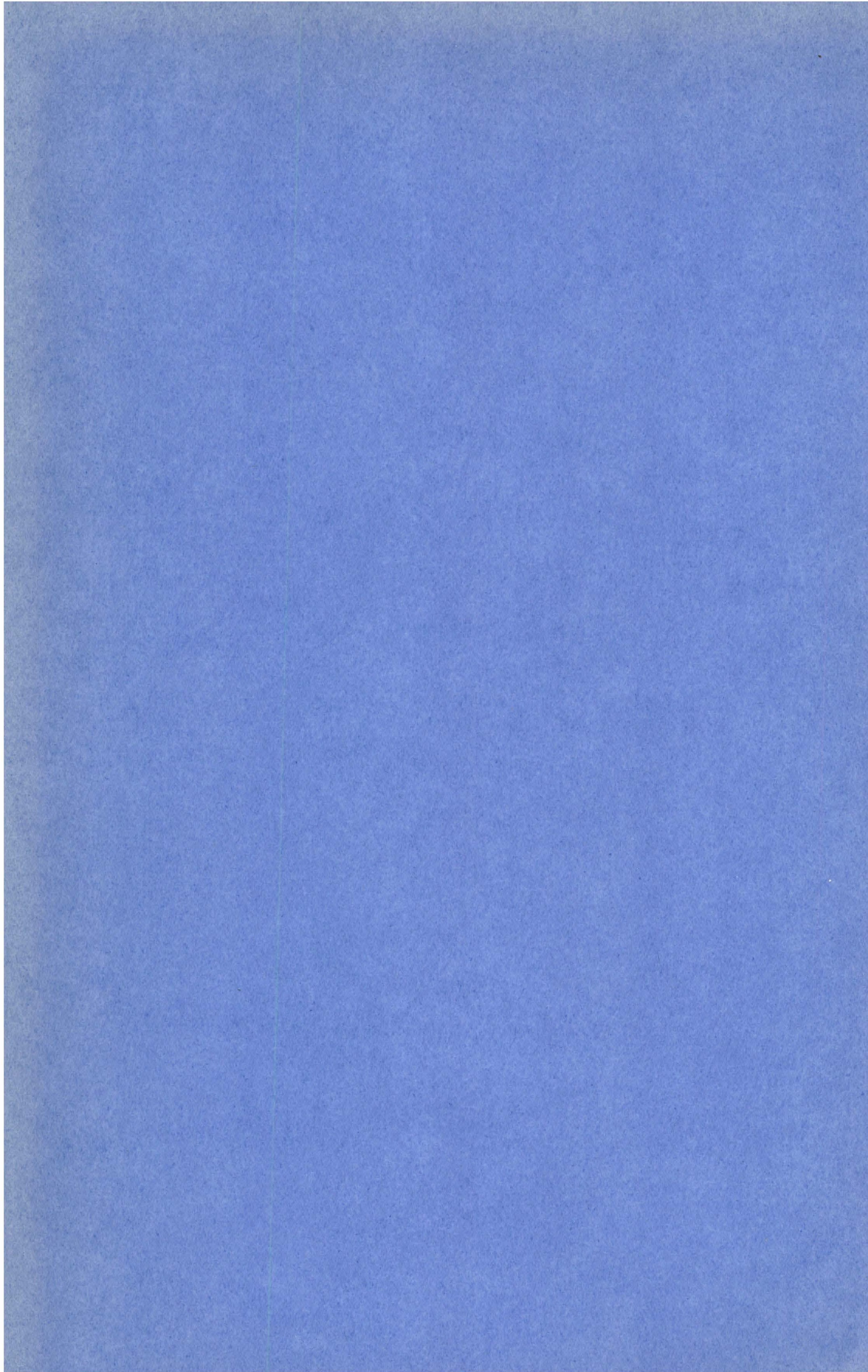
VOLUME II

20

MAINE STATE DEPARTMENT OF HEALTH AND WELFARE

BIENNIAL REPORT

1950-52



STATE OF MAINE

DEPARTMENT OF HEALTH AND WELFARE

DAVID H. STEVENS, COMMISSIONER

Advisory Council

Frederick T. Hill, M.D., Waterville

Mrs. Theodore B. Fobes, Cape Cottage

Leonard A. Pierce, Portland

James D. Ewing, Bangor

Mrs. Adelaide Owen, Milo

Mrs. Edward I. Gleszer, Bangor

David H. Stevens, Commissioner, Ex Officio

INDEX

	Page
Title and Advisory Council	1
Letter of Transmittal	3
Departmental Directory	4
Bureau of Administration	5
Bureau of Health	7
Diagnostic Laboratory	9
Division of Sanitary Engineering	13
Division of Maternal and Child Health (Including Services for Crippled Children)	17
Division of Mental Health	22
Division of Communicable Disease Control	25
Division of Hospital Services	28
Division of Dental Health	31
Division of Venereal Disease Control	34
Division of Tuberculosis Control	36
Division of Public Health Nursing	42
Division of Vital Statistics	49
Public Health Education Program	51
Bureau of Social Welfare	54
Division of Public Assistance	55
Division of Child Welfare	60
Division of Services for the Blind	63
Division of General Relief	66
Division of Licensing	70
Indian Affairs	73
Division of Legal Services	74

To His Excellency, The Governor
and the Honorable Council:

In accordance with statutory provision, I submit herewith the report of the Department of Health and Welfare for the biennium ending June 30, 1952.

Respectfully submitted,

DAVID H. STEVENS,

Commissioner

State of Maine

DEPARTMENT OF HEALTH AND WELFARE

State House **Augusta, Maine**

COMMISSIONER
DAVID H. STEVENS

Bureau of Social Welfare

- Commissioner Stevens, Acting Director
  - Division of Public Assistance
    - Old Age Assistance
    - Aid to Dependent Children
    - Aid to the Blind
  - Division of Child Welfare
  - Division of Services to the Blind
  - Division of General Relief
  - Division of Licensing
  - Indian Affairs

Bureau of Health

- Dean H. Fisher, M.D., Director
  - Division of Communicable Disease Control
  - Diagnostic Laboratory
  - Division of Tuberculosis Control
  - Division of Vital Statistics
  - Division of Mental Health
  - Division of Sanitary Engineering
  - Division of Maternal and Child Health and Crippled Children's Services
  - Division of Hospital Services
  - Division of Venereal Disease Control
  - Division of Public Health Nursing
  - Division of Dental Health

Bureau of Administration

- Edward I. Albling, Director
  - Division of Accounts and Audit
  - Division of Research and Statistics
  - Division of Business Management

Assistant Attorneys General assigned to the Department

- George C. West
- Roscoe J. Grover, Jr.

BUREAU OF ADMINISTRATION

Edward I. Albling, Director

Expenditures for Health and Welfare services, established by law for the fiscal years 1951 and 1952, amounted to $33.7 million. This was an increase of $5.7 million over the previous two fiscal years. Of this increase in total expenditures, the amount of $3.4 million was financed by Federal money. Over $4 million of this increase was accounted for by assistance given to the aged, and dependent children.

The increase in expenditure resulted in increased workload of the Bureau of Administration. Changes in procedure enabled the Bureau to perform the additional work without any increase in personnel.

Some of the changes in the execution of the functions of the Department during the past biennium were:

1) Reproducing forms, pamphlets, and informational material by multilith process rather than mimeograph. This has resulted in greater versatility and savings in reproduction costs.
2) Greater use of individual cost records of individuals receiving general relief. The Bureau's cost cards were used primarily for checking for duplication in payment. By making these records accessible to the Division of General Relief, the same records are used to a greater degree by the Division of General Relief for checking reasonableness of relief grants to individuals. By the reassignment of duties among other personnel in the Bureau, the replacement of a person who retired was not made.
3) Use of new dictating equipment has resulted in expediting the recording of case records and correspondence as well as decreased costs in postage.
4) Microfilming of vital records submitted to the National Office of Vital Statistics has decreased cost and expedited this function. Formerly these records were copied manually. By using the microfilm process, one clerk has been eliminated.
5) The lack of filing space has been somewhat alleviated by the microfilming of records.
6) Through modification of the control records of the Department, the encumbrance system has been installed with no additional increase in personnel.
7) Health records, maintained for federal reporting, were simplified.
8) Separate rolls for new cases have been instituted, which enables

a person who has been determined eligible to receive a grant, to receive his check at an earlier date.

9) In order to obtain information quickly, a permanent sample of public assistance cases was established.

For the coming biennium, it would appear that space is the primary problem. The housing of the Department in four separate locations in Augusta forces costly makeshift arrangements. The crowded conditions of the Department's stockroom, and the crowding of personnel in too small quarters, are not conducive to maximum efficiency.

Another problem facing the Department is the replacement of office furniture. Most of the office furniture of the Department is over 20 years old. In addition, a great many of the items were transferred from other agencies of government. Much of this equipment should be replaced in the next biennium.

Continuing effort will be spent on analyzing procedures of the Department, especially in the Bureau of Health, to improve efficiency and provide savings in operating costs.

Following are two tables showing expenditures and source of funds for the fiscal years 1951 and 1952.

Expenditures by Fiscal Years 1951 and 1952

	1951	1952
Administration	$674,899.68	$725,851.42
Welfare Programs	15,223,576.32	15,237,227.90
Health Programs	870,516.54	904,011.30
Charitable Institutions	51,069.04	62,951.53
Total	$16,820,061.58	$16,930,042.15

Expenditures by Source of Funds

Fiscal Years 1951 and 1952

	1951	1952
State Appropriation	8,065,516.75	8,127,310.49
Town Funds	491,495.22	554,128.27
Fees and Misc. Revenues	186,719.90	235,978.93
Federal Funds	8,076,329.71	8,012,624.46
Total	$16,820,061.58	$16,930,042.15

BUREAU OF HEALTH

Dean Fisher, M.D., Director

By and large, the activities of the Bureau of Health are adequately presented in the various division reports. However, it should be remembered that a large portion of the actual work indicated in the various summaries has been done by the members of the staffs of the district offices, and it is they who act in day-to-day contact with the people of the State and translate plans into accomplishments. Furthermore, improvements in general health levels do not result from the efforts of any one agency, but represent the cumulative benefits from a multitude of social and economic forces, and the work of almost innumerable interested individuals, agencies and committees. The medical, hospital and allied professions have made their own great, direct or indirect contribution.

The Bureau, with the shortage of personnel common to all such agencies, has made continuous efforts through a variety of studies and trials to utilize its facilities for the maximum benefit of the State. Reviewing the various individual reports with the relatively constant budget and staff in mind, increased efficiencies of operation are apparent.

A concerted effort has been made to increase participation by both organized and unorganized groups in the Bureau's planning and operations for it was felt that through this means increased interest and assistance could be secured, and the programs would more nearly respond to existing needs. Essentially this has meant increasing emphasis on health education, a method of approach which has amply demonstrated its effectiveness. It is in this field that the Bureau is most anxious to develop the means for expansion.

No justification can be seen for curtailing any programs, and general conditions suggest that several should be strengthened.

An important activity has been the continued administration of the hospital construction program made possible by Federal grants of funds. Under this program, the Department and the Hospital Advisory Council have been able to assist communities in Maine to complete during the biennium the construction of enlarged or new general hospitals costing over $5,000,000. In addition, it has been possible to assist other communities with the development of plans for future construction.

It is felt that through this construction and the hospital licensing law, the Department has been able to make a great contribution to improving the physical facilities for medical care.

As a final word of introduction to the individual reports, it is appropriate to express for the Bureau its appreciation of the cooperation received from other State departments, for the assistance received from other divisions in this Department, and for the friendly spirit of the U. S. Public Health Service and other agencies with whom working relationships are maintained. A particular word of appreciation should go to the many committees, advisory councils, local health officers and community groups who have assisted with or helped guide the work, and to the medical and allied professions, without whose participation and cooperation many of the programs would not be possible.

DIAGNOSTIC LABORATORY

Arch H. Morrell, M.D., Director

Over the biennium, services provided by the Diagnostic Laboratory for physicians, hospitals, and individuals throughout the State have kept at a steady pace. The major part of the work of this Division consists of diagnostic work for physicians, public health work, and tests for indigent cases.

The total number of tests performed during the fiscal year 1951-52 shows a slight increase over the previous year, indicating only the normal fluctuations which are to be expected.

The following table points up some of the more important of these fluctuations which, broadly interpreted, would appear to demonstrate a general improvement in quantity and quality of medical care for the people of Maine, as individual physician and hospital services each make their distinctive contributions to this end.

Test	1951	1952
T. B. Cultures	5371	3919
Guinea Pig Inoculation	324	440
Sputum for Tuberculosis	454	188
Papanicolaou Smears	5	26
Hintons	7201	13461
Kahns	7239	13484
V. D. R. L.	74585	67978
Bloods for Typing	2792	2366
Heterophile Antibodies	384	536

To comment but briefly on some of the above items, it should be stated generally that the diagnostic laboratory work, i.e., cultures, blood chemistries and other tests of this nature have been maintained at their usual level. Specifically, it is felt that the training in malaria diagnosis from blood smears which was given to members of the Division staff at the Communicable Disease Center in Georgia during the biennium has proved to be of great value for the men returning from service.

In serology, the volume of both Hinton and Kahn tests has increased nearly 100 per cent over the previous year, whereas the V.D.R.L. tests —a screening technique developed by the Venereal Disease Research Laboratory of the Public Health Service as a test for venereal diseases —have decreased in volume, indicating again, it is believed, an improvement in the general picture of medical care and follow up for those needing this service. A marked decrease in the volume of specimens previously sent in by the armed forces accounts as well for some of this decrease, it is felt.

The volume of bloods submitted to the laboratory for typing has also decreased over the past two years. This can be explained by the fact that the individual towns are not now asking for a sponsored program whereby their townspeople may be typed in anticipation of possible emergency. However, requests from individual physicians over the State have increased perceptibly during this same period.

DIAGNOSTIC LABORATORY

		1951-1952
I.	Venereal disease tests:	
	Bloods for syphilis—	
	Hinton	13461
	V. D. R. L.	67978
	Kahn	13484
	Kolmer	327
	Quantitative Kahn	1348
	Spinal fluid examinations	361
	Examinations for gonorrhea	1883
II.	Intestinal tract disease tests—	
	Cultures for typhoid and dysentery	1361
	Blood tests for typhoid	2550
	Examinations for parasites	160
III.	Respiratory tract disease tests—	
	Diphtheria	272
	Tuberculosis—	
	Guinea Pigs inoculated	440
	Guinea Pigs autopsied	442
	T. B. Cultures	3919
	Sputum (unsatisfactory for culture)	188
	Feces for Tuberculosis	19
	Streptococcal	644
IV.	Special blood tests—	
	Cultures	81
	Heterophile Antibody	536
	Rh	13663
	Typing	2366
	Chemistry	2181
V.	Miscellaneous	864
VI.	Tissue specimens	1747
	Papanicolaou Smears	26
		130301

CANCER CONTROL PROGRAM

Primarily, the work done in conjunction with this Program, which is carried on for Maine as an activity of the Division of Diagnostic Laboratory Services, has centered about the following:

Service to clinics: The program continues to participate in tumor clinic service through payment to hospitals on bills submitted for Papanicolaou stain or cellular material on medically indigent ward or clinic patients.

State Laboratory tests on Papanicolaou smears submitted from the physicians in the State have been small in volume, as pointed up in the preceding table. Since the first smear was received at the Laboratory in January, 1951, however, a steady increase in volume has been noted, indicating that the physicians are more and more employing this procedure.

Hospital aid: Payment on medically indigent patients who are hospitalized with a diagnosis of cancer to hospitals eligible for this aid on a per diem basis, continues as a part of the Hospital Services program.

Nursing services: Follow-up of terminal cancer patients in 232 bedside nursing visits were made by the staff of the Public Health Nursing Division during the second year of the biennium. The entire nursing staff participates in a cancer prevention program on a year-round basis, in addition to giving care in terminal cases, as part of a continuing generalized nursing program.

Professional and other education: Under the Program, free annual subscriptions to The Cancer Bulletin were provided all physicians in the State for 1950-51; for 1951-52, on a limited basis (only to physicians specifically requesting this service). The revised edition of Cancer—A Manual for Practitioners published by the Massachusetts Division of the American Cancer Society has also been supplied all physicians in the State. Cancer studies released intermittently by the Public Health Service are sent routinely to members of the Cancer Committee, Maine Medical Association.

Demands for professional and lay films on cancer continue to be heavy. During the biennium there were approximately 75 cancer film requests met through the Department's Film Library with an estimated total viewing audience of 5,848 persons. Medical societies, schools of nursing, Health Councils, Parent Teacher Associations, hospitals and allied professional and lay groups comprise the bulk of the borrowers.

The Program supplies on a continuing basis varied types of free educational materials on cancer, chiefly of a professional nature. Over 7,500 such pieces were sent out during the biennium.

During the past year, staff members of the Public Health Nursing Division from each District participated in 4 Cancer Nursing Institutes sponsored by the Maine Cancer Society and held in Presque Isle, Bangor, Portland and Lewiston.

A meeting of a representation from the Department with the Cancer Committee of the Maine Medical Association and the Maine Cancer Society, held at Thayer Hospital in April of 1952, offered opportunity for a review of the cancer activities carried on by each of these organizations and laid the ground work for an over-all program of more closely integrated activity for the future.

The Program continues to provide consultative service and assistance in promoting special programs, in conjunction with the pathologists of the State; hospital and medical staffs; medical societies and allied groups.

As general comment, and in conclusion, it should be stated here that the Laboratory is at the present time carrying the peak load of work allowed by its limited personnel. It is recognized in this respect that the complexities of obtaining trained technicians, which exist not alone for Maine but throughout the New England region, present an increasing problem in light of public demand for the services of this Division. Such limitation of personnel not only prevents the fuller development of desirable services but what is perhaps more serious, that staff training necessary to putting into operation the various new techniques and scientific developments requisite to a totally modern, constructive program.

DIVISION OF SANITARY ENGINEERING

E. W. Campbell, Dr. P.H., Director

A new duty was acquired by the Division of Sanitary Engineering during this biennium; namely, the enforcement of rules and regulations made by the Department of Health and Welfare for the use of fluorides in public water supplies. This was brought about by Chapter 131, Public Laws of 1951, an amendment to Chapter 22, Revised Statutes of 1944. The law and rules and regulations adopted for its operation became effective August 20, 1951. During the second half of the biennium, the Town of Norway with technical assistance supplied by the Division of Sanitary Engineering became the pioneer in the State of Maine in the introduction of fluorides to its water supply. At the close of the biennium, practically all arrangements had been made and necessary equipment purchased but operation had not actually started.

Through the coordinated efforts of the State Department of Health and Welfare, Division of Sanitary Engineering and the Sanitary Water Board, in collaboration with the State Department of Agriculture and Sea and Shore Fisheries a "Report on Water Pollution in the State of Maine—1950" was published in the first half of the biennium. Two thousand copies were printed at a cost of $3,000 made possible by an allotment of Federal funds for stream pollution activities. The bulletin presented to the people of the State and other interested parties a summary of stream and coastal studies carried on in preceding years. As of June 30, 1952, a total of 1,102 copies have been distributed largely by request of interested individuals and groups.

In the early part of this biennium, a complete sanitary survey was made of the village of Stratton including the designing of plans for a sewerage system and disposal plant. Two engineers, one employed by the Sanitary Water Board and the other by the Division conducted the field survey under the supervision of the Division Director. The total cost of the survey was $1,490.04 of which $859.76 was supplied by the Sanitary Water Board and $628.38 by the Central Maine Power Company, Augusta, Maine.

Stream pollution activities for the last half of this biennium included the testing of many river and stream waters in order to provide essential data to be used in the future classification of all state waters. For the first time, tests were conducted during the winter months to determine water conditions under extreme low temperatures. These tests also provided vital information regarding hazards to be encountered in

the collection and testing of water samples during the winter months by mobile laboratories.

In order to present more complete data on coastal pollution, a survey of sewer outfalls discharging to tidal waters was initiated at the beginning of this biennium. As of June 30, 1952, nearly 98% of the entire coastline of Maine had been surveyed. A chemist and engineer employed by the Sanitary Water Board together with 2 engineers and 1 chemist employed by the State Department of Health and Welfare were engaged in this survey.

The requirement of testing semi-public supplies such as those from isolated hotels, lodging places, recreational camps and similar sources together with samples sent from private water supplies resulted in the submission of 17,779 samples for both bacteriological and chemical analysis.

The program for testing of water from public water supplies resulted in the submission of 8,830 samples for both bacteriological and chemical analysis during the biennium.

The average cost of water analyses for the last half of the biennium was estimated at $1.40 per bacteriological sample, $3.89 per gallon sample and $5.21 for each case of four bacteriological samples.

A publication entitled "Private Water Supplies" was prepared and published for distribution to those interested in providing for themselves or other parties an adequate and safe water supply.

The examination of horse saliva and urine for the State Racing Commission increased substantially during the biennium and resulted in the testing of 1,872 samples.

Cosmetics submitted for registration showed an increase of 539 samples over the number received for examination during the previous biennium. An increase of 3,197 was also noted in the total number of cosmetic and electrical apparatus certificates issued.

Two additional personnel were assigned to the Division's regular staff by the U.S.P.H.S. during this biennium. Both sanitarians were assigned to Rodent and Insect Control and Refuse Disposal, although one worked mostly in collaboration with the Maine State Forestry Department, Entomology Section. Their duties were to make known to local health departments and other municipal officials the availability of consultive service in their field and to lay the ground work for future activities. During the biennium, rat infestation surveys were made in 23 municipal-

ities during which 141 buildings and 35 dumps were checked for evidence of infestation, also six state institutions, 11 armories, 1 naval station and 2 housing authority developments. Survey of the refuse handling practices of 211 cities and towns having a combined population of 763,844 was accomplished during the last half of this biennium.

Inspections of eating and lodging places, recreational, overnight and trailer camps showed a slight decrease of 622 over those made during the previous biennium resulting in a total of 28,785. The cost of inspection of such establishments for the biennium was estimated at $4.96 where inspection alone was involved, but where the establishment had its own water supply there was an additional cost of the water analysis making a total for such establishments of $8.85 for the services provided by the Division. During the previous biennium cost of inspection without a water supply was $6.10 and those having private water supplies $9.10.

During the biennium, the Industrial Health Section has made 594 visits to 298 manufacturing plants employing 70,334 workers. Four hundred and thirteen recommendations have been made for elimination of health hazards affecting 4,543 persons. Compliance has been secured with 176 recommendations involving 3,782 workers. Recommendations for sanitary improvements have been complied with affecting 32,601 workers. Three hundred and fifty field determinations have been made for poisonous or detrimental substances.

Special emphasis has been placed on investigation and control of exposures to radioactivity, carbon monoxide, silica-bearing dust, mercury, and solvents such as benzol and carbon tetrachloride. During the last of the biennium, a state-wide survey of radium hazards relating to shoe X-ray machines was begun. Arrangements were also made to conduct a noise study in cooperation with scientists of the Liberty Mutual Insurance Company. It is anticipated that these projects will be continued into the next biennium.

During the past year, the activities of the District Sanitary Engineers have been included in the monthly summaries of the Division activities and likewise for the annual summary.

The following table summarizes all the Division activities for the past two years.

Activities of the District Sanitary Engineers
July 1, 1950 to June 30, 1952

	Districts						
	No. 1	Nos. 2-3	No. 4	No. 5	No. 6	*Gower	Totals
Addresses or Lectures, Public			1	4	4		9
Chlorinators Installed	1	6	10	9	9		35
Conferences	2	5	119	33	232	6	397
Inspections:							
Beaches & Pools, Swimming				11	3		14
Camps, Boys' & Girls'	232	25	4	6			267
Cross-Connections (Mills)	28	231	47	33	10		349
Federal Housing Adm.		43	12	15	9	232	311
Federal Watering Points	9	20	32	31	4		96
Hospitals	7	1	39	25	35		107
Springs, Commercial	9	27		25	29		90
Veterans' Housing	3	30	3	11		130	177
Other Inspections	431	503	152	1410	571	25	3092
Investigations	20	181	27	66	197		491
Days							
Office	53½	109	225½	74½	72½	149¼	684¼

*Inspector employed by Plumbers' Examining Board assigned to inspection of F.H.A. and V.A. private sewage disposal systems.

July 1, 1950-June 30, 1952

Water samples submitted from Public Water Supplies	8,830
Water samples submitted from Private Water Supplies	17,779
Specimens submitted for special and toxicological analyses	8,282
Total samples tested	34,891

Conferences	405
Cosmetic Samples Received	3,993
Cosmetic Working Samples Received	0
Electrical Equipment Received	16
Cosmetic and Electrical Equipment Certificates Issued	21,778
Court Cases	15
Cross Connections Inspected by State	490
Cross Connections Inspected by Company	1,884
Cross Connections Inspected by Owner	2,728
*Eating and Lodging Place Inspections	28,785
Eating and Lodging Place Licenses Issued	18,874
Schools, Food Handlers	0
†Inspections, Special and Routine	5,629
Investigations	569
Bedding, Books of stamps issued	1,846
Bedding, Registrations Issued	121
Bedding, Retail Places Inspected	725
Bedding, Manufacturing Plants Inspected	8
Bedding, Pieces of Bedding Analysed	1
Plumbing, Applications Received	11,920
Plumbing Permits Received	12,280
Plumbing Certificates of Inspection Received	12,444
Plumbing Codes Sent	517
School Plumbing Plans Approved	127
School Plumbing Plants Submitted	167
Prophylactic Inspections	602
Prophylactic Investigations	0
Prophylactic Licenses Issued	602
Public Addresses	11

*Includes inspections of boys' and girls' and family recreational camps.

†Includes inspections of swimming beaches and pools, cross-connections (Mills), federal watering points, hospitals and commercial springs.

DIVISION OF MATERNAL AND CHILD HEALTH

(Including Services for Crippled Children)

Ella Langer, M.D., Director

In Maine, the divisions of Maternal and Child Health and Crippled Children's Services are combined in one organizational unit under the direction of a single program director. Although separate budgets and records are maintained by each, organizationally and administratively the programs are integrated as closely as possible. Broadly speaking, the program's objective is to help secure and maintain optimum health for mothers and children. Under the program, preventive health work, diagnostic services for children, school health service, the care of sick children, and corrections of defects are provided.

Specifically, the Maternal and Child Health program is charged with the planning, promoting and coordinating of Maternal and Child Health Services, and the administration of this unit and its staff as outlined in the State Plan. Likewise, the Services for Crippled Children, charged with the responsibility of planning, promoting and coordinating a program of services for crippled children in the field of health, and the administration of this unit and its staff as provided under the State Plan.

Maternal and Child Health

Over the biennium, it is believed that steady advances can be claimed for this program as reflected in the following summary:

In the years 1950 and 1951, the maternal death rates were maintained at the low level of less than 1 per cent. Infant death rates decreased during the two year period. During 1951, the number of live births decreased slightly.

	Live Births	Infant Deaths	Infant Death Rate per 1,000 Live Births	Puerperal Deaths	Puerperal Death Rates per 1,000 Live Births
1950	21,239	663	31.2	12	0.6
1951	21,143	604	28.6 (provisional)	18	0.8

Statistics on premature births and deaths have been completed for the period of January to July, 1951. These statistics show that 7 per cent of all live births reported during this period were prematurely born infants (birth weight of 5 lbs. and 8 oz. or less). The death rate for these premature infants is 18.67 per cent as compared to 2.86 per cent for all infant deaths. These figures, it is believed, well demonstrate the need for an extensive premature care program within the State and plans are currently being made for such program on a state wide basis. Through the cooperation of the physicians, hospitals, and maternity

homes, it is hoped that it will soon be possible to reduce the present premature death rate and that concerted emphasis on early prenatal care may lead to a marked reduction in the number of premature births.

The Child Health activities of the Division have increased in scope during the biennium. The number of Child Health Conferences has increased as has the number of regular monthly conferences; irregular conferences (annual or semiannual) have, however, decreased. In all, more than 1,000 State Child Health Conferences were conducted each year of the biennium. Immunization services have also shown substantial increase over the two year period.

Diagnostic clinics have been held monthly in Bangor and Waterville and every two months in Presque Isle. These clinics are conducted by pediatricians with nutrition, medical social and public health nursing services available. Follow-up care is also provided by the Services. The following table shows the number of clinics and attendances:

	1951	1952
Number of Clinics	28	30
Attendance	248	317

38 patients were hospitalized with a total of 397 hospital days.

The Demonstration Rural School Health Program which was started in Washington County in April, 1947 and developed in conjunction with the Department of Education, has now been in operation for five years. As a demonstration program, it has been conducted with federal funds only. Through allotment of funds for 1953, the Program has been extended for the next fiscal year. The demonstration area covers a coastal school union of nine towns. Program objectives are: to determine health needs and provide corrective services when needed; to develop community interest and participation in a local program. For the school year 1952-53, the communities in the area involved have voted through town meetings to participate in the costs of the program. The Divisions of Maternal and Child Health and Dental Health and Public Health Nursing are all working in close cooperation with the Department of Education in the administration of this program. The following summary shows a more detailed analysis of the program activities:

	1950-51	1951-52
Cases examined	230	260
Medical follow-up care	110	110
Nutrition	35	24
Tonsillectomies	16	24
Glasses Supplied	45	53

In July, 1951, 114 received prophylactic sodium fluoride treatment.

Additional activities for the Division include: a yearly pediatric institute for general practitioners, co-sponsored by the Maine Medical Association; a program of field training in Maternal and Child Health activities for graduate students in conjunction with the Harvard School of Public Health.

In June of 1952, a Pediatric Section of the Maine Medical Association was formed, with the Director of the Division of Maternal and Child Health and Crippled Children's Services acting as secretary.

Crippled Children's Services

Services for Crippled Children provide medical guidance and treatment for children who are crippled or who suffer from conditions which lead to crippling or physical handicapping. Under the program, medical and after-care services for the physical restoration and social adjustment of crippled children are provided on a state wide basis for children under 21 years of age. At present, over 4,000 crippled children are listed on the state register as active cases. Since the beginning of the program in 1936, approximately 6,000 cases have been removed for such reasons as age limitation, removal from the State, or cure. Currently included are cases suffering from rheumatic fever, and congenital heart disease, and cases with impaired hearing.

Clinic Services—At the present time, ten clinic centers, located at Portland, Lewiston, Rumford, Waterville, Bangor, Rockland, Machias, Presque Isle, Houlton, and Fort Kent, are providing easily accessible clinic service for physically handicapped children in the six health districts. The following table shows the volume of the service:

	1951	1952
Number of Clinics	65	60
Attendance	1,763	1,747

In the fiscal year 1951, hospital care was provided for a period of 7,461 days for 341 patients, thus averaging 22 days per patient. In 1952, there were 7,030 days care for 334 patients with average stay of 21 days. Appliances were provided for 130 patients in 1951; 90 patients in 1952.

Included in the Crippled Children's Services is a program for children with rheumatic fever and congenital heart disease. Two clinic centers are operating at present in this respect—one in Portland, and one in Bangor. The Portland clinic is conducted weekly; the Bangor clinic operates on a monthly basis. Both clinics offer the services of pediatricians and cardiologists for diagnosis; provide for necessary laboratory

or diagnostic tests, and for hospitalization or convalescent care when needed. Following is the summary of activities for the two clinic centers over the biennium:

	1951	1952
Number of clinics	63	62
Attendance	815	767

In 1951, hospital care for cardiac patients was provided for a period of 801 days for 49 patients, with an average stay per case of 16.3 days. In 1952, hospital care was provided 45 patients for a period of 949 days, or an average stay of 21 days.

In order to prevent recurrences of rheumatic fever attacks, a program has been continued for keeping carefully selected cases on prophylactic medication.

A Hard of Hearing Program covering Waterville and the surrounding area is also included in the Services for Crippled Children.

	1951	1952
Number of clinics	4	4
Attendance	60	60

In 1951, hospital care for cases with impaired hearing was provided for 12 patients—days of hospitalization, 26; in 1952, 11 patients—days of hospitalization, 33.

Speech Services—A full-time speech therapist is included on the staff of Crippled Children's Services. In 1951, 105 speech clinics, with an attendance of 560 in toto, were conducted for 193 patients; in 1952, 93 speech clinics, total attendance 557, were conducted for 204 patients.

Medical Social Services—In 1951, the staff included 2 medical social workers; at the present time, one. Activities for this program over the biennium may be summarized as follows: 1951 (for both Maternal and Child Health and Crippled Children's Services) 51 clinics, including pediatric, orthopedic, hard of hearing, cardiac and school health, were attended. 1,773 cases received this service. In 1952, due to the resignation of the senior medical social consultant on the staff, there was a slight decline in this service.

Nutrition Services—Consultative nutrition service is another of the services offered in the Division program. At the present time the staff included a nutrition consultant, and a nutritionist. Among the major activities of this service for the biennium were the following:

	1951	1952
Clinic interviews	435	518
Conferences attended	12	13
Talks to lay groups	27	12
Talks to Professional groups	5	9
Talks to teachers	3	2
Talks to State staff	5	3
Hospital staff consultations	6	12
Others	1	4

Teaching materials developed by the Nutrition Consultant numbered 14 for the biennium and include pamphlets, charts, special diet lists and food charts, posters, conference check sheets, and diet and mass feeding manuals.

Consultation service to the Bureau of Social Welfare of the Department, as well as for other departments of State service, is provided by professional staff of the Division. Cooperation with voluntary health agencies, such as the Pine Tree Society for Crippled Children and Adults, Inc., and the National Foundation of Infantile Paralysis, is also maintained. In respect to this last, a yearly Polio Preparedness Meeting is called in some central area by the Director of Maternal and Child Health and Crippled Children's Services who serves as chairman to prepare early plans for meeting any needs which may arise in the event of outbreaks of poliomyelitis within the State.

For the future, Division plans include a new Crippled Children's Clinic center for Augusta, in August of 1952. Expansion of the Hard of Hearing Program is also planned for the next biennial period. Current plans anticipate, as well, the team approach to cleft palate cases involving evaluation and program of patient care on an individual basis.

DIVISION OF MENTAL HEALTH

Margaret R. Simpson, M.D., Director

Requests for psychiatric services for children and adults have continued to increase during the past two years. The Division has been able to supply these services, although all clinics now have a long waiting list. Community interest in the mental health field continues to be high. Several cities are interested in setting up their own clinics if psychiatric personnel can be obtained. A representative from the National Association for Mental Health came to the State in June 1952 for the purpose of meeting with community groups and laying the groundwork for a State Mental Hygiene Association.

Clinics: Mental Health Clinics for children and adults are held weekly in Portland, Lewiston and Augusta; monthly clinics in Waterville and Bangor. A traveling clinic covers other areas—Caribou, Houlton, Machias, Rockland, Rumford. These are all-purpose clinics. The Portland clinic has a staff of one part-time psychiatrist, one psychologist, one psychiatric social worker and one clerk. The Augusta office is staffed by one psychiatrist-director, one psychologist and one clerk-stenographer. About 35 per cent of clinic referrals come from schools; other sources of referral are physicians, families, social and welfare agencies and courts. Reasons for referral include: difficult and a social behavior, anxiety, speech problems, school placement and mental retardation. Intensive treatment is carried on at the weekly clinics. Playtherapy rooms are part of the clinic set-up in Portland and Lewiston. Group therapy with mothers and adolescents is carried on at the Portland clinic.

During 1950-1951 there were 234 clinics with a total of 1081 patient visits. An increase occurred in 1951-1952, with 327 clinics and a total of 1466 patient visits.

Summary of Activities	1950-1951	1951-1952
Number of New Cases	420	419
Number of Return Visits	654	1031
Number of Consultations	7	16
Total Number of Patient Visits	1081	1466
Number of Interviews and Conferences	626	740
Number of Playtherapy Sessions	320	251
Number of Group Therapy Sessions	80	46
Number of Psychological Tests Administered	957	1099
Number of Speeches and Lectures	105	70

Personnel: One team—psychiatrist, psychiatric social worker and psychologist and clerk—is stationed at the Portland Clinic on a full-time

basis. A director-psychiatrist and psychologist cover the rest of the State. The psychiatric social worker at the Portland Clinic was trained through funds received under the National Mental Health Act. A psychologist, also trained under this program, will be added to the Division's staff on July 1, 1952, and will be in the Lewiston Clinic area on a full-time basis. There is great need for two psychiatric social workers and another psychiatrist to complete three clinic teams. These would give fair coverage to the State.

Education: The Division takes an active part in teaching mental health principles through lectures to nurses, teachers, social workers, parents and other interested groups. In 1950-51 approximately 105 talks or lectures were given by the clinic personnel. This was decreased in 1951-52 to 70 because of an increase in the number of treatment cases being seen. Many requests for speakers had to be refused because of lack of personnel.

A film library is being built up and ten films are now available. The Division distributes twenty-five different pamphlets to individuals and organizations in the State in order to further the understanding of mental health principles.

A good portion of the psychiatric social worker's time has been devoted to community contact in relation to dissemination of information regarding the clinic program and mental health. The worker has had frequent conferences with other workers in the Health and Welfare Department—Public Health nurses, Child Welfare and Public Assistance workers, Services for the Blind workers, etc.

The Portland office has had frequent visitors—teachers, nurses and others who wish information about the State program. During the past year student nurses from Colby College attended the group therapy meetings for several weeks. Foreign exchange students and foreign social worker observers had several conferences at the clinic. Nurses from the Maine General Hospital attended discussion sessions in connection with their course in public health activities in Portland.

In November 1950 a two-day Mental Health Institute for Nurses was held in Portland and Bangor, with excellent attendance. The Mental Health Nursing Consultant and the Consultant in Clinical Psychology from the United States Public Health Service, Region I, participated and helped make the Institute a most successful one. The Division has received much assistance from all members of the Region I team, and their advice and help is greatly appreciated.

A Mental Health Institute for elementary teachers was held for one day in Bangor on April 28, 1952. This was well attended and was the first teacher institute sponsored by the Division.

A staff casework conference program was worked out between the Division and the Sweetser Children's Home in Saco. This home is a study home for emotionally disturbed children, and a number of this Division's clinic patients have received treatment there. These conferences are held bi-monthly, one presentation being at the Sweetser Home and the other at the Division's office in Portland. Purposes of the meetings include community and staff education, discussion of successes and failures in treatment of individual cases, future treatment planning, etc. Those attending include the clinic staff, professional and non-professional Sweetser Home staff, invited interested lay persons such as teachers, judges, physicians, social workers, ministers and health officers. These meetings have been most enlightening to the non-professional people in understanding treatment concepts, dynamics and understanding of children.

The psychologists of the Division attended the Orthopsychiatric Association annual meeting in Atlantic City. One of the psychologists attended a two-weeks' course in Rorschach technique.

The need for greater clinic services has become very apparent. More disturbed children are being seen and more treatment facilities are needed. This can be achieved only through increased staff. The Division's aim is to have three full clinic teams for the State in order to meet more adequately the needs of the people at the present time.

DIVISION OF COMMUNICABLE DISEASE CONTROL

Margaret H. Oakes, Assistant to the Director

During the last biennium the Division of Communicable Disease Control has received, and processed into its permanent files, reports of 41,527 cases of communicable disease. This procedure involves tabulations, recording, and the preparation of various statistical reports, as well as all correspondence necessary to the completeness and accuracy of the records.

In addition, the Division has cooperated with the district health officers in epidemiological study of 495 individual cases and their contacts, some scattered and others occurring in outbreaks, many of them requiring repeated referrals, reports and study of laboratory examinations. The Division serves as a center for these activities, and analyzes and records the information assembled from the field workers and the Diagnostic Laboratory.

One diphtheria outbreak involved seven non-immunized children, one of whom died, and two adults. Another diphtheria outbreak of seventeen adult females, one of whom died, occurred in a large institution. Laboratory tests on the cases and possible carriers in these two outbreaks ran into several hundred. The possible danger to those never protected against diphtheria—whether children never immunized or adults whose childhood antedated wide scale immunization—is well illustrated by these two outbreaks.

The 145 cases of poliomyelitis reported during the biennium occurred, as is usual in this part of the country, in the late summer and fall of the two biennial years. Study of the two outbreaks revealed the following facts:

	Cases	Rate per 100,000	Paralytic Cases	% Paralytic	Deaths	% Fatal
1950-51	91	10.0	61	67.0%	10	11.0%
1951-52	54	5.9	25	46.3%	3	5.6%

	Male Cases	Female Cases	Cases Under 15	% Under 15	Paralytic Cases Under 15	% of Total Paralytic
1950-51	47	46	55	60.4%	38	62.3%
1951-52	31	23	29	53.6%	17	68.0%

Special study was made of an outbreak of 40 cases of streptococcal nasopharyngitis (scarlet fever and streptococcal throat) in one town of 2400 population, mostly among school children. Infection took place directly from person to person.

Probable source was found for nine of the fourteen cases of undulant fever (brucellosis). Three were farmers with reacting cattle in their herds, who could have been infected by either contact or raw milk. The other six were users of raw milk from herds containing reactors. The Division of Animal Industry of the State Department of Agriculture cooperated in the investigation of all the undulant fever cases.

Three outbreaks of food poisoning and two of trichinosis were investigated. One of the food poisoning outbreaks involved 80 cases. Such outbreaks emphasize the need for constant care in preparing food, in public places or in the home.

Of the diseases which are particularly likely to be spread by faulty environmental sanitation or careless personal hygiene, five outbreaks involving 25 cases and many contacts occurred and were thoroughly studied. This was in addition to the investigation of 30 scattered cases, with their contacts.

Three of these five outbreaks involved bacillary dysentery cases in families. The other two outbreaks comprised one of five cases of typhoid fever, probably raw milk-borne but not so proved, and one of ten cases of paratyphoid B fever, milk-borne through contamination of raw milk by a carrier. Phage typing, a comparatively new laboratory procedure, gave scientific confirmation to the circumstantial evidence implicating this carrier. The use of pasteurized milk and cream would prevent outbreaks like these.

Five typhoid and two paratyphoid B carriers were found during the biennium, six females and one male. Four are "chronic" carriers—three discovered during investigation of cases caused by them and one referred from Canada. Three others are "convalescent" carriers following illness and may recover from their carrier state. Three chronic carriers were removed from the list during the biennium—two due to death; one due to removal out of State. The total number of carriers on the list as of June 30, 1952 was 71.

In addition to the regular semiannual visits to carriers by district health officers, a program was instituted during the biennium of determining the phage type of the organism harbored by each carrier, in case of future need of this information.

No changes in the rules and regulations for communicable disease control were made during the biennium except that those relating to psittacine birds were repealed in December, 1951, in conformity with the relaxation of the Federal restrictions on interstate shipment of these birds.

Besides its statistical and epidemiological activities, the Division has carried on its usual program of health education. An informational or educational article has been carried each week on the Communicable Disease Report, which is sent to all physicians, general hospitals and local health officers, as well as to many individuals interested in public health. In addition, a large amount of literature on communicable diseases and their control has been distributed.

It is felt that one of the most useful programs which the Division could carry on would be one of increased service to, and cooperation with, local health officers, who have the responsibility for communicable disease control in their own towns. To this end, plans have been made for a Manual for Local Health Officers, and much material for it assembled through interviews and correspondence. This Manual is designed to serve as a ready reference book on all problems which the health officer and others concerned with local health are likely to meet. Its preparation, in which the other Divisions will cooperate, is expected to be one of the important activities of the Division of Communicable Disease Control in the next biennium.

Reported Cases of Some Important Communicable Diseases
Biennial Periods 1950-52, 1948-50, 1940-42 and 1930-32

	1950-52	1948-50	1940-42	1930-32
Chickenpox	7,155	5,864	5,090	3,203
Diphtheria	37	36	45	370
Dysentery, Bacillary	13	5	1	1
Food Poisoning	107	60	—*	—*
German Measles	1,389	3,277	9,414	1,540
Hepatitis, Infectious	108	28	—*	—*
Influenza	9,742	2,647	4,670	1,959
Measles	13,439	13,717	10,392	12,830
Meningitis, Meningococcal	56	37	79	32
Mumps	3,602	7,425	8,115	2,677
Poliomyelitis	145	489	59	286
(*Paralytic*)	(86)	(286)	(39)	(207)
Streptococcal Nasopharyngitis	988	1,162	962	2,279
Typhoid and Paratyphoid Fevers	42	35	76	377
Undulant Fever	14	23	60	12
Whooping Cough	2,292	1,584	2,687	3,432

*Not reportable at that time.

DIVISION OF HOSPITAL SERVICES

Lillian Nash, R.N., Director

Three programs have been administered by this Division in the biennium ending June 30, 1952, as in the previous biennium. These programs include Hospital Licensing, State Hospital Aid, and Hospitalization on State Paid Programs.

Hospital Licensing

No changes have been made in the licensing law or in standards pursuant thereto in this period.

Number of licensed hospitals and related institutions in Maine with bed capacity: June 30, 1951, 269 Institutions—5,629 Beds. June 30, 1952, 281 Institutions—6,034 Beds.

As in the past biennium, official annual inspections have been routinely made by the District Health Officer and the District Sanitary Engineer from the Department of Health and Welfare. In these inspections, specific recommendations are made concerning physical features, environmental sanitation, heating, staffing, nursing care, and food service for meeting of minimum standards. Continued interest on the part of these institutions in the elimination of faulty plumbing has resulted in marked conformity with the State Plumbing Code, generally, it is believed.

Approximately twenty per cent of the licensed institutions use drinking water from a private supply. This necessitates an annual analysis by the Division of Sanitary Engineering of the Department. In full conformity with the licensing program, it is necessary to know the source and adequacy of the water supply, also that a potable supply is in use for drinking and culinary purposes in each of the institutions.

Fire inspections are made by the State Insurance Department and by municipal authorities where fire ordinances exist. The problems connected with fire safety have been paramount in the licensing program.

Fire safety clearance has continued to be a prerequisite for a license. It is noteworthy that improvement in fire safety is more evident each year, with more general cognizance of need to promote a maximum degree of safety to occupants of the institution.

In the past year all licensed institutions have been provided with a copy of "Development of Fire Emergency Programs" published by the American Hospital Association. This is a 63 page manual with valuable suggestions on the pattern to be followed in a fire emergency program.

Because of the nature of specific hazards associated with construction, equipment, electrical and electrostatic hazards, storage areas for combustible anesthetic agents, and all other potential hazards applicable to such institutions, hospitals are being reminded through periodic inspections specifically made by the State Insurance Department, of the need for vigilance in providing for the maximum degree of safety in this regard.

In the next biennium, it is believed that service in nutrition consultation should be continued and expanded in order to meet the needs of small hospitals and nursing homes for guidance in meal service and diet therapy.

A second service that would appear to strengthen the licensing program is that of a generalized nurse consultation service with an aim to promoting, through possible specialized consultants, better patient care, particularly in maternity and nursing homes. The objective of such programs should provide for periodic reviews and conferences on methods and standards of nursing care as they relate to inspections and surveys, and for the best use of all resources in this direction. The expert advice and counsel inherent in this service could provide, as well, an highly desirable educational function.

Hospitalization Procedure on State Paid Programs

State paid programs, which deal with individuals for whom the State is responsible in respect to the purchase of medical care, include the following groups:

Venereal Program
Committed Children
Dependent Poor Relief Child
Temporary Dependent Child
Blind-Vocational Rehabilitation
Passamaquoddy Indians
Penobscot Indians
General Relief (State)
Crippled Children Program
Rheumatic Fever Program
Hard of Hearing Program
Maternal and Child Health Program
School Health Programs
Blind-Medical Services

On July 1, 1951 the maximum all inclusive per diem ceiling rate was changed to $11.00 from $10.00 on these State programs. This rate is now paid to hospitals where medical service is provided without charge during hospitalization, if the average per diem cost of care is $11.00 or over, when a contract exists with the Department for acceptance of these individuals at an all inclusive per diem rate.

If medical service is not provided without charge, the maximum all inclusive per diem payment is $8.50.

State Hospital Aid

The 1951 Legislature made an annual appropriation of $1,000,000 for the fiscal year ending June 30, 1952, and $800,000 for the fiscal year

ending June 30, 1953. This represents an increase over the appropriation of $578,000 in the previous biennium.

During the last legislative session, the law governing the administration of State Hospital Aid was amended to include compensation to hospitals located in the State of New Hampshire within five miles of the Maine-New Hampshire border for hospital care of persons resident in the State of Maine. This shall also include such individuals as may be eligible for this form of assistance under the existing regulations. Under the provision of this statute, three hospitals,—namely, Frisbie Hospital in Rochester, the Wentworth Hospital, Dover, and the Portsmouth Hospital, Portsmouth, may participate in this program at the present time.

Rules and regulations governing the administration of State Hospital Aid were revised by the Department, and approved by the Advisory Council of Health and Welfare in December 1951.

The following summary indicates the extent to which this appropriation has been made available:

HOSPITAL AID

Financial Report

Fiscal Year: July 1, 1950 to June 30, 1951		Fiscal Year: July 1, 1951 to June 30, 1952	
Funds Available		**Funds Available**	
State appropriation	$578,000.00	State appropriation	$1,000,000.00
Refunds from hospitals	7,694.49	Refunds from hospitals	42,522.00
Total Available	$585,694.49	Total Available	$1,042,522.00
Expenditures		**Expenditures**	
Hospitals	585,685.25	Hospitals	$1,042,490.98
Unexpended Balance	9.24	Unexpended Balance	31.02
Patient rate per day paid all hospitals quarterly:		Patient rate per day paid all hospitals quarterly:	
Quarter ending Sept. 30, 1950	4.742	Quarter ending Sept. 30, 1951	8.277
Quarter ending Dec. 31, 1950	4.694	Quarter ending Dec. 31, 1951	7.805
Quarter ending Mar. 31, 1951	4.073	Quarter ending Mar. 31, 1952	7.739
Quarter ending June 30, 1951	4.341	Quarter ending June 30, 1952	7.721
Average rate for year	4.463	Average rate for year	7.885

SERVICE SUMMARY

Fiscal Year Ending June 30, 1951		Fiscal Year Ending June 30, 1952	
Participating Hospitals	55	Participating Hospitals	56
Total days allowed	125,493	Total days allowed	131,676
Total newborn days	6,721	Total newborn days	5,213
Cases paid by State	8,369	Cases paid by State	8,277
Average number days treatment per case	16	Average number days treatment per case	17

DIVISION OF DENTAL HEALTH

Alonzo H. Garcelon, D.D.S., Director

The program of the Division of Dental Health is one that is designed and based on long range objectives with the thought that if sufficient of the public, especially in the younger age group, are informed of things available today for the prevention of dental decay and the maintaining of the health of the gingival tissues and of the oral cavity, eventually the dental status of the public of Maine will be greatly improved.

In the field of dental health education, a program has been established and conducted for some years in the schools of the State. This program is conducted by registered dental hygienists who during the past two years taught dental health to 11,471 children in 60 towns within the State. As part of this teaching program 9,436 mouth examinations were made and reports sent home to the individual children's parents notifying them of the various dental needs observed.

Many teaching aids have been designed and are used routinely in these educational programs. Pamphlets describing the correct method of toothbrushing, preferred dentifrices, the value of the topical applications of sodium fluoride, and various classrooms exercises are also employed.

It has been routine to apply a 2 percent sodium fluoride solution to the teeth of selected children in each town as a measure for preventing dental decay. This procedure is set up on a graduated scale so that over a period of years each child in each of these towns will eventually have the advantage of fluorine applications. During the past two years 4,551 children have received these applications in the school health program.

During the period from July 1, 1950 to June 30, 1951, a U. S. Public Health Service Sodium Fluoride Demonstration Team operated in 74 cities and towns applying the fluorine applications to the teeth of school children, and a total of 7,960 children were treated by this group of three dental hygienists. This team is now reduced so that there is one dental hygienist still working under this program which is now a cooperative one between the Department of Health and Welfare and the U. S. Public Health Service.

Results from these efforts have been evaluated in communities in which the program has been repeated over a period of years, and there

is a definite improvement in the oral hygiene of the children of these towns in which the Department has operated.

The mobile dental unit has not been operated by the Department chiefly because of inability to obtain dentists to operate the trailer. It has been loaned, however, to the Maine Sea Coast Missionary Society for several months, and a good many of the people living on the islands off the coast where no dental care is available were treated.

A great deal of effort has been made in an attempt to encourage communities of the State to add fluorine to the public water supplies wherever possible, and it is encouraging to know that several towns are in the process of installing feeder units and are planning to take advantage of this method of reducing dental decay. It is hoped that in the next few years many communities in Maine will see the great advantage in this method of preventing dental decay and will take appropriate steps to make it available to their citizens.

Several towns have been urged to establish corrective clinic programs and also health education and topical application of sodium fluoride programs with some success. Local dentists in many communities have taken the lead in establishing these local clinic programs and dental health education programs.

In the adult education field many talks to groups including parents, teachers, in service and in training, service and civic clubs and women's organizations in the value of good dental health have been made by various members of the Division staff.

The Division staff have been responsible for the setting up of several clinics and have acted as consultants for several local programs.

In cooperation with the Maine Dental Society a fee schedule for all public programs to be conducted in the State has been established and is in the process of being adopted in order to standardize the various State corrective dental programs.

The Division staff has acted in consultation for the Vocational Rehabilitation program of the State Department of Education, and also with the various divisions of the Department of Health and Welfare.

The dental hygienist staff of the Division of Dental Health made 9436 mouth examinations in 60 different towns. 4551 sodium fluoride applications were completed. 11,471 children were taught in the classrooms.

The Maine Sodium Fluoride Demonstration Team consisting of three dental hygienists and a clerk, in operation from July 1, 1950 to June 30, 1951 reports as follows: 6820 sodium fluoride applications were completed; 1140 sodium fluoride applications were not completed. Total number of children treated by Sodium Fluoride Demonstration Team, 7960.

This represents work done by the Demonstration Team in 12 different demonstration areas embracing 74 cities and towns.

DIVISION OF VENEREAL DISEASE CONTROL

The venereal disease control program, with primary interest in syphilis, is based on the activities of early case finding, the provision of adequate therapy through financial assistance where necessary, and post-therapy follow-up. The program must also include the maintenance of the necessary records for individual patients and for determining changes in incidence or distribution of the venereal diseases.

Other Bureau divisions and other medical and social agencies or facilities have all contributed to the venereal disease control activity, and to the present favorable incidence rates of syphilis in particular. Incidence rates based on reported cases have many inaccuracies, but all of the indices tend to show that infection with syphilis is becoming less common. For example, of 29,604 premarital blood tests done in the biennium, only 0.45% were positive, and included in these few positives, there may have been some duplication and some not representing actual infection. As a mechanism for finding previously unknown cases of syphilis, the premarital blood test is becoming less important.

During the year 1950, with 21,239 births, 6,733 blood samples were submitted from pregnant mothers. Thus approximately 1/3 of the infants were given this protection, although undoubtedly many additional maternal blood samples went to hospital laboratories. Of those submitted to the State laboratory, less than 0.9% were positive.

As a further indication of present incidence and the availability of better drugs and medical services, only 7 congenital infections were reported during the biennium in infants of less than one year of age. The opportunity for sampling of the general population provided by mass blood typing activities likewise indicated low rates.

The creation of defense areas and the disruptions associated with semi-mobilization have not yet been reflected in the venereal disease rates.

Summary

	1950-51	1951-52
Reported Cases of Syphilis		
Early	75	31
Early latent	52	31
Late latent	163	139
Treatment		
Payments for drugs and physicians' services	$8,227.49	$5,790.60

			1950-51			1951-52
Clinic Activity						
Admitted for diagnosis			373			271
Infected		193			131	
Syphilis	82			41		
Gonorrhea	111			90		
Not infected		180			140	
Contact Investigations						
Brought to Treatment:						
Syphilis			28			12
Gonorrhea			47			57

DIVISION OF TUBERCULOSIS CONTROL

Katharine D. Gay, Administrative Assistant

The Department of Health and Welfare, through its Tuberculosis Control Division, works toward the ultimate goal of reducing the incidence of tuberculosis to a point where it becomes no longer one of the major infectious diseases and one of the major causes of death and disability.

Tuberculosis, which is chronic in nature as contrasted with short-term illnesses which leave the individual immune to subsequent attacks, is recognized as requiring for its control a continuous coordinated plan of public education, case finding, treatment, rehabilitation, economic assistance, and periodic observation and evaluation of those infected.

Basic to all programs is recognition of the fact that early discovery and adequate medical supervision of tuberculosis permits arrest of the disease in a comparatively short time with all of the consequent economies of human and financial resources.

The chest x-ray has proven to be one of the most effective methods of case finding in tuberculosis. Lack of understanding of its importance, inertia, fear of possible diagnosis, cost, lack of opportunity for, or a combination of all or any of these factors limit the utilization of this method unless, through education, wide public acceptance of the method can be attained and x-ray service made easily available. A tax supported program of this type seems to be the best means of reaching the greatest number of people.

Because of its tendency to recur, those individuals who have arrested disease must continue indefinitely under medical supervision, including periodic x-ray. In large part, those who have been obliged to spend long periods of time in a hospital are not financially able to pay for the necessary medical post-hospital supervision, and tax supported facilities for this purpose are required.

Adequate clinic facilities for diagnosis and follow-up are considered to be the greatest single need in the control program in Maine at the present time. A program of periodic free chest x-ray has been carried on by the Division of Tuberculosis Control for some years past. While this plan is of some help in a material way to many people, it is recognized that it is but a substitute for a well-equipped and well-staffed clinic program carried on at frequent intervals in established clinic centers for those in need of such assistance.

Due to the fact that this disease has been known to exist in man since history was first recorded, its control is more than a matter of attack from one direction only. Its occurrence presents social and economic as well as medical problems. Not only must the known case be treated, but the unknown case found and the new case prevented. The Department of Health and Welfare has the responsibility of the latter two—finding the unknown case and preventing the new, as well as maintaining supervision of the known case until it is no longer infectious.

Any plan of attack requires a knowledge of existing conditions. In a tuberculosis control program the first essential is to know the extent of the problem in any given area in order that necessary control facilities may be provided.

The Department is dependent upon the medical profession in large part for providing information which will enable it to locate areas where cases of tuberculosis exist, as well as the numbers of such cases. The law provides that each new case shall be reported by the physician making the diagnosis. A problem of the Division is that of obtaining verification of diagnosis in many cases where the only information on file is that of reports of positive sputum cultures.

From information provided by the physician making the diagnosis, the Division of Tuberculosis Control maintains a current register of individual cases, which gives information regarding the type and current status of the disease, the geographical location and other usual statistical data such as sex, age, etc. Compilation of the data which can be obtained from this register assists the Division in planning its future course of action. Exclusive of those cases known to be in mental institutions, the Register contains at the present time an average of 2,100 cases.

Such reports of diagnosed cases also permits epidemiological investigation aimed at finding out from whom each individual got his disease and helping to prevent its spread to someone else. It is only by breaking the links in this chain that control can be established.

Individuals who have lived during relatively long periods of time in close association with a person who has active tuberculosis show a much higher rate of disease than do those people who come in contact with an active case only infrequently. The periodic chest x-ray clinics which admit those who have lived in this close association with a patient who has active tuberculosis, as well as suspected and known cases, are recognized as a more important, though less spectacular, part of case finding in the control program than are the more popular mass x-ray surveys of entire communities.

Fewer patients were x-rayed at Regional Clinics during the last biennium than during the previous one, due to an attempt at improvement of the quality, as contrasted to the quantity, of service for the patients. To amplify: x-ray facilities at Regional Clinics are not intended to be used for screening out abnormal chests from among the apparently healthy adult population. That is the objective and purpose of mass case finding programs. Patients admitted to Regional Clinics are referred because of history or clinical evidence which make x-ray advisable. Mass x-ray programs admit anyone over 15 years of age. The equipment, type of film, and time spent with individual patients in the two programs varies greatly.

The cost to the Department of a patient visit at a Regional Clinic is $4.05. The cost per patient visit during a mass x-ray survey is 77 cents.

X-rays totaling 3,827 were taken at Regional Clinics during the past biennium, representing 51 clinics at 17 centers.

Twenty-four new cases of pulmonary tuberculosis were diagnosed, 9 of them in an active stage. 239 previously known cases reported for follow-up x-rays. 56 were classified as still active.

Survey films totaling 93,539 were taken under the mass survey program, including work with colleges, State mental and penal institutions, school department personnel, naval reserve groups, industrial groups and community projects. This is an increase of 20,500 films over the last biennium, and represents 37 separate equipment set-ups throughout the State with free x-rays offered to residents of 137 towns and plantations.

The expansion of this program was absorbed by the technical and clerical personnel of the Division. It should be pointed out here that the increase in the number of people to whom this service could be offered was mainly in the field of community programs and was made possible only by the availability of the Health Education Consultant of the Department, who worked with local groups in each community preparing the way for the actual x-raying by stimulation of interest through education of the public. Division personnel helped with this aspect of the program where it seemed advisable.

It is interesting to observe, and serves as a strong argument for a more intensified program of health education within the Division of Tuberculosis Control, that in spite of the use of every available media of information, only between 35 and 45% of the eligible population of communities took advantage of the chance for free chest x-ray offered in

community surveys. This response is not out of line with the experience in other states when surveys are offered to communities the first time. However, when it is realized that in those groups which do not respond the first time, there is probably a higher per cent of pulmonary tuberculosis than in the group who do respond, the urgency for the means with which to re-survey is clearly apparent. Present personnel and equipment require a waiting period of about two years for communities requesting surveys.

In considering the number of active cases diagnosed through surveys, the results vary from community to community, from 1.4 newly diagnosed active cases per 1,000 x-rays in a community project, to .03 of a case per 1,000 x-rays among certain college groups.

Although the hospitalization of the tuberculous is under the jurisdiction of another Department, 26% of the patients discharged from the State Tuberculosis Sanatoria were discharged against medical advice during the last two years. 46% of those discharged against medical advice went back into the community with positive sputa and thus became part of the responsibility of the Department of Health and Welfare.

New cases of tuberculosis totaling 893 were reported during the biennium. 463 in 1950-51. 430 in 1951-52. 794 were pulmonary cases—454 in an advanced stage of disease—143 were reported unclassified as to stage. Disregarding the 143 unclassified, the fact that 57% of cases were known to be in an advanced stage when reported points out the great importance and urgency of greater control efforts.

Of the 430 patients reported during the fiscal year 1951-52, the following table shows the sex and age distribution.

		Pulmonary TB		Non-Pulmonary TB	
	Total	Male	Female	Male	Female
0-4	12	3	3	4	2
5-14	33	13	12	6	2
15-24	65	11	51	2	1
25-44	136	65	60	5	6
45-64	101	72	19	3	7
65 & over	65	43	16	2	4
Not stated	18	13	3	1	1
Total	430	220	164	23	23

It will be noted from this table that in Maine during the last year, females between the ages of 15-24 were reported to have nearly five times as much tuberculosis as males in that age group,—and that males 45 years and over were reported more than three times as frequently as

females of the same age group. The 25-44 age group was nearly equal for both sexes, the greatest single number being reported for males between 45 and 64.

Because the group of individuals admitted to general hospitals show a higher rate of pulmonary tuberculosis than is found among similar age groups in a community, the Division of Tuberculosis Control has for some years past encouraged admission x-rays in hospitals throughout the State, providing equipment in some instances, and 4 x 5 inch survey film for all institutions so requesting. Where a wide discrepancy exists between the number of hospital patients admitted and the number receiving admission x-rays, the Division is questioning the feasibility of continuing its participation. In order to justify the expenditure of funds, it is believed that a definite policy in regard to the percentage of admission x-rays constituting a satisfactory program should be established, and material support withdrawn from those who fail to qualify.

Within the last two years an impressive effort in the revision of the record system has been completed in the central Tuberculosis Control office. This consisted of establishing a central index of all cases reported daily, as well as reviewing thirty years of old records, disposing of useless material, and integrating the remainder with the current cases. It is believed that at the present time any one of the thousands of records which pass through the office in the various programs under its supervision can be readily located in a compact form.

Two new District case registers were established during the past two years. These were the last to be established in the six health districts of the State. All District registers are checked by the Register Clerk from the Central office at six month intervals.

At the close of the last biennium a new portable photofluorographic unit was purchased to replace the one then currently in use. The bus type of mobile x-ray equipment is impractical for year-round use in this State, because of our winter climate and driving conditions. However, the addition of such equipment for use during the warmer months of the year in rural areas would add flexibility to the community mass x-ray program, and increase local participation by eliminating the need of long travel distance for those wishing to be x-rayed but living in outlying communities.

The Division believes it has made progress during the biennium especially in that intangible field known as health education. The fact that 93,000 residents of the State received a chest x-ray could not but focus the attention of that segment of the population on tuberculosis, if

only for a short time. Certainly the 55% to whom the service was offered and who refused must have given the subject some thought. That tuberculosis still carries a stigma in the minds of many emphasizes the need for continued and intensive education if the fear engendered is to be overcome.

Much, too, remains to be done by way of material help, because of the extensive rural areas, many of which still lack adequate medical facilities, and because of the comparatively low average of family income in that segment of the population where tuberculosis is known to occur most frequently.

DIVISION OF PUBLIC HEALTH NURSING

Helen F. Dunn, R.N., Director

Public health nurses make up the largest professional group in the public health team. It is through their efforts that many of the public health programs are implemented on the local level. Their aim is to establish, in cooperation with other community workers, a high level of health among the citizens of Maine.

A policy of the Department is to provide direct public health nursing service in those areas of the state where service is not available through some other agency.

On January 1, 1952, there were 68 agencies, excluding the Department, sponsoring public health nursing programs: 6 local health departments, 21 Boards of Education, 40 non-official agencies, and one school of nursing. The total number of nurses employed by these agencies was 148; and in addition, 67 nurses were employed by industrial organizations. The statistics show a decrease of 7 agencies and 3 nurses since the last biennium.

The recommended ratio of nurse to population is 1-2,500 when bedside nursing is included in the program, and 1-5,000 when care of the sick is on a demonstration basis only. With a total of 148 nurses, it would seem that the ratio of nurse to population—1-6,000—is not too inadequate. However, when the distribution of nurses is considered, it will be seen that the majority of them are concentrated in the cities and larger towns, and that nurses in rural areas frequently must serve a population of 10,000. This means that only the most outstanding health needs can be met.

Organization Changes

The Metropolitan Life Insurance Company and the John Hancock Life Insurance Company have discontinued nursing services which for many years they had offered to policyholders through the employment of public health nurses or through contracts for service with established nursing organizations. Those agencies which had contracts for service to policyholders will continue to give service, but must find other ways to secure funds to replace fees from the insurance companies. Efforts have been made to organize community nursing services in Rumford and Waterville, where previously nursing service was available through nurses employed by Metropolitan Life Insurance Company. Although there is, in the communities, interest in such programs, organization plans have not been completed.

The Maine Tuberculosis Association has encouraged some of its local organizations now sponsoring nursing programs to discontinue such services and use their funds for educational purposes and to supplement existing services. In the fall of 1951 the nursing program covering a number of towns in Hancock County was discontinued, and the Aroostook County Anti-Tuberculosis Association nursing program was discontinued at the end of the last fiscal year.

Personnel

During the biennium there were 12 appointments and 13 resignations, leaving a staff of 47 at the end of this period. In December 1950 a nursing consultant from the U.S.P.H. Service, who had been loaned to the Department to serve as educational director, was recalled for reassignment. In August 1951 a part-time educational supervisor was employed, to assume responsibility for the student program and to assist with in-service education.

Enabling Act Services

Nine communities have nursing service organized under the provisions of the enabling act. Vinalhaven and Madison established new services in 1950. Because of the resignation of the nurse in Madison, the town was uncovered for ten months.

Staff Education

A staff education program is essential if the nurses are to keep abreast of the developments in public health and allied fields.

All districts continued to work on the Evaluation project which was started in 1950. The task of describing the standards of performance of the different elements of their work required careful consideration of public health nursing activities and stimulated interest in better job performance. Although the staff was not entirely satisfied with the final product of its work, it was decided to use the Evaluation form, with the expectation that weak spots will be discovered through use of the form and a better one may be evolved. Other topics considered in the staff education program were tuberculosis, crippled children's service, mental health, growth and development, geriatrics, and trends and new treatments in medicine and public health.

Several members of the staff were given the opportunity to participate in Institutes arranged through the Bingham-Kellogg-Boston University Education project. Under this plan two nurses had the privilege of attending workshops at New England Center Hospital in Boston; one on cancer and one on orthopedic nursing.

Three graduate nurses were given a period of orientation in public health nursing and sent to college for one semester, followed by a carefully supervised program in the field, until they were prepared to assume responsibility for an area. One member of the staff was granted educational leave to complete a public health nursing program of study.

Student Program

A total of 19 students had public health nursing field observation or experience with the Department. In the year 1950-51, ten students in their basic nursing course were accepted for one month of field observation. While this short period had value for the individual, two months field experience is necessary if the course is to be accredited. Therefore, in 1951-52, no students were accepted for less than two months.

The institutions from which students were accepted were:

New England Baptist Hospital..........	11 students
Boston College........................	1 "
Boston University.....................	3 "
Simmons College.......................	3 "
Yale University.......................	1 "

Each program was carefully planned and the educational director held conferences in the field with the student, field teacher and supervisor at least three times during each student's experience. A representative from the student's school was invited to participate in the conferences.

Accomplishments

Although for reporting purposes, statistics are kept on different types of service given by the public health nurse, the emphasis in all visiting is on family health.

Home Visits

Following is a chart showing admissions to service and home visits by type for a five-year period. Although during these years the staff was of comparable size, the number of days on duty varied greatly. For instance, in 1951-52, because of sick leave, educational leave and for other reasons, staff members were off duty 696 days, not including vacations. Most of the increases or decreases can be interpreted as difference of program emphasis in a given year, or the addition of new programs.

Number of Individuals Admitted to Service

	1947-48	1948-49	1949-50	1950-51	1951-52
Totals	11,635	13,055	12,578	13,001	10,673
Antepartum	1,007	1,061	1,046	998	722
Postpartum	754	822	894	928	737
Infants	4,138	4,319	4,149	3,981	3,261
Preschool	2,206	3,275	2,968	3,269	2,676
School	842	1,047	964	1,069	872
Crippled Children	1,050	1,017	1,107	1,303	1,093
Morbidity	833	528	729	501	397
Adult Health	206	230	231	260	298
Communicable Disease	68	107	38	61	66
Tuberculosis	462	599	424	574	523
Venereal Disease	69	50	28	57	28

Number of Home Visits

	1947-48	1948-49	1949-50	1950-51	1951-52
Totals	32,152	30,482	29,543	30,699	27,638
Antepartum	1,800	1,807	1,797	1,799	1,311
Postpartum	1,216	822	894	1,248	1,121
Infants	9,327	9,438	9,363	9,107	7,819
Preschool	7,196	8,004	7,118	7,707	7,254
School	3,816	2,906	2,561	2,730	2,368
Crippled Children	2,256	2,033	2,519	3,007	2,552
Morbidity	3,063	2,488	2,835	2,439	2,423
Adult Health	964	702	604	675	696
Communicable Disease	295	260	87	132	114
Tuberculosis	1,911	1,849	1,696	1,708	1,889
Venereal Disease	308	173	69	147	91

Immunizations

In the fall of 1950 the staff made a survey to determine the approximate number of young children who were not protected against smallpox, diphtheria, whooping cough and tetanus. The results indicated the need for an intensive immunization campaign. In the year 1950-51, the number of immunizations was increased 87% over the previous year. Although the number recorded in 1951-52 was not so large, it was 10,000 more than in 1948-49. During the past five years, 203,625 children living in territory where Department nurses work have been immunized.

Although some recorded immunizations were booster doses, statistics indicate that a large number of Maine children are protected against smallpox, whooping cough, diphtheria, and tetanus. In many communities, nurses assisted town officials to organize immunization clinics in which they did not participate; therefore the immunizations given at those clinics are not included. Also, there is no record of the number of children having this service at the office of the family physician, but undoubtedly an increasing number of parents each year are becoming aware of the importance of protecting their children against communicable disease.

Immunizations

	1947-48	1948-49	1949-50	1950-51	1951-52
Totals	30,341	35,671	31,038	58,052	46,011
Smallpox	9,330	9,651	7,081	12,586	9,163
Diphtheria	12,060	13,374	10,080	16,996	13,544
Whooping Cough	5,831	6,920	7,216	12,789	10,698
Tetanus	1,713	5,369	6,661	15,030	11,774
Typhoid	1,407	357		651	832

Child Health Conferences

Child Health Conferences are among the most popular activities carried on by public health nurses. Objectives of this program are to obtain health supervision of infants and preschool children and to aid parents in maintaining, at the highest level, the mental and physical health of their children. The ideal plan to reach this objective would be to have every child under the supervision of his own physician, but with the scarcity of physicians in rural areas, this is not possible. Then, too, many physicians have such a heavy practice in caring for the sick that they cannot devote time to health supervision. The organization of a Child Health Conference by the local community provides the setting, saves the time of the physician, and also makes available the services of the nutrition consultant and dentist.

During the last year it became increasingly difficult to find physicians to serve at the conferences. In some areas the conference committee questioned the feasibility of conducting conferences in remote areas where there are a small number of children and where travel of the physician would be excessive. In some instances children are taken to conferences in an adjoining town, or the committee may plan conferences every other year.

Following is shown the number of towns sponsoring conferences, the number of sessions held, and the total attendance, over a five-year period.

Child Health Conference

Year	No. of Towns	No. of Conferences	Total Attendance
1947-48	244	948	11,095
1948-49	240	902	15,244
1949-50	262	977	17,997
1950-51	276	1,068	18,919
1951-52	273	1,065	17,672

School

In the past, many school programs consisted of mass examination of school children with little time for adequate follow-up of the defects

discovered at the examination. The objective in the present program is to adapt it to local needs and resources. Through the cooperation of parents, school and health personnel, programs are planned to meet more nearly the needs of children. Greater emphasis is placed on helping children to a better understanding of their health needs.

There has been improvement in the quality of school programs, with an increase each year in the number of towns where physical examinations are done on a selective basis; that is, complete medical examination of children in three or four grades, and of children from other grades on a referral basis. An effort is made to have the parent present at the examination, affording an opportunity to discuss with the physician his findings. Through the cooperation of teachers, parents, nurses and physicians, the examination becomes a learning experience for the child.

The Demonstration School Health Program has completed its fifth year. The purpose of the program was to study ways of meeting the health needs of school age children in a rural area. Each year children in three grades were given complete medical examination, and children not in the grades scheduled might be referred for special needs. Efforts were made to have adequate follow-up on all children needing attention. When possible this was done through local physicians and facilities. The amount of assistance given to families was based on individual needs. The success of the program which was planned by the Departments of Education and Health and Welfare with local groups is a splendid example of cooperation and team work on the state and local levels. Much of the success of the program was due to the parents, teachers, physicians and nurses who participated in the planning and execution of the project.

Clinics

Public health nurses play an important role in clinic programs—orthopedic, cardiac, and pediatric—not only through their service at the clinics but in case finding during home visiting and in follow-up care. Each year nurses serve at over 160 clinic sessions.

Health Councils

The development of local health councils, many of which started as Child Health Conference committees, is unique in Eastern United States, and they have made an outstanding contribution to public health. Not only the increase in number of councils, but wider representation and more active participation have been most encouraging. Fifteen new councils were organized during the biennium. Representatives from

local councils met together for annual district meetings and one county held a mid-year meeting. Districts IV and V, the first to hold annual meetings, held their eighth such meeting.

Cost Analysis

A cost analysis, using the method developed by the National Organization for Public Health Nursing, was made. This was based on time studies of the nurses' work covering four 2-week periods. Through various grouping, it was possible to secure a wide range of information in relation to time and costs of service. It is useful in comparing costs of different services and in planning programs.

The most urgent need at the present time is for a larger staff. As public health nursing functions are better understood in local communities, and as new programs are developed, more and more demands are made upon the nurses. This has resulted in spreading the service so thin that despite long hours and much overtime work, only the most urgent needs can be met.

DIVISION OF VITAL STATISTICS

Parker B. Stinson, Director

Summary of Vital Statistics
Maine, 1950 and 1951

1950			1951	
915,438		Estimated midyear population	921,023	
21,239	(23.2)	Births and rates per 1,000	21,143	(22.9)
8,617	(9.4)	Marriages and rates per 1,000	8,219*	(8.9)
9,962	(10.9)	Deaths and rates per 1,000	9,967*	(10.8)
804		Adoptions	823	
2,162		Divorces	2,040	
		Selected Causes of Death and Rates per 100,000		
3,708	(405)	All heart diseases	3,917*	(425)
1,614	(176)	Malignant neoplasms (cancer)	1,515*	(164)
1,189	(130)	Cerebral hemorrhage, embolism, and thrombosis	1,163*	(126)
551	(60)	Accidents, all types	526*	(57)
268	(29)	Pneumonia and influenza	350*	(38)
		Deaths and Rates per 1,000 Live Births		
663	(31.2)	Deaths of infants under 1 year of age	604*	(28.6)
12	(0.5)	Maternal deaths	18*	(0.8)

*Provisional

With the addition of nearly 85,000 records received during the biennium ending June 30, 1952, the Division of Vital Statistics now has approximately 2,350,500 vital records of all types in its files. Current Birth Registration in Maine is now estimated at 98.9 percent complete.

The Division of Vital Statistics has issued 19,208 certified copies of vital records, and has verified 19,755 vital events for official purposes during the biennium.

Since 1945, the Division of Vital Statistics has operated a routine birth query program whereby a photostatic copy of each birth record received is returned to the parents as a final check on accuracy. During the biennium the division has returned 39,983 photostatic copies to parents. In addition to the routine birth query, the division has queried 3,528 records for completeness or inaccuracies. All querying is carried on with franked mailing privileges granted by the U. S. Public Health Service with the director acting as a special agent.

In February, 1952, the Division of Vital Statistics acquired microfilm equipment. Records of all current births are now microfilmed and microfilm copies are now submitted to the U. S. Public Health Service rather than hand copied statistical transcripts. Microfilming should effect a substantial saving in time, effort, and money. A further advan-

tage accruing from microfilming is that the division retains the microfilm negative which might prove invaluable in the event that the regular records should ever be destroyed.

In addition to the routine programs of microfilming records, the equipment is now being used to microfilm closed case records and other material for other divisions in the department for the purpose of conserving file space.

PUBLIC HEALTH EDUCATION PROGRAM

Ruth T. Clough, Consultant

Although the personnel of each administrative unit of the Bureau of Health carry on a continuing program of health education in conjunction with their respective services, certain technical and special aspects of health education are promoted through the work of the program specifically defined as Public Health Education.

Primarily, the major objectives of this program are as follows:

1. To promote and stimulate the desire for individual and community health through a variety of educational media,—and to acquaint the public with the health services available for their use;
2. To assist all Bureau personnel with educational aspects of their respective programs;
3. To cooperate with and assist in the development, promotion and expansion of health programs conducted by voluntary agencies and other official agencies.

Since the value and effectiveness of public health services are greatly dependent upon the extent to which the public understands and supports these services, the first of these objectives has assumed a significant role in the activities of the program as it has operated for the biennium.

Health Information

The approaches to public understanding are many. First and most obvious, perhaps, is the informational approach. To that end, a substantial part of the program effort has been devoted to the selection, assembly, development and distribution of such educational media as pamphlets, bulletins, bibliographies, reports, exhibits, films, radio and press releases, and other "information centered" materials for use in local health programs, schools, hospitals, and for individuals, other agencies, and organized groups throughout Maine.

Pamphlets—an estimated weekly distribution of 25 different types of pamphlet material through this office. In addition, 615 requests for information requiring research or special assembling of materials, processed.

Special reports—9, involving Bureau and Departmental programs and services.

Radio releases—straight health talks, 5; briefs, spot announcements, newscasts, 84; preparation of health scripts, 10.

Press releases—119, largely in conjunction with promotional campaigns for community chest x-ray survey.

Exhibits—9, prepared for health councils, health conferences and fairs, local health officers' meetings, State fairs, Farm Home Week.

Films—Through the Department, approximately 100, 16 mm. films and filmstrips on health, covering basic and current health subjects, are available for public use. The demand for these has risen sharply over the past year and continues to be heavy. Chief sources of request: schools and colleges, P.T.A. groups, professional groups, church groups, civic and fraternal groups. Continued pre-viewing of new films, followed by critique conferences with Bureau personnel and others, is a responsibility of this office as is the selection, assembly and processing of all film requests.

Publications—The Department publication: "Health and Welfare Notes" is published quarterly and widely distributed to professional and lay sources. Health articles and news items emanating from the divisions of the Bureau are compiled through this office; so also are special health articles for other publications within the State.

Health Talks—24 health talks were made during the biennium, largely to such groups as social agencies, medical auxiliaries, health councils, civic and professional groups.

Community Programs

As the emphasis in public health practise moves away from major dependence upon laws, rules and regulations toward more persuasive measures for individual and community self help in raising the general health level, the responsibilities of the Program increase proportionately. Guidance and assistance in planning community health programs and training for leadership constitute a substantial measure of the Program activities. The promotion of community campaigns for mass chest x-ray surveys, requiring from six to eight weeks of organizational effort in each instance, is planned and guided by the Bureau consultant in cooperation with the personnel of the local voluntary agency, and community leaders. Over the biennium, 18 such surveys were conducted involving a total of 84 conferences, including sponsor and planning meetings; canvassers' meetings, and conferences with individual leaders. Department materials compiled and distributed in conjunction with these surveys numbered many thousands.

Assistance and guidance in planning other types of community and school health programs of general or specific nature are offered as a service of the Program. Workshops, panel and group discussions, general conferences, institutes and seminars continue to be effective and popular current methods of obtaining group involvement and general citizen participation.

Interagency Participation

Correlation and coordination of public health education services throughout the State is a continuing concern of the Program. To this end, participation in and assistance with the programs of voluntary health agencies and committees is made in a diversified number of ways. These include: health aspects of Civil Defense, heart, cancer, tuberculosis and polio programs, hospitals, parent-teacher groups, nursing, medical and allied professional groups.

Joint planning with other official agencies in evolving techniques and methods of health education is likewise a concern of the Program and a phase of activity which would appear to merit even wider attention in the immediate future.

Interdivisional Activities

A major responsibility of the Program is that of assistance to all departmental divisions concerned in part or wholly with phases of health education. By reason of the considerable number of services involved, the nature of this assistance is necessarily highly diversified. Technical assistance is made available to these divisions on a limited basis; consultant service is continuous and involves program planning, personnel and visitor orientation; informational reference and resource service; assistance to district and local health officers, field service and similar consultative activities.

Plans for the next biennial period include emphasis on the development of evaluation techniques for use in the measurement of individual program activities; wider involvement in staff programs and community activities; more technical assistance to divisional programs.

BUREAU OF SOCIAL WELFARE

Commissioner Stevens, Acting Director

Detailed information regarding the activities of the Division of Public Assistance (which administers the programs of Old Age Assistance, Aid to Dependent Children and Aid to the Blind); the Divisions of Child Welfare; Services for the Blind; General Relief and Licensing and Indian Affairs will be found on the following pages.

DIVISION OF PUBLIC ASSISTANCE

Pauline A. Smith, Director

Administration

The Division of Public Assistance is responsible for the administration of the three public assistance programs, Old Age Assistance, Aid to the Blind, and Aid to Dependent Children. These programs are carried on through a decentralized plan of operation with staff in 13 district offices responsible for receiving and processing applications, making decisions regarding eligibility, maintaining complete records which reflect the basis for decisions and validate eligibility determinations, and at all times maintaining follow up to know whether eligibility continues to exist throughout receipt of assistance, and when it ceases to exist or circumstances change, to discontinue or adjust the assistance appropriately.

The function of the state office is largely supervision over the district offices, development of rules, regulations and instructions for state-wide administration that are in accordance with the assistance laws, and fiscal operations.

The staff of the Division consists of a director responsible for overall, state-wide administration, a supervisor of field services responsible for maintaining liaison between the state office and district supervisors, a case reviewer responsible for reading district office case records for conformity, a training supervisor responsible for teaching new workers the public assistance job, 7 district supervisors, each responsible for the administration of the public assistance programs and supervision of staff in his district, 86 social workers, each responsible for service to an average of 230 individuals and family recipients of assistance and for processing an average of 8 applications a month, and 38 clerical workers, one assigned to state office and 37 located in the district offices, all responsible for a wide variety of clerical duties.

Dual Responsibility and Accountability

The Division is responsible to the public,—the public that pays the bills and the public that receives benefits,—for the highest quality service that can be achieved to the less fortunate and needy people who use assistance, and for administration that is efficient and economical. These responsibilities are in fact inseparable and what contributes to one contributes to the other. Specifically, good service to the beneficiary group consists of a sound eligibility determination that makes assistance available to those who meet the requirements specified by law and withholds it from those who do not meet these requirements, helping the latter

group to make use of other resources and services when they are or can be made available, and helping all who seek and/or receive assistance to make maximum use of their own capacities to help themselves. Policies, methods and practices of the Division have this service as a goal and the extent to which it is achieved determines the degree of efficiency and economy in administration.

The Division accounts to the public in innumerable ways, and a few examples will illustrate the extent to which its activities are reviewed by outside agents. Some of these are publication of monthly, quarterly, annual and biennial reports on expenditures, statistics, or general activities to be studied by all interested persons and special reports made to the Legislature representing the public, particularly to legislative committees charged with responsibility for specific activities such as the Welfare Committee, the Appropriations Committee and the Research Committee. In addition, there are such safeguards as the constant vigil of continuing audits, both federal and state, by persons outside the Division; fair hearings in which the Commissioner of the Department formally reviews decisions made by the Division's staff, when requested to do so by a dissatisfied assistance applicant or recipient; and finally, an open door to all who wish information regarding regulations, policies and methods of administration in the programs.

Facts and Figures Regarding Public Assistance

Some of the facts and figures used in the previous biennial report are brought up to date here for purposes of comparison with the previous biennium while some new ones are added because they seem significant and of general interest. Interpretation given in the previous report and still pertinent will not be repeated here. Many of the factors that contributed to the need for public assistance then are still applicable, such as increasingly high cost of living, low retirement age, scarcity of opportunities for those with age and other employment handicaps, inadequacy of medical and other rehabilitation facilities, family breakdown and high divorce rates, low per capita income, and dependence on seasonal and irregular employment, to mention a few.

During this biennium there were 4,181 persons authorized for new Old Age Assistance payments, 3,115 families authorized for new Aid to Dependent Children payments and 133 individuals authorized for new Aid to the Blind payments. Taking the two largest groups, 26% of the total Old Age Assistance recipients were added because of loss of earnings and 28% because of depletion of savings and assets, while in Aid to Dependent Children, 37% were added because of loss of employment

(largely fathers who became incapacitated for work) or decreased earnings, and 36% because of absence of the wage earner in the home (largely a result of death and separation of the father).

Recipient rates are brought up to December 1951 when 15.6% of Maine's population aged 65 and over were recipients of Old Age Assistance as compared with a national average of 21.8%. Maine ranked 40th among the 48 states. In Aid to Dependent Children, 3.8% of the children aged 18 and under in Maine were being assisted as compared with a national average of 3.2%. In this program Maine ranked 17th among the 48 states. In general relief which is administered and largely financed by the local municipalities, Maine ranked highest in the nation in its recipient rate with 1.4% of its citizens dependent on general relief as compared with a national average of .6%.

A look at average payments to recipients reveals for June 1952 that Maine was paying an average of $43.19 per month to each Old Age Assistance recipient as compared with the national average of $45.19, ranking 30th among all states which ranged up to a high of $70.56 a month in Colorado. In Aid to Dependent Children in the same month Maine was paying an average of $73.07 per month to each recipient family as compared with the national average of $75.88, also ranking 30th among the states which paid up to a high of $117.08 a month in California. Fifteen states were making an average monthly Aid to Dependent Children payment of more than $100.

Finally a look at Maine's income for 1951 sheds considerable light on the above statistical picture, especially as it is compared with a few other states. Maine ranked 35th among the 48 states with a per capita income in 1951 of $1,298 as compared with the per capita income for the continental United States of $1,584 in the same period. Maine ranked lowest among the New England States which averaged $1,715 while Connecticut ranked highest with $1,999 in the same year.

Highlights in Public Assistance

In this section the most significant changes and developments for the biennium are highlighted in summary form.

1. In the last fiscal year applications have decreased by 15.3% in Old Age Assistance, 5.4% in Aid to Dependent Children and 14% in Aid to the Blind. In the fiscal year 1950-1951 they dropped by 19.3% in Old Age Assistance, 2.3% in Aid to Dependent Children and 3.2% in Aid to the Blind.

2. Amendments to the Social Security Act in September 1950 which extended coverage and increased benefits in Old Age and Survivors Insurance resulted in almost immediate closure of 229 public assistance cases and payment reductions in an additional 2,888. Further savings due to the expansion have not been exactly calculated, but are considerable and far-reaching.

3. Amendments to the Social Security Act in September 1950 making more federal funds available for Aid to Dependent Children, which resulted in an increased maximum payment of $54 a month for the first child and adult and $18 a month for each additional child up to a family maximum of $180 a month.

4. Reduction in number of recipients in Old Age Assistance and Aid to the Blind and increase in Aid to Dependent Children accompanied by a decrease in the average monthly payments in Old Age Assistance and increase in Aid to the Blind and Aid to Dependent Children (See table at the end of this section).

5. Increasingly more prompt and efficient handling of applications by staff, despite staff vacancies, complex eligibility requirements and other handicaps, resulting in the disposal of the majority of public assistance applications in less than 30 days from their receipt.

6. Intensified activity on referrals of relatives, especially fathers of Aid to Dependent Children families, to the Attorney General's Department for collection of contributions toward the support of public assistance recipients.

7. Enactment of Federal and State legislation requiring the first $50 per month of income earned by Aid to the Blind recipients to be disregarded in establishing eligibility.

8. Special state-wide studies, primarily reviews of case records in the district offices to evaluate adherence to regulations and policies, general method and practice and extent of uniformity throughout the state. As a direct result of the demonstrated value of such reviews, a permanent case reviewer position has been established. In the past fiscal year the case reviewer has read, analyzed and reported on 40 cases for each worker in four of the seven districts. The remaining three districts will be reviewed in the same manner next year.

9. Establishment of a training center in the Brewer district office with a training supervisor who also carries other functions when

not fully engaged in training of all new staff in fundamentals of the public assistance job before assignment to their permanent caseloads.

10. Completion of one year of professional training by one supervisor and one worker under the Division's educational leave plan.

11. A highly successful four-day workshop for supervisors on improved methods in group supervision and staff development.

Public Assistance Statistics

Fiscal years 1950-51 and 1951-52

	Fiscal year ended June 30	
	1951	**1952**
1. Active cases		
Old Age Assistance		
Number of recipients receiving payments in June	15,054	14,086
Total payments authorized in June	$643,573	$608,323
Average payment in June	42.75	43.19
Number of cases approved for payment during year	2,462	1,719
Number of cases discontinued during year	2,565	2,864
Aid to Dependent Children		
Number of families receiving payment in June	4,554	4,416
Number of eligible children in families	11,576	11,113
Number of eligible adults in families	4,321	4,233
Total payments authorized in June	$335,954	$322,689
Average payment in June—per family	73.77	73.07
—per person	21.13	21.03
Number of cases approved for payment during year	1,684	1,431
Number of cases discontinued during year	1,197	1,679
Aid to Blind		
Number of recipients receiving payments in June	646	588
Total payments authorized in June	$29,469	$26,988
Average payment in June	45.62	45.90
Number of cases approved for payment during year	82	51
Number of cases discontinued during year	95	122

2. Pending Cases

Number of applications

	Received			Disposed of			Pending June 30		
Fiscal Year	OAA	ADC	AB	OAA	ADC	AB	OAA	ADC	AB
1950-1951	3,483	2,112	147	3,636	2,175	160	199	82	18
1951-1952	2,897	1,967	127	2,850	1,927	131	246	122	14

DIVISION OF CHILD WELFARE

Lena Parrott, Director

While the Division of Child Welfare is interested in the broad aspects of child welfare, at the present time, it must, of necessity, confine its efforts to the care and protection of neglected children. The activities of the staff include giving case work service to neglected children living in their own homes, providing foster care to children in the custody of the department, placing children in adoptive homes, making investigations for Superior, Probate, and Municipal Courts, certifying homes to board children, and licensing children's agencies and institutions.

The Division of Child Welfare maintains a staff of social workers especially prepared to do child welfare work. The service which the staff gives is state wide and is carried on from offices located in different parts of the state.

Children in the Custody of the Department

The major part of the time of the staff is devoted to children in the custody of the department. These are children adjudged to be neglected by local courts, and the custody has been given to the department by order of the court. The department stands in the relation of parents to the children so far as support and planning for their welfare is concerned. The legislature makes an annual appropriation to the department for the support of the children. No part of the expense is chargeable to any other governmental unit. The department furnishes such items of care as board, clothing, medical, dental, hospital, and incidentals. Although the court order divests parents of legal rights, it does not relieve them of financial support whenever they can assume it.

In addition to furnishing financial support, the staff is prepared to give case work service to the children and their parents. This includes a variety of services. Most of the children in custody are cared for in foster homes. An important part of a child welfare worker's job, therefore, is to select suitable homes for the children. This requires a careful study of the foster family to determine the fitness of the foster parents to care for and bring up children. After a child is placed in a foster home, the child welfare worker makes regular visits to the home to see the child and become acquainted with him. The worker and foster parents must work together for the welfare of the child to help him develop to the limit of his natural capabilities. Children attend local public schools. They are encouraged to go as far as their abilities will carry them. Many of the children graduate from high school. Some children, with the aid of private resources, go beyond high school.

Although the department is the guardian of the children, it is important to recognize the feelings that children have for their own parents. The child welfare workers, therefore, keep a relationship with parents even after children are in the custody of the department. This is done for various reasons. An important one is to determine if the parents can be helped to make a suitable home for their children. If they can, then plans are made to return the children to their own home. The children are placed on a trial basis and for at least a year. The children are visited during this period and if the parents have shown that they can again provide and care for the children, the department petitions the court having jurisdiction to return custody to the parents.

For children who either have no home to return to or where parents have shown themselves inadequate to assume parental responsibility, the department must make permanent plans for these children away from their own families. For the young children, adoption is planned for them if they are found to be adoptable from the standpoint of their physical and emotional development. The division has more than 100 children in adoptable homes all the time and the number is gradually increasing. For older children, who for various reasons are not adoptable, boarding care with a family who can make them feel a part of their family circle may be the best plan for these children. It is surprising and heartening to find so many families who are willing to share their home and affection with foster children but are not financially able to support the children.

Some statistics on children in the custody of the department are as follows:

No. of children	under care beginning of biennium	2502
" " "	taken in custody during biennium	633
" " "	cared for during biennium.......	3135
" " "	dismissed from custody during bien.	670
" " "	under care at end of biennium....	2465

Of the 670 children dismissed, 144 were dismissed by reason of adoption. The largest number adopted in any previous biennium was in 1948-50 when 114 were adopted.

Collections for the Support of Children in Custody

Amount collected from court orders and voluntary payments during the biennium..........	$26,010.70
Amount collected from Old Age & Survivors Insurance during the biennium	67,706.70
Amount collected from Veterans Administration during the biennium....	20,847.97
Amount collected from other sources during the biennium.............	3,627.04
Total..........	$118,192.41

Service Cases

In addition to the case work service that was given to the 633 children and their parents prior to the time the children were taken into custody, the staff worked with 1,478 other children who had not been taken into custody at the end of the biennium. The services of the child welfare workers were requested to help with a variety of social problems. The problems ranged all the way from working with parents and encouraging them to provide more wholesome environment for their children, to working with unmarried mothers around plans for their babies. In other cases the service included work with school officials and parents in an effort to help a child to make a better school adjustment. Other parents in need of medical or psychological care for their children used the services of the child welfare workers to locate these services. Investigations were undertaken for Superior, Probate, and Municipal Courts when in the opinion of the judge the welfare of some particular child was endangered and a study of the situation by a child welfare worker was needed in order to help the judge make a decision.

The Division has no funds which the workers can use to give financial assistance to children and parents accepted for service. Workers can only offer the skills they have developed in understanding and working with people in trouble and the knowledge they have acquired in the use of resources that are available to people in trouble.

The main objective in all cases has been to prevent breakdown of family life by helping parents to have faith in themselves and in their ability as parents to bring up their children and at the same time, make certain that proper safeguards were thrown around the children whose parents were unable to fully accept their parental responsibilities.

Licensing and Other Functions

The Division of Child Welfare serves as the state-wide licensing agency for (1) licensing homes to board children (2) licensing private child-caring agencies and institutions to operate.

In addition to its licensing function, a member of the staff approves reimbursements made to private child-caring organizations which receive annual appropriations from the legislature.

DIVISION OF SERVICES FOR THE BLIND

Emily T. Murchie, Director

The Division has continued to provide a varied program of services, exclusive of financial assistance, to blind residents of Maine. Service is offered on a state wide basis within the limitations of personnel and funds. The staff includes a director, two home teachers (blind), two rehabilitation counselors, an employment counselor (blind) and three secretaries. This report will attempt to present briefly a picture of the services provided by the Division. The particular service offered to a blind person depends upon his special interests, needs and capacities.

Service to blind adults is provided through both the home teaching and vocational rehabilitation programs. The home teachers, located in Augusta and Portland, visit the homes of blind persons referred to the Division in the central and southern areas of the state. Other parts of the state are provided with limited home teaching service through correspondence and occasional visits. The home teacher's major responsibility is helping the blind person to carry on a normal, satisfying life without the use of sight. She helps the newly blinded person to face the emotional shock of loss of sight and helps him to learn to substitute the other senses for lack of vision. She uses many different skills in working with the blind person and may, if desired, give instruction in braille reading and writing, typing and handicrafts. She helps in developing recreational activities for the client and gives him information in regard to various devices which have been developed for the use of the blind.

In order to provide a market for articles made by blind persons in their homes under the instruction of the home teachers, the Division has developed a small sales program. Two-day Christmas sales are held at the State House and in Bangor in cooperation with the Penobscot County Association for the Blind. An exhibit and sale is held at Farm and Home Week at the University of Maine each spring and small consignments of the merchandise are now placed in twelve gift shops which cater to summer visitors. An interesting development in the sales program is the knitting of mittens for use of children under the care of the Child Welfare Division. During the biennium over 1200 pairs of mittens were purchased by Child Welfare workers for children under care. This constituted more than half of the sales of the program. Proceeds of the sales in 1950-1951 were $2,005.54 and in 1951-52 were $2,314.27.

An important service to adults in their homes is the distribution on a loan basis of a device known as a Talking Book Machine. These record

players especially developed for the use of blind persons are produced and owned by the Library of Congress. They are allotted to state agencies on the basis of population. Records are borrowed from Perkins Institution Library, Watertown, Mass. A wide variety of literature is available to blind persons through these records. This service is increasingly being used and appreciated by blind residents of Maine. During 1950-51, the total number of readers using Talking Book Machines was 233 and in 1951-52 the number was 252. Vocational rehabilitation services to potentially employable blind persons throughout the state have been strengthened during the biennium. The use of psychological tests adapted to the blind have been helpful in making a rehabilitation plan with a client. Some use has been made of rehabilitation centers to provide for a period of adjustment to blindness and for work try-outs. Due to economic conditions throughout the state there have been fewer opportunities for blind persons in industrial work than previously but more people have been assisted in becoming self employed. A new modernized vending stand operated by a blind operator in the Federal Building in Portland has replaced the small one previously located there. The new stand offers an opportunity for the operator to expand his business by handling soft drinks, packaged foods and coffee.

During the biennium, rehabilitation services have been provided for 303 individuals, an increase of 67 over the previous total. A total of 48 cases has been closed as satisfactorily employed. Others have received guidance and counseling, physical restoration services and have been referred to other agencies for various types of services.

Of the 48 cases closed as satisfactorily employed, 33 were males and fifteen females. 25 of these clients received physical restoration services of various types such as cataract surgery, dental care, hernia repair and hearing aids. Nine people were placed in industrial employment, four in agricultural employment. Five obtained work as laborers, three in hospitals, two in grocery stores. Seven women were enabled to resume their responsibilities as housewives and six additional men and women are employed as family workers holding families together and thus enabling other members of the families to go out as wage earners. Three men were placed in sheltered work shops. Nine others are working in miscellaneous occupations such as grounds keeper, parking lot attendant, domestic worker, nursery school attendant and the like.

At the close of the biennium, 59 clients are in the process of rehabilitation plans. Of these, seventeen are already employed but still under supervision and ten are ready for employment. Twelve are receiving physical restoration services and ten are in training.

The education of blind children including services for pre-school children has continued to be an important function of the division. Education has been provided at Perkins Institution and Massachusetts School for the Blind and through a few specially adjusted programs in public schools in Maine. The attendance of Maine children at Perkins Institution in 1950-51 was 27, and during 1951-52 was 23, although two of these children dropped out during the year because of illness. The cost of tuition and maintenance of these children for the past biennium has been $1,000 yearly per pupil. The Department has been notified that because of increasing costs of operation, it will be necessary for Perkins Institution to raise its rates beginning in September, 1953 to $1,750 per pupil.

During the biennium, the Division of Special Education, Department of Education, and the Division of Services for the Blind, have cooperated closely in working with local schools to provide specially adjusted programs for a small number of so-called "educationally blind" children to remain in public schools in their own communities. Excess costs of these individual plans are paid from the appropriation of education for the blind. In 1950-51 ten children, and in 1951-52 thirteen children, attended public schools with specially adjusted programs.

Services for pre-school blind children and their parents have received an increasing amount of attention during the past biennium throughout the nation as well as in this state. Agencies for the blind have learned of a large and steadily increasing number of pre-school blind children. In part, this increase may be due to an eye condition found in certain prematurely born children called retrolental fibroplasia. Interest in this eye condition may have focused attention on blindness in pre-school children and resulted in earlier reporting of children with seriously defective vision. At the close of the biennium, services are being provided to the families of 21 pre-school blind children and five have been reported but not yet visited.

As one of the important services offered to indigent Maine people, the Division administers a small program of eye care. Treatment is limited to eye conditions in which blindness may be prevented or vision restored. The services provided include visits to the offices of eye physicians for diagnosis and treatment, hospitalization for eye surgery, glasses as part of the medical treatment—as in cataract cases—and an annual eye clinic in Aroostook County. Approximately 500 patients have received eye care through this program each year of the biennium. More than half of the patients have been those with cataracts. The second group of importance are those with glaucoma in which early diagnosis and treatment is of utmost importance to prevent blindness.

DIVISION OF GENERAL RELIEF

Paul D. McClay, Director

Q. What is General Relief?

A. General Relief is assistance given to needy individuals and families who have fallen into financial distress for various reasons and who do not meet the eligibility requirements of categorical programs, i.e., Old Age Assistance, Aid to the Blind, Aid to Dependent Children.

Q. Who administers General Relief?

A. General Relief is administered by the local overseers of the poor, aided in an advisory capacity by the State Division of General Relief, said Division reimbursing the municipalities for necessary expenditures.

Q. What is the Division of General Relief?

A. The Division of General Relief is a division within the Department of Health and Welfare, composed of a Director, five Field Representatives, and appropriate clerical staff, and is charged with the responsibility of working with the local overseers of the poor in the administering of assistance to those without a legal settlement in any Maine municipality and who are found to be in distress.

Q. How does the Division of General Relief operate geographically?

A. Previous to February 1952, the entire staff of the Division of General Relief operated from headquarters at the State Office in Augusta. In February 1952, a reorganization was effected. The State was divided into five districts on a County basis. The field representatives were assigned strategic official headquarters throughout the State, and as nearly as possible centrally, according to their volume of work. As a result the Division has been successful in being able to give more efficient service to local overseers of the poor, and resulting in clearer and more constant knowledge of case loads. Also as the result of this organization, permanent histories are being compiled on each General Relief case which will tend to show justification for all action taken. The field representatives now are easily contacted in emergencies by the local officials, and they report to the State Office only for dictation and work assignment purposes.

Q. Is the Division of General Relief financed by Federal funds?

A. No. The Division of General Relief operates entirely from State funds.

General Relief Statistics

Expenditures 1950-1951		Expenditures 1951-1952	
General expenses	$857,374.07	General expenses	$662,055.29
Medical expenses	89,048.54	Medical expenses	61,298.17
Hospital expenses	166,588.59	Hospital expenses	110,925.33
Burial expenses	13,099.16	Burial expenses	8,780.36
Total	$1,126,110.36	Total	$843,059.15
Av. monthly expenditure	$93,842.53	Av. monthly expenditure	$70,254.93

Type and number of cases assisted in comparative months:

June 1951		June 1952	
Families	548	Families	459
Persons in families	2,796	Persons in families	2,298
Single persons	388	Single persons	341
Children	115	Children	74

The above does not include cases where hospital and medical expenses were involved exclusively.

Total of collections from recipients of Social Security benefits:

1950-1951	$4,036.54	1951-1952	$6,626.90

There were lump-sum death benefits received from Social Security as follows:

1950-1951, 20 cases	$1,978.89	1951-1952, 17 cases	$1,576.97

Jefferson Camp

Q. What is Jefferson Camp?

A. Jefferson Camp is an institution established in 1942 for the purpose of housing indigent and homeless men who are without settlement in any municipality in the State of Maine.

Q. Who is responsible for the administration of Jefferson Camp?

A. Jefferson Camp is a sub-division of General Relief and is administered by that Division.

Q. What size staff is required to operate Jefferson Camp?

A. The resident staff of Jefferson Camp consists of a Supervisor who is in complete charge of operations. He is assisted by a clerk, a work foreman, a truck-driver, chef, second cook and night watchman.

Q. What type of individuals are maintained at Jefferson Camp?

A. On the whole the men housed at Jefferson Camp are single itinerant workers who, because of age, health, lack of employment, homes, and funds, are in need of assistance.

Q. Are able-bodied men admitted to Jefferson Camp or allowed to remain if employment is available?

A. No. A very stringent admission program is maintained and the State Employment Office is utilized constantly.

Q. Are there any inmates of Jefferson Camp receiving income?

A. Yes. Many men at Jefferson Camp are in receipt of Social Security benefits and are expected to apply a specified amount toward their maintenance.

Jefferson Camp Statistics

Cost of maintenance exclusive of repairs and capital expenditures:

1950-1951	$67,187.32	1951-1952	$57,861.48
The average monthly enrollment:			
1950-1951	142	1951-1952	102
Monthly per capita cost:			
1950-1951	$39.43	1951-1952	$47.27
Income:			
1950-1951		1951-1952	
Social Security Collections	$14,112.77	Social Security Collections	$12,296.69
Miscellaneous Revenue	5,363.28	Miscellaneous Revenue	3,908.03
Total	$19,476.05	Total	$17,204.72

Special Resolve Pensions

Q. What are Special Resolve Pensions?

A. Special Resolve Pensions are grants paid monthly through an act of the Legislature to individuals in need.

Q. What agency supervises Special Resolve Pensions after they are granted?

A. The Division of General Relief is charged with the responsibility of making periodic visits to recipients of Special Resolve Pensions to determine continued need, the suspending and reinstating of said pensions as indicated.

Q. Does the Division of General Relief have the authority to grant or increase Special Resolve Pensions?

A. No. The State Legislature has sole authority to grant or increase Special Resolve Pensions.

Special Resolve Statistics

The number of Special Resolve Pensions active and the total amount expended in comparable months, as follows:

June 1951 353 cases $8,257.33 June 1952 333 cases $7,581.23

Total number of pensions granted by the 1951 Legislature: 92 involving $1,928.89.

DIVISION OF LICENSING

Frank W. Haines, Director

The Bureau of Social Welfare is responsible for issuing licenses to operate for the following purposes:

1. To board children under 16 years of age unattended by parent(s) or a guardian;

   a. In homes maintained by individuals, usually called foster homes;

   b. In institutions maintained by private child-caring organizations.

A license is necessary to board one child or more under 16 years of age, regardless of whether the child may be placed by the Department of Health and Welfare, by a private welfare organization, by a parent, or other relative, or by an unrelated person, including a municipal welfare official. In addition, there are several private child-caring organizations in Maine which provide institutional care and these must be licensed.

Exceptions. No license is necessary for a free home provided by an individual for a child under 16; or when the child is related to the individual by blood or marriage; or when a child is in a home pending adoption; or when a child has been legally adopted. No license is necessary for a home which provides only for day-care for children.

2. To conduct private child-placing organizations which do not maintain an institution.

   Private child-placing organizations must be licensed to operate even when such organizations do not maintain their own children's homes or institutions:

3. To board the aged, blind, or persons 16 years of age or over who are dependent, defective or delinquent;

   a. In homes maintained by individuals;

   b. In homes maintained by private organizations.

Boarding homes for the aged, blind, and others as noted in paragraph three above, include those maintained by individuals and also those maintained by any private organization, partly or wholly for the purpose of boarding any of the types of persons mentioned.

General statement. Licenses for all types of boarding homes and for private institutions as previously mentioned are issued on a yearly basis and must be renewed each year. Before a license may be issued or renewed, the home or private institution must be examined by a fire inspector from the Fire Prevention Bureau of the office of the State Insurance Commissioner and certain recommendations may be made to the applicant for the license concerning necessary changes or repairs. The home or private institution is not eligible for a license until these recommendations are put into effect. An exception to this was caused by a change in the law effective in August 1951, so that a renewal license may be issued without a consecutive annual fire inspection in the case of homes boarding not over two children.

If the water used in the home or private institution for drinking and culinary purposes is not obtained from a municipal water system, a sample of the water used from a private well or spring must be analyzed by the Division of Sanitary Engineering of this department. The applicant is notified in writing of the results of the analysis, and the home is eligible for a license from the water supply standpoint if the analysis shows a satisfactory supply. If not, the applicant must agree either to make such water supply safe by proper treatment, or to obtain water from a different source which is known to be satisfactory.

Other standards and general requirements for the different types of homes have been set up by the department, and must be met before the license can be issued. Whether or not they are met is determined by visits to the home by a representative of the department. Such standards afford protection to the children and to the aged and other persons in these homes, including the licensee.

4. To solicit funds for charitable or benevolent purposes;

If a person, firm, corporation or association wishes to solicit funds for charitable or benevolent purposes, outside of the municipality where such person resides, or where such firm, corporation or association has its place of business, a license is necessary. It must be shown to the satisfaction of the department that the person or organization requesting the license is reputable and responsible and has suitable facilities for applying the funds to the purpose for which solicited, and that proper records will be accurately kept.

The department is indebted to the Portland Better Business Bureau for its cooperation in the matter of solicitation of funds.

The table below shows licenses in effect at the end of each fiscal year of the biennium:

	Licenses in effect	Year Ending 6-30-51	Year Ending 6-30-52
1a.	Children's Homes (Foster Homes)	1039	1002
1b.	Children's Homes (Private Institutions)	14	15
2.	Private Child-Placing Agencies	11	12
3a.	Homes for the Aged, etc., maintained by Individuals	209	194
3b.	Homes for the Aged, etc., maintained by Private Agencies	26	28
4.	To solicit funds for charitable or benevolent purposes	17	18

INDIAN AFFAIRS

Commissioner Stevens

With the exception of school and home improvement projects at the three Indian reservations, at Indian Island, Pleasant Point and Peter Dana Point, there was no change in the administration of Indian affairs during the biennium. The Department continued to be responsible for the welfare of needy Indians and the education of Indian children.

A program of renovation and repairs to the three schoolhouses at the three reservations was started during the second year of the biennium. This program among other things, will provide for a complete new lighting system with new wiring within the buildings in each schoolhouse; oil burner equipment at the Indian Island and Pleasant Point schoolhouses; new school desks at Indian Island; repairs to windows, roofs, walls, and ceilings of classrooms and a complete paint job for both inside and outside of the three buildings.

A building project was carried on each of the past two years by the American Friends Society with the Department of Health and Welfare supplying the necessary materials.

Mr. Hiram Hall of Robbinston continued as Indian Agent throughout the biennium. The appointment of the Indian Agent is by the Governor of the State with the approval of the Governor's Council.

As the funds appropriated were only sufficient to provide the necessities of life for needy Indians and for the education of Indian children, no progress can be reported regarding rehabilitation.

Expenditures for the two tribes for the first year of the biennium amounted to $135,095.97 and for the second year, $168,067.22.

(A detailed report on the problems of the Indians will be filed with the Legislative Research Committee at its September, 1952 meeting in accordance with the request of that group.)

LEGAL SERVICES

George C. West, Assistant Attorney General

Roscoe J. Grover, Jr., Assistant Attorney General

At the start of the biennium Miss Jean Lois Bangs was a part-time Assistant Attorney General assigned to the Department of Health and Welfare. Miss Bangs started with the Department in May of 1943 and served until her resignation, effective December 31, 1950. Miss Bangs had done a very outstanding job in setting up a system of collections of the State's claims against estates of deceased Old Age Assistance recipients. She also has done a great deal of pioneering in the field of Child Welfare legal services. This work included commitment of children to the State, collection of court orders against fathers of committed children, and in the adoption field. The systems which she had set up in these fields have been a great help to her successor.

Mr. Roscoe J. Grover, Jr. of Brewer was appointed Assistant Attorney General on a full-time basis in March, 1951, assigned to the Department of Health and Welfare. Mr. Grover took over the handling of the legal work for the Division of Child Welfare and a part of the work of collecting from fathers in the Aid to Dependent Children program. In this last respect he has handled the northern and eastern part of the State, with the assistance of a new investigator, Donald B. Estabrook, who was transferred from the Division of Public Assistance in June, 1951.

The collection record of the legal unit has shown a definite increase with the addition of an Assistant Attorney General on a full-time basis. In the Aid to Dependent Children program during the fiscal year 1950-51 collections amounted to $21,615.00. In the fiscal year 1951-52 the total collections were $45,581.21. This increase in collections may be accounted for by the fact that both Assistant Attorneys General are working on a full-time basis, and the additional fact of having a third field investigator. It has been possible for this group to devote more time to this important phase of the Department's activity with the increased collections as the result.

In the field of collections from parents of committed children the collections for the fiscal year 1950-51 totalled $9,281.00. For the fiscal year 1951-52 the collections were $15,069.61. Once again the increased collections are a reflection of the work of a full-time individual as against the work of a person employed on a part-time basis.

Collections from estates of deceased Old Age Assistance recipients has remained at a fairly stable figure during the past four years. There has been little variance from year to year. Collections in this field, of course, are dependent to a great extent upon the market value of real estate and the number of persons passing away who owned property. This work is quite routine and collections are more or less automatic and do not require a large percentage of an attorney's time.

In addition to the work indicated above, there is a great amount of time used in advising various divisions of the Department on legal problems, as well as approving of various papers, leases, and other documents. Every two years it is also necessary for the attorneys to participate in the drafting of legislation affecting the Department, and in some instances presenting the matters before the various committees of the legislature.