FINAL REPORT

OF

COMPREHENSIVE STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

MAINE

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COMPREHENSIVE STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

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MAINE COMMISSION ON REHABILITATION NEEDS

83 Western Avenue

Augusta, Maine

Peter C. Doran, Ph.D.,

Executive Director

Planning Period: February 15, 1967 to June 30, 1969

Report Date: April 16, 1969

This planning program was supported by a grant, under Section 4 (a) (2) (b) from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C.

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MAINE COMMISSION ON REHABILITATION NEEDS
83 Western Avenue
Augusta, Maine 04330
207 289-2366

April 16, 1969

The Honorable Kenneth M. Curtis
Governor of Maine
Executive Department
State House
Augusta, Maine 04330

My dear Governor Curtis:

I take pleasure in presenting to you herewith the final report of your Commission on Rehabilitation Needs, which, since February of 1967, has been conducting its statewide study under your auspices.

I have been honored that you appointed me to succeed Mr. George T. Nilson whose professional responsibilities required him to leave the State in the early part of 1968. It has been a pleasure and privilege to work with Senator Katz, Vice Chairman, the members of the Commission and its several Task Forces, and with the project staff headed by Dr. Peter C. Doran and Mr. Larry A. LaPointe.

In my view the Commission has faithfully carried out your mandate, which was to develop a comprehensive plan for the rehabilitation of Maine's handicapped, with the hope that the recommendations contained herein may be realized during the next decade.

It has been gratifying to all of us involved in this project to work under a Governor who has a comprehensive and sympathetic understanding of both the social and economic values of rehabilitation.

The Commission and members of the Task Forces have asked me to assure you of their continuing interest in the development of the program, and in the implementation of these recommendations.

Very truly yours,

Leonard W. Mayo

Leonard W. Mayo
Chairman

(iii)

LWM/h

A CREED FOR THOSE WHO BELIEVE IN THE HANDICAPPED

by

Leonard W. Mayo*
Chairman, Maine Commission on Rehabilitation Needs

1. We believe in the American promise of equality of opportunity for all people, regardless of nationality, cultural, or ethnic background, race, religion, or geographical location.

2. We believe that every country, city, town, village, and plantation, and every individual in the State of Maine has an obligation to help bring to fruition in this generation the ideal of a full and useful life for every handicapped person in the State.

3. We believe that this is only possible through effective team work, wise planning, the efficient expenditure of additional public and private funds, and the development of a network of resources and services as set forth in the recommendations of the Commission on Rehabilitation Needs.

4. We believe in the interest, the concern, and the basic compassion of our fellow citizens when human needs are brought to their attention and in their ultimate response to the challenge of rehabilitation as part of the American dream.

We believe that the vast majority of our people want to replace violence with peaceful solutions, injustice with justice, indecencies with decency, rejection with acceptance, dependency with independence, and hence, disability, physical, mental, or social, with the opportunity for rehabilitation.

5. Finally, we believe in the handicapped person himself and in his capacity for development so frequently limited by our lack of imagination and neglect; we believe in his passion for freedom and independence that can be his only when those upon whom he must rely for education, training, guidance, and employment, do not fail him, but become articulate, dynamic, and effective partners in his determined struggle to help himself.

These things we believe, and believing, we pledge our hearts, our hands, our funds, and our full cooperation to the end that they shall be carried out.

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* Delivered before the Governor's Conference on Rehabilitation Needs, Augusta, Maine, October 29, 1968.

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FOREWORD

In presenting this critique of rehabilitation services and recommendations for improving them, the Commission on Rehabilitation Needs has attempted to specify some positive courses of action to be taken in the immediate future by our state leaders, the various providers of rehabilitation services, and the general public. It will be apparant that the many hundreds of Maine citizens who have contributed to this study view rehabilitation as the process of mobilizing all of the state's resources to the end that every handicapped individual may be enabled to realize his maximum potential.

We believe the measures proposed here are realistic and that they are essential to improve the quality of our individual and corporate life. Throughout this state and nation it has become increasingly clear that we can no longer afford to consign large numbers of our fellow citizens to lives of hopelessness and dependency and then as a consequence of this neglect to shoulder the immense financial burden which this mass dependency entails.

The Commission has been one of several planning groups which have addressed themselves to finding better ways of utilizing to the fullest extent the vast reservoir of untapped human resources here in the state. As partners in this shared effort, our findings and recommendations have often paralleled those of groups studying medical care, mental health, retardation, social welfare, manpower programs and health facilities, in the same way that our thinking has been reflected in the measures which they, too, have proposed.

Cooperative planning for rehabilitation has enlisted the active participation of virtually all the public and voluntary agencies in Maine which seek to achieve the physical, mental, and socioeconomic restoration of the handicapped. It is essential we continue to work even more closely together to translate these mutual objectives into concrete programs for people. The statewide planning project described in this report has been a massive team effort, to which hundreds of dedicated persons have contributed. Especially significant has been the continuing support and impetus generated at the local level, in communities and regional areas throughout the state.

Ours has been essentially a "grass roots" approach; at the same time, however, we have had the guidance and inspiration of Social and Rehabilitation Service personnel in Washington, D. C., and the regional office in Boston, and of a great many

well-known and greatly admired national and international leaders in the rehabilitation field. Among those who have come to Maine to assist us in the past two years have been Howard A. Rusk, M.D., founder-director of the famed New York University Institute for Rehabilitation Medicine who has been instrumental in helping us draw up plans for a statewide system of restorative medicine, including a comprehensive rehabilitation center; Henry Viscardi, Jr., author and founder-director of "Abilities, and Human Resources Inc." of Long Island, New York who helped launch this study at the Governor's Kick-Off Conference; and Harold Russell, chairman of the President's Committee on Employment of the Handicapped, who visited at the invitation of Gov. Kenneth M. Curtis to advise him and the Commission members and to create an educational television program with Chairman Mayo. Most recently, William P. McCahill, executive secretary of the President's Committee on Employment of the Handicapped, addressed the Governor's Conference on Rehabilitation Needs at which these recommendations were presented. The proceedings of this conference including the major recommendations were recorded in the Congressional Record (February 18, 1969) through the efforts of Mr. McCahill and Senator Edmund S. Muskie.

At the state level, literally hundreds of persons representing the public and voluntary rehabilitation agencies have given their full cooperation and many hours of time to evaluating existing programs and making specific recommendations for improvement.

All of these many persons and agencies have pledged their continuing interest and support, now that we have emerged from the planning phase into the more crucial one of ensuring the effective implementation of these proposals. As the project has evolved, more and more persons have contributed, and their number increases daily. This fact above all assures us that the abilities of Maine's handicapped and disadvantaged people will soon, for the first time, be recruited for the mutual betterment of us all.

Maine Commission on Rehabilitation Needs

SUMMARY OF KEY RECOMMENDATIONS

Recommendations presented in this section have been selected for special consideration from among those to be found in the body of the report. For the location of each one in the text and its supporting rationale, the reader is referred to the page number in the right hand column.

These key recommendations have been abridged and are categorized as follows:

A. ORGANIZATION AND ADMINISTRATIVE STRUCTURE

B. CLIENT SERVICES

C. EMPLOYMENT AND PLACEMENT

D. DEVELOPMENT OF REHABILITATION PERSONNEL

E. FACILITIES

F. INTERAGENCY LIAISON

G. PUBLIC AWARENESS AND INVOLVEMENT

H. RESEARCH AND PLANNING

Indicated are:

(a) PRIORITY. . . . . .Current (1969-70); Intermediate (1971-73); Long Range (1974-75).

(b) IMPLEMENTATION . . . . . .Action required; i. e., Legislation.

(c) FUNDING . . . . . .Estimate of annual or biennial costs if information available. COST ESTIMATES REFLECT STATE AND LOCAL FUNDING REQUIREMENTS ONLY. THEY ARE NOT INTENDED TO INDICATE FEDERAL MATCHING COMPONENTS.

(d) WHO. . . . . .Agency, person, or branch of government which should provide leadership in carrying out the recommendation.

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Organization and Administrative Structure				
1. A functional unit of rehabilitation services should be created within the Department of Health and Welfare which shall be equal in administrative level and status with the other major administrative units within the Department.	Current Legislation (L.D. #925)	$27,394 for 1969-1971 biennium	State Dept. of Health and Welfare	242
2. The Division of Vocational Rehabilitation should be transferred from the Department of Education to the Department of Health and Welfare and placed within the Rehabilitation Services Unit.	Current Provided for in L.D. #925			242
3. Combine vocational rehabilitation services for the blind and visually impaired with those for all other disability groups.	Current Provided for in L.D. #925			107
4. The Disability Determination Unit should be transferred from the Department of Education to the Department of Health and Welfare.	Current Provided for in L.D. #925			188
5. The Director of Rehabilitation Services should administer the Rehabilitation Services Unit under the general supervision of the Commissioner of Health and Welfare.	Current Provided for in L.D. #925			291

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
6. The prime responsibility of the rehabilitation service unit's deputy director should be in the area of research, planning and development.	Current Provided for in L. D. #925			291
7. A statewide citizens advisory committee to the Rehabilitation Services Unit should be appointed by the Governor with representation from each of the six regions utilized in statewide rehabilitation planning.	Current Appointment	$500 Per year approx. meeting costs	Governor	290
8. Citizens advisory committees should be established in each of the major planning regions to provide counsel to the regional rehabilitation functions.	Current Appointment	$300 Per year approx. meeting costs	Governor's Rehabilitation Advisory Committee	290
9. At least one member of each regional rehabilitation advisory committee should also serve on the regional comprehensive health planning advisory committee in his area.	Current Appointment		State Comprehensive Health Planning Advisory Committee	291
10. Reorganize and expand treatment services within the Bureau of Corrections.	Current Legislation (L.D. #1057) (L.D. #1277)		Bureau of Corrections	147
11. A body of knowledgeable lay citizens should be appointed to serve as an advisory committee to the Bureau of Corrections.	Current Legislation (L.D. #379) By appointment	$2,000 per year approx.	Governor	149

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
12. Sentence offenders initially to the Bureau of Corrections instead of to institutions specified by the courts.	Current Legislation (L.D. #1049)		Bureau of Corrections	147
13. The Women's Correctional Center and the Stevens School should be merged on a single campus.	Current Legislation	$100,000	Bureau of Corrections	156
14. Women sentenced to the Maine State Prison should be provided for under an interstate compact.	Current Legislation	Approx. annual savings of $88,000	Bureau of Corrections	156
15. Permanent status should be granted for ten vocational rehabilitation "limited appointment" positions in cooperative vocational rehabilitation units of the state correctional institutions.	Current Legislative approval in Dept. of Education Budget request 1969-1971	In-kind matching	Division of Vocational Rehabilitation	238
16. Transfer and other reciprocal working agreements designed to promote the rehabilitation of inmates should be arranged between the regional jails and other state institutions and services.	Current Legislation (L.D. #651) (L.D. #1195)		Bureau of Corrections	158
17. Serious consideration should be given to establishing a statewide system of regional jails.	Intermediate Legislation		Law Enforcement Planning and Assistance Agency	158

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
18. The Bureau of Mental Retardation approved by the 103rd. Legislature should be adequately funded and staffed with a director, assistant director, and other central office employees in order to provide the professional supervision and administration needed for the development of coordinated mental retardation programs throughout the State.	Current Legislative Appropriation to Bureau of Mental Retardation	$61,500 for the 1969-1971 biennium	Dept. of Mental Health and Corrections	131
19. The administration and funding of all general assistance programs should be transferred from the municipalities to the State Department of Health and Welfare.	Current Legislation (L.D. #918)	Approx. 4 million additional State monies needed 1970-1971	Dept. of Health and Welfare	179

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Client Services				
20. Human resources information and referral centers should be established in strategic locations in the State.	Intermediate Administrative Action	$50,000	Dept. of Health and Welfare	96
21. Continuing attention should be given to the extended utilization of modern technological systems, i.e., closed circuit television as an aid to diagnosis, treatment, and counseling.	Intermediate Budgeting provisions		Hospital Association, Regional Medical Programs, Dept. of Health and Welfare, Maine ETV Networks	186
22. Vocational Rehabilitation Services should be broadened to include those of a preventive nature, increasing the capacity to meet the needs of handicapped children, in conjunction with other child-serving agencies.	Current Vocational Rehabilitation Agency budget request	$6,800 for 1969-1971 biennium	Divisions of Vocational Rehabilitation, Child Health, Bureaus of Special Education, Vocational Education	190
23. The Bureau of Guidance and Special Education in the Department of Education, through specialists should have primary responsibility for identifying handicapped children at the elementary school level, and develop liaison responsibilities with rehabilitation agency services.	Intermediate Bureau of Special Education budget request	$30,000 for 1971-1973 biennium	Bureau of Special Education	190

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
24. Vocational rehabilitation counselors should be assigned to major public school systems at the secondary school level for the purpose of developing prevocational rehabilitation plans for known handicapped youth.	Current Vocational Rehabilitation Agency budget request	$20,000 for 1969-1971 biennium	Division of Vocational Rehabilitation	190
25. A clinical-school psychologist should be hired by the Bureau of Special Education to work as a consultant to the public schools in identifying emotionally disturbed children, referring them to the proper helping agencies, and assisting administrative districts to set up special classes for the emotionally disturbed.	Current Administrative action	Federal funds currently available	Bureau of Special Education	195
26. School administrative units should develop their programs of instruction for educable retardates at the secondary school level.	Current Administrative action		School Administrative Districts	129
27. The Central Department of Mental Health and Corrections should employ a fulltime vocational rehabilitation specialist to serve all the state institutions and clinic centers.	Intermediate Budget Provision	$7,700 for 1971-1973 biennium	Dept. of Mental Health and Corrections and Vocational Rehabilitation Agency	121
28. Vocational rehabilitation counselors should be assigned to each of the regional mental health centers to function as members of the evaluation and treatment teams.	Intermediate Budget Provision	$13,780 for 1971-1973 biennium	Vocational Rehabilitation Agency	120

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
29. Adequate evaluation and screening for children who may be eligible for special schooling should be provided at regional mental health clinics.	Current Budget Provision	$2,750 for 1969-1971 biennium	Bureau of Special Education	125
30. Develop more effective detection and screening programs for vision problems and eye disease.	Current Budget Request	$8,179 for 1969-1971 biennium	Division of Eye Care	107
31. The Governor Baxter School should employ immediately a full time psychologist, audiologist, and school social worker.	Current Budget Request	$37,000 for 1969-1971 biennium	Dep. of Mental Health and Corrections	116
32. The State Vocational Rehabilitation Agency should employ a specially trained counselor to work with speech and hearing impairments.	Current Budget Provisions	$3,445 for 1969-1971 biennium	Vocational Rehabilitation Agency	110
33. Improve early detection and treatment of speech and hearing problems, especially among the pre-school population.	Intermediate Budget Provision	$10,000 for 1971-1973 biennium	Division of Child Health	109
34. Provision should be made for more thorough differential diagnosis and evaluation of speech and hearing impaired children including improved psychological and neurological assessment.	Intermediate Develop as part of Comprehensive rehabilitation center services	$25,000 per year	Pine Tree Society for Crippled Children and Adults	115

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
35. Develop more extensive programs of speech and hearing therapy in the public schools	Current School district budget requests	To be determined	School Administrative districts	110
36. The Armed Forces rejectee program should be reinstated as a permanent project to provide referrals and counseling services.	Current Budget Request	$22,000 for 1969-1971 biennium	Dept. of Health and Welfare	177
37. The "Outreach" program of the Senior Citizen's Corps should be extended and supported through combined public and private funding.	Current Approval of Federal application	$15,000 for 1969-1971 biennium	Services for Aging, Dept. of Health and Welfare	145
38. Title III activities of the Older Americans Act should include a transportation program for recruiting volunteer drivers to transport elderly persons to medical, educational, and social services and to part-time jobs.	Current Approval of Federal application	$45,000 for 1969-1971 biennium	Services for Aging, Dept. of Health and Welfare	145
39. In regional medical program development, home health services for the elderly should be extended from the medical care centers through affiliated regionalized home health services.	Intermediate	To be determined	Regional Medical Programs and Dept. of Health and Welfare	146
40. Social and vocational adjustment services should be available to county jail inmates during their period of confinement and continuing after release	Long range	To be determined	Dept. of Health & Welfare and Bureau of Corrections	157

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Employment and Placement				
41. The Governor's Committee on Employment of the Handicapped should be strengthened through adequate funding and a paid executive secretary.	Current Legislation L.D. 277	$39,771 for 1969-1971 biennium	Governor's Committee on Employment of the Handicapped	263
42. Vocational and prevocational programming should be carried out in close cooperation with business and industry, the Employment Security Commission, and other individuals and agencies that have knowledge of present and projected trends in the labor market.	Current Agency-Employer Liaison		Cooperative Area Manpower Planning System	114
43. Regional employment offices should adopt a systematic approach to informing local rehabilitation counselors about potentially eligible disadvantaged individuals who are seeking employment assistance.	Current Administrative Action		Maine Employment Security Commission	163
44. Employers should review and revise their standards of eligibility for group medical coverage which now favor younger men and women so that they correspond to the demands of the particular job, regardless of the applicant's age.	Current Special Study Committee		Associated Industries of Maine--Personnel Section	142
45. Public and private employers, union officials, group medical programs, and other concerned agencies and individuals should be encouraged to review and revise their policies regarding the hiring of older workers.	Current Administrative Review		Dept. of Labor and Industry	141

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
46. Employers should review their mandatory age 65 retirement policies; whenever feasible these policies should permit voluntary retirement and/or mandatory retirement at a later age	Current Administrative Review		Associated Industries of Maine-Personnel Section	143
47. Programs should be developed for locating and/or creating part time paying jobs for retired persons.	Current Federal Appropriation		Community Action Programs & Serv. for Aging; Dept. of Health and Welfare	144
48. Transportation programs should be implemented to help the rural disabled get to and from employment and community services.	Current Federal Grant		Rural Youth Corps, Community Action Programs, Jaycees	186
49. In-school and out-of-school Neighborhood Youth Corps programs should continue to be expanded and funded.	Current Federal Appropriation		Office of Economic Opportunity and Dept. of Education	199
50. In all sheltered workshop situations, employees should receive adequate financial remuneration for their work.	Current Administrative Review		Governor's Committee on Employment of the Handicapped	131
51. Current use being made of the recently enacted Work Release Statute for public offenders should be explored.	Current Committee Review		Advisory Committee to Bureau of Corrections	157

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Development of Rehabilitation Personnel				
52. An intensive study of vocational rehabilitation personnel in terms of the current classification system, salary structure, employment classes, and staff utilization should be conducted.	Current Study by Consultant		Commission on Rehabilitation Needs	248
53. Salaries and caseloads of rehabilitation counselors should be adjusted to more nearly conform to prevailing national and New England standards.	Current Legislation L.D. 226	$10,000 for 1969-1971 biennium	Personnel Board	252
54. At least one additional counselor should be placed in each of the vocational rehabilitation district offices.	Current Legislation L.D. 226	$140,000 for 1969-1971 biennium	Vocational Rehabilitation Agency	237
55. All persons hired for counseling positions in the public rehabilitation agencies should have a minimum of a baccalaureate degree with a strong emphasis on the behavioral and social sciences.	Current Administrative Action		Personnel Board	248
56. Newly hired rehabilitation counselors should receive adequate orientation and at least six months of on-the-job supervision.	Current Administrative Action		Vocational Rehabilitation Agency & Dept. of Personnel	249
57. All professional rehabilitation staff hired with less than a master's degree should be granted educational leave as soon as possible and no later than six years after being hired.	Intermediate Administrative Action		Vocational Rehabilitation Agency and Dept. of Personnel	249

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
58. Public rehabilitation agencies should be sufficiently staffed that the granting of educational leave will not cause an unreasonable work load to fall on anyone.	Intermediate Legislative Budget Request	$160,000 for 1971-1973 biennium	Rehabilitation Services Unit	249
59. Tuition costs for advanced courses taken by professional rehabilitation employees should be reimbursed when these courses are related to job performance.	Intermediate Legislative Budget Request	$10,000 for 1971-1973 biennium	Rehabilitation Services Unit	249
60. The State Department of Personnel should be encouraged to review its policies regarding the educational advancement of rehabilitation personnel with a view to implementing a uniform procedure which will grant due recognition and financial rewards to employees who achieve recognized educational objectives.	Current Administrative Review		Dept. of Personnel	250
61. Whenever rehabilitation personnel complete a major course of in-service training or recognized off-site program, they should receive wage increases commensurate with their new or advanced training according to acceptable personnel department regulations.	Intermediate Administrative Action	To be determined	Dept. of Personnel and Rehabilitation Services Unit	250

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
62. The positions of counselor trainee, counselor aid, and counselor technician should be created within the Vocational Rehabilitation Services as the first rungs of the career ladder, leading to the position of counselor.	Current Legislative Action		Personnel Board	252
63. Recruitment and training programs should be developed leading to the utilization of paraprofessional and supportive personnel, such as technicians, aides, and assistants, for provision of services not requiring full professional preparation.	Intermediate Adminstrative Action		Rehabilitation Services Unit	251
64. The public rehabilitation agencies should offer summer traineeships to college students as a means of orientation and for testing of career decisions.	Current Administrative Action	$4,000 for 1969-1971 biennium	Rehabilitation Services Unit	251
65. The State University system should proceed immediately to develop formal degree programs for the training and accreditation of rehabilitation personnel with provision for transfer of credits earned in accordance with terms of the New England Education Compact.	Current University Study Committee	To be determined	Board of Trusties, University of Maine	250

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
66. Public and private agencies engaged in rehabilitation should contract with the continuing education division (CED) of the University of Maine and other institutions of higher learning to provide a wide range of both credit and non-credit courses in the behavioral and social sciences and the functional aspects of rehabilitation practices.	Current Interagency Liaison	To be determined	University of Maine & Rehabilitation Services Unit	250
67. Public rehabilitation agencies and state institutions should provide continuing in-service training programs for all employees, with strong emphasis on the interpersonal approach.	Current Administrative Action		Rehabilitation Services Unit	249
68. At least four more probation-parole officers, two men and two women, should be employed by the Division of Probation and Parole for general supervision and community adjustment. In addition, each district office (Portland, Augusta and Bangor) should include at least one probation-parole officer with prime responsibility for establishing contacts leading to job placement through the Employment Security Commission.	Current Legislation (L.D. 226)	$100,000 for 1969-1971 biennium	Division of Probation-Parole, Dept. of Mental Health and Corrections	154

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
69. At least one probation-parole officer, with responsibility for juveniles only, should be assigned to each of the following areas: Lewiston-Auburn, Augusta-Waterville; Bangor-Brewer-Old Town; and Aroostook County.	Current Legislative Budget Request	$50,000 for 1969-1971	Division of Probation& Parole	155
70. Student traineeships should be established at the Governor Baxter School for the Deaf.	Intermediate Administrative Action		Dept. of Mental Health and Corrections	116

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Facilities				
71. A plan for the orderly development of a statewide regionalized system of comprehensive medical rehabilitation services and facilities should be implemented.	Current Rehabilitation Services Advisory Committee Guidance		Dept. of Health & Welfare	99
72. A comprehensive rehabilitation center for the state and region should be developed in southern Maine.	Intermediate Interagency Coordination	$1,500,000 for Coordinating Facility	A private, non-profit coordinating council	101
73. Medical rehabilitation centers should be further developed at major medical facilities in central, eastern and northern Maine.	Intermediate Hospital Board and Administrative Action	$500,000 approx per medical center	Hospital Boards	102
74. Cooperative vocational rehabilitation units should be established at major medical centers.	Current Legislation (L.D. 226)	$52,000 for 1969-1971 biennium	Vocational Rehabilitation Agency	103
75. Expand rehabilitation services at a major medical center in the Greater Portland area to include vocational evaluation and training in the "hospital industries."	Current Cooperative Agreement	$35,000 per year	Maine Medical Center, Pine Tree Society for Crippled Children & Adults, Vocational Rehabilitation Agency	172

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
76. A hospital in Central Maine should expand its rehabilitation function to include vocational evaluation and training, especially in its "hospital industries."	Intermediate Cooperative Agreement	$35,000 per year	A Central Maine Hospital and Vocational Rehabilitation Agency	174
77. A hospital in Penobscot County should expand its rehabilitation function to include vocational evaluation and training, especially in its "hospital industries."	Current Cooperative Agreement	$35,000 per year	Eastern Maine General Hospital and Vocational Rehabilitation Agency	171
78. Expand medical rehabilitation services at a hospital in Aroostook County to include vocational evaluation and training, especially in its "hospital industries."	Intermediate Cooperative Agreement	$35,000 per year	A Central Aroostook Hospital & Vocational Rehabilitation Agency	175
79. Extended care facilities should be surveyed and an attempt made to improve domiciliary health and rehabilitation care services on a regional basis.	Intermediate Administrative Survey		Bureau of Medical Care, Dept. of Health & Welfare	146
80. Expand services offered by the merging Goodwill Industries and Work Adjustment Center of Portland including domiciliary care.	Current Joint Board Action	$100,000	Joint Board of Work Adjustment Center and Goodwill Industries	172
81. Expand services offered at the Lewiston-Auburn Occupational Training Center to provide domiciliary care.	Intermediate Board Action	$75,000	Lewiston-Auburn Occupational Training Center Board	172
82. Develop a system of satellite workshops associated with the Lewiston-Auburn Occupational Training Center.	Long Range Cooperative Agreement	To be determined	Rehabilitation Facilities Advisory Committee	175

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
83. A vocational adjustment/sheltered employment facility should be established in the Bangor/Brewer area.	Intermediate Federal Grant	$50,000 per year	A private non-profit council.	171
84. Establish a vocational adjustment and sheltered employment facility in Aroostook County.	Intermediate Federal Grant	$35,000 per year	Opportunity Training Center of Presque Isle	173
85. Develop a satellite workshop in York County.	Intermediate Federal Grant	$35,000 per year	A private non-profit council	174
86. A comprehensive work adjustment and training center, together with a sheltered workshop for both temporary and terminal employment, should be established in conjunction with Pineland Hospital and Training Center in Pownal.	Long Range Legislation	$150,000	Bureau of Retardation, Dept. of Mental Health & Corrections	130
87. Fulltime cooperative vocational rehabilitation units should be established at the state hospitals in Bangor and Augusta.	Current Administrative Action	In-kind Matching	Bureau of Mental Health & Vocational Rehabilitation Agency	121
88. Speech and hearing clinics should be established or further developed at the separate institutions which comprise the University of Maine and selected private colleges.	Intermediate University Health Services Committee	$7,500 per year State matching	University of Maine	111
89. Establish a multidisciplinary diagnostic and reception center for adult male public offenders.	Current Legislation L.D. 479	$976,000	Bureau of Corrections	148

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
90. Establish a diagnostic and treatment center for juvenile public offenders, male and female.	Current Legislation	$300,000	Bureau of Corrections	173
91. A pre-release center should be established for adult male offenders, to be located preferably in the southern Maine area.	Current Legislation L.D. 478	$300,000	Bureau of Corrections	151
92. Establish a prerelease center for female offenders.	Intermediate Legislation	$300,000	Bureau of Corrections	173
93. Establish a halfway house for male public offenders in the Lewiston-Auburn vicinity.	Intermediate Legislation	$50,000	Bureau of Corrections	174
94. Establish a halfway house for female public offenders in the Bangor-Brewer vicinity.	Current Legislation	$50,000	Bureau of Corrections	174
95. Intensive treatment centers should be established at the state hospitals in Augusta and Bangor for the detoxification, evaluation, and rehabilitation of confirmed alcoholic offenders.	Current Administrative Action	$25,000 per year for staff	Bureau of Mental Health	152
96. Establish a halfway house for male alcoholics in Portland.	Current Interagency Agreement	$10,000 per year	Vocational Rehabilitation Agency & Alcoholism Services	173

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
97. Sequential academic and vocational training programs to include the handicapped should be developed at the area vocational-technical high schools.	Intermediate Administrative Action		Vocational Rehabilitation & Bureau of Vocational Education	198
98. The Park and Recreation Commission should equip at least one state park with suitable facilities for physically handicapped children and adults, and new state parks being developed by the Commission should incorporate such facilities.	Current Administrative Action		Park and Recreation Commission	260

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Interagency Liaison				
99. An interdepartmental commission on health manpower services should be created to evaluate the intra- and interagency roles of present and projected health service personnel.	Intermediate Appointment		Governor and State Planning Office	247
100. All public agencies responsible for the delivery of social and rehabilitation services and funded under federal-state provisions of the Vocational Rehabilitation and Social Security Acts should give greater emphasis to coordinating their activities in order to reach families and individuals in all areas of their need and to further their total rehabilitation.	Current Interagency Liaison		Commissioner of Dept. of Health and Welfare	188
101. Planning for quality medical and restorative services should continue as a function of Maine's comprehensive health planning.	Current Administrative Coordination		Dept. of Health and Welfare	118
102. The quality of medical and restorative services to persons stricken by heart disease, cancer, stroke, or a related illness should continue to be upgraded through the cooperative efforts of Maine's regional medical programs, and the Bureaus of Health and Medical Care in the Department of Health and Welfare.	Current Administrative Coordination		Regional Medical Programs and Bureau of Medical Care	118

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
103. Medical rehabilitation facilities should coordinate their programs closely with those of the university and colleges.	Long Range Administrative Coordination		University of Maine Health Services Committee and Hospital Boards	112
104. Referral, treatment, and re-employment procedures for occupationally disabled workers should be improved through (a) insurance carriers maintaining accurate records of rehabilitation prospects, and (b) early reports from the attending physician covering rehabilitation opinions and plans.	Current Administrative Action		Industrial Accident Commission, Vocational Rehabilitation Agency and Insurance Company Claims Managers	205
105. Close liaison should be established and maintained between state and local Economic Opportunity programs and the state rehabilitation agency for case identification, referral, and follow-up.	Current Interagency Liaison		Community Action Program Directors and Vocational Rehabilitation District Supervisors	162
106. CAMPS should be recognized and supported as the most effective mechanism for meeting client-centered manpower needs through cooperative agency planning.	Current Interagency Liaison		Cooperative Area Manpower Planning System - Maine Employment Security Commission	212
107. CAMPS should provide for full representation from private and voluntary organizations which provide services to the handicapped and disadvantaged.	Current Coordinating Committee outreach		CAMPS	212

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
108. VISTA project directors and volunteers should report all cases whom they believe may be eligible to the rehabilitation counselors in their region.	Current Interagency Agreement		Office of Economic Opportunity and Rehabilitation Services Unit	162
109. Public Rehabilitation Services and the Rural Youth Corps should establish closer working relationships to ensure the rehabilitation of the disadvantaged rural population.	Current		Office of Economic Opportunity and Rehabilitation Services Unit	204
110. Colleges and community action agencies should increase the number of eligible young adults enrolled in Upward Bound programs and coordinate their programming with public vocational rehabilitation services.	Current Administrative Action		Office of Economic Opportunity	201
111. The Bureau of Corrections, in cooperation with other responsible agencies, public and private, should explore the feasibility of a project to encourage local communities to assist materially in the rehabilitation of their own public offenders.	Current Legislation and Interagency Agreement	$20,000 for Pilot Program	Advisory Committe to Bureau of Corrections	150

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Public Awareness and Involvement				
112. A public information and education service should be created within Public Rehabilitation Services in the Department of Health and Welfare and headed by a fulltime information officer.	Current Legislation L.D. 226	$6,612 for 1969-1971 biennium	Rehabilitation Services Unit	229
113. The position of information writer should be created in the Division of Vocational Rehabilitation.	Current Legislation	$4,500 for 1969-1971 biennium	Vocational Rehabilitation Agency	230
114. The Pine Tree Society for Crippled Children and Adults should continue to create public interest in eliminating and preventing community barriers to rehabilitation through organized state and local action.	Intermediate and Long range Interagency Involvement		Pine Tree Society for Crippled Children and Adults	258
115. Voluntary organizations should be encouraged and assisted in utilizing portions of their annual meetings for educational programs on the rehabilitation process.	Intermediate and Long Range Interagency Cooperation		Rehabilitation Services Unit	208
116. An effective public information program should be established in the Department of Mental Health and Corrections	Current Legislation L.D. #226	$16,000 for 1969-1971 biennium	Dept. of Mental Health and Corrections	149
117. Community volunteers should be recruited and trained to assist in all appropriate phases of the correctional process, particularly the probation and parole effort.	Current Administrative Authorization	$2,000 per year	Bureau of Corrections	150

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
Research and Program Planning				
118. The Statewide Plan for Rehabilitation Services should be updated annually, preferably in the spring before the close of each fiscal year.	From 1970 on Advisory Committee liaison		Advisory Committee to Rehabilitation Services Unit	290
119. An advisory committee on research to the Rehabilitation Services Unit should be established, with representation from all agencies concerned with rehabilitation.	Intermediate Appointment	$500 per year meeting costs	Commissioner of Health and Welfare	255
120. Public rehabilitation services should develop and keep current a non-duplicative list of known handicapped persons in Maine eligible for rehabilitation services.	Current Administrative Action	$17,000 for Pilot Project	Rehabilitation Services Unit and Bureau of Administration, Dept. of Health and Welfare	94
121. An intensive study of rehabilitation referral patterns and practices should be made, and continuing program assessment of all rehabilitation services and facilities should be maintained.	Intermediate Administrative Action	Part of L.D. #925	Rehabilitation Services Unit	254
122. Improved case finding, reporting and referral systems should be developed for persons afflicted with heart disease, cancer, and stroke.	Intermediate Board Authorization	$20,000 for Pilot Project	Regional Medical Programs	118

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
123. Transportation problems of rehabilitation clients and other disabled persons should be given periodic review by the Governor's Committee on Employment of the Handicapped in cooperation with the Pine Tree Society for Crippled Children and Adults	Current Interagency Research		Governor's Committee on Employment of the Handicapped and Pine Tree Society	262
124. The feasibility of utilizing mobile clinics and modern transportation methods, such as aircraft, should be explored.	Long range Interagency Research		State Planning Office and Dept. of Health and Welfare	186
125. Institutional and state agency research in rehabilitation should be augmented by increasing emphasis on community-oriented research.	Intermediate Interagency Coordination		Advisory Committee on Rehabilitation Research	255
126. Five percent of state money appropriated for vocational rehabilitation services should be earmarked for research each year.	Intermediate Administrative Action		Rehabilitation Services Unit	254
127. The Rehabilitation Services Unit should stimulate basic and applied research through the state university system, the private colleges, and the public and private hospitals and laboratories.	Long Range Cooperative Planning		Rehabilitation Services Unit-Research Committee	254
128. Increasing emphasis should be given to the prevention of mental retardation by minimizing known causes.	Current State-Federal Programming		President's Committee on Mental Retardation	123

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
129. An officer with responsibility for research and personnel training should be employed by the central probation-parole office.	Intermediate Legislation	$18,000 for 1971-1973 biennium	Division of Probation-Parole	154
130. The quality of health instruction in the public schools should be upgraded by instituting a comprehensive course in health education supervised by a qualified health educator in the Department of Education's Division of Instruction.	Current Legislation L.D. #383	$30,200 for 1969-1971 biennium	Dept. of Education	198
131. Additional programs should be initiated for (a) children of preschool age and (b) children with learning disabilities at the Governor Baxter School for the Deaf.	Current Administrative Action	To be Determined	Dept. of Mental Health and Corrections	116
132. The State Rehabilitation Act should be revised periodically in conformance with the amended federal statutes to permit vocational rehabilitation services to be extended to all handicapped and disadvantaged individuals.	Intermediate and Long Range Administrative Review		Rehabilitation Services Unit - Advisory Committee	290
133. The Governor's Committee on Employment of the Handicapped should periodically review the Architectural Barriers Law to ascertain its effectiveness.	Intermediate and Long Range Committee Review		Governor's Committee on Employment of the Handicapped	259

KEY RECOMMENDATIONS

RECOMMENDATIONS	PRIORITY & IMPLEMENTATION	FUNDING	WHO	PAGE
134. Cooperative arrangements for medical rehabilitation services should be made with neighboring New England states and Canada.	Intermediate International Agreement		Executive Department, Legislative Research Committee	103

CHAPTER I

INTRODUCTION

A. BACKGROUND INFORMATION

The 1965 amendments to the Vocational Rehabilitation Act enabled states to apply for funds for the purpose of carrying out statewide planning programs for comprehensive vocational rehabilitation services. Upon receipt of this federal authorization in 1966, former Gov. John H. Reed appointed 31 Maine citizens to serve as members of a special commission responsible for the planning effort. Designated the "Maine Commission on Rehabilitation Needs," it became fully operational in February 1967 with the hiring of an executive director, assistant director, and a full-time secretary.

Purpose

The purpose of this study has been to formulate a plan for the orderly development of comprehensive rehabilitation services in Maine, including those provided by private nonprofit agencies, with a view to making them available by 1975 to all of the state's disabled persons who can benefit from these services.

Scope

Specific guidelines for planning have been:

1. To identify the numbers and types of disabled who need services now, and will be needing them in the target year 1975,

2. To identify the barriers that delay or prevent eligible clients from receiving services,

3. To identify the services and facilities that will be required to meet present and future needs,

4. To encourage broad community support, and to recommend the specific legislative action necessary for reaching the planning objectives,

5. To recommend ways of strengthening coordination within state agencies, and between public and private agencies responsible for delivering rehabilitation services,

6. To study employment opportunities and training programs for the handicapped.

Although the Commission's planning has focused primarily on persons with physical and mental impairments, it has recognized that several other kinds of disabling conditions exist and must be

accounted for within any program of comprehensive rehabilitation planning. Attention, therefore, has been given to the psychosocially, the educationally and the low income disabled--groups which comprise a disproportionate share of the state's vocationally handicapped population.

The Commission and its task forces have recognized also that while economic self-sufficiency is an important goal in rehabilitation, it is by no means the only one. Prevention of disabling conditions, and the restoration of as many persons as possible to whatever degree of functional living they are able to achieve are vital components in the total rehabilitation effort. To this end, we have also explored the needs and have made recommendations pertaining to rehabilitation services for persons with severe physical disabilities, the aging, and others for whom full or even part-time employment is not an objective.

As a guideline for planning, the Commission's task forces adopted the following definition as stated prior to this study by Commission Chairman Leonard W. Mayo:

> All rational rehabilitation starts with an attempt to remove the physical or mental source of the disability. Therefore, the first goals are medical. Nevertheless, careful attention must be paid to the social and psychological obstacles. Goals in rehabilitation may be interpreted as movement toward more independent living as expressed by a reduction in the amount of care required by the person, as well as in the movement toward remuneration for production. The definition of rehabilitation includes all of these goals. Any definition which excludes any of these is not a definition, regardless of the name of the agency.

CHAPTER II

THE PLANNING ORGANIZATION

A. THE DESIGNATED ORGANIZATION

Planning for statewide rehabilitation services in Maine has been the responsibility of the Commission on Rehabilitation Needs during the two-year planning period.

This body, which now has 32 members, was appointed by former Gov. John H. Reed in September 1966. Although many of those who serve on it have professional ties with federal-state rehabilitation programs, the Commission itself is completely independent from any other state agency.

The broad approach to objectives which has characterized this planning effort has been due in large part to the Commission's wide geographical representation and to its inclusion of such diverse interests as management, labor, education, law, medicine, state and local government, public and voluntary agencies, the mass media, and many more.

B. THE POLICY COMMISSION

The 32-man Policy Commission has been responsible for making all major decisions regarding the conduct of the study. It has adopted an organizational plan, defined the planning objectives, and authorized the steps to be taken in reaching these objectives. In the phases of evaluation, reporting and implementing, it formulated and officially approved the recommendations which appear in this report.

The full Policy Commission has held meetings at least quarterly in addition to sponsoring special conferences and attending functions concerned with the planning and performance of rehabilitation services throughout the state.

After assuming a new job in Massachusetts, the Commission's original chairman, George T. Nilson, was unable to continue in this post, and in June 1968, Gov. Kenneth M. Curtis appointed Prof. Leonard W. Mayo of Colby College as his successor. Dr. Mayo has gained world prominence as a leader in rehabilitation. Among the many offices he holds are those of vice chairman of the President's Committees on Employment of the Handicapped and on Mental Retardation.

Members of the Policy Commission, their professional affiliations and place of residence are as follows:

Chairman:

Leonard W. Mayo, S.Sc.D.
Professor of Human Development
Colby College
Waterville

Vice Chairman

Bennett D. Katz, State Senator
President, Nicholson and Ryan
Augusta

Executive Committee (in addition to Chairman and Vice Chairman)

William F. Haney
Executive Director
Pine Tree Society for Crippled Children and Adults
Bath

Elmer L. Mitchell, Director
State Vocational Rehabilitation Division
Manchester

C.Owen Pollard, Director
Division of Eye Care and Special Services
Readfield

Members

Louis Benoit
Board Member
Goodwill Industries & Merchant
Portland

Mrs. Catherine Carswell
Former State Representative
Portland

Casper Ciarvino
Superintendent of Schools
Owls' Head

Barrie Cooper
Administrator
Maine Coast Memorial Hospital
Ellsworth

Joseph E.A. Cote, Commissioner
Employment Security Commission
Augusta

*Joseph A. D'Alfonso
State Representative
Portland

Charles J. DiPerri, D.O.
Osteopathic Physician
Wiscasset

Benjamin J. Dorsky, President
Maine State Federated Labor Council
Bangor

Miss Elaine L. Gagne, R.N.
Assoc. Dir. School of Nursing
Mercy Hospital
Portland

*Arthur Gouin
Extension Agent
University of Maine
South Paris

William Gilman
Private Citizen
Old Orchard Beach

Charles R. Hagan
Retired Safety Director
Oxford Paper Company
Augusta

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*Appointed February, 1969.

Frederick T. Hill, M.D. (Deceased)
Vice President
Planning and Development
Thayer Hospital
Waterville

Philip N. Johnson
WCSH News Commentator
North Windham

Eugene C. Jorgensen, Ed.D.
Dean, Washington State College
Machias

Thomas J. Kane, M.S.W., Director
Child & Family Mental Health
Services
Lewiston

*W.A. Leavell, Jr., Ph.D.
Syndicated Columnist
Belfast

Mrs. Carolyn G. Lombardi
Past President
Maine Federated Womens Club
Bangor

Mrs. Hazel C. Lord
Former Legislator
Portland

John J. Lorentz, M.D.
Director of Medical Rehabilitation
Maine Medical Center
Portland

*Roland MacLeod
Vice President
Merrill Trust Co.
Bangor

Charles D. McEvoy, Jr., M.D.
Maine Medical Association
Bangor

Donald McAllister
Town Manager
Norway

Sister Mary Miguel, R.S.M., Director
Blind Children's Resource Center
Portland

Leo Morency
Town Manager
Rumford

John A. Platz, LL.B.
Attorney at Law
Lewiston

Louis A. Ploch, Ph.D.
Prof., Rural Sociology
University of Maine
Orono

Norman Rogerson
Former Legislator
Houlton

Francis H. Sleeper, M.D.
Former Superintendent
Augusta State Hospital
Augusta

George E. Sullivan, M.D.
Maine Medical Association
Waterville

*Andrew C. Walsh, M.D.
Director of Rehabilitation Medicine
Mercy Hospital
Portland

Edmund P. Wells, Exec. Director
Maine Tuberculosis and Health
Association
Augusta

*Miss Mary G. Worthley
Lay Minister
West Lebanon

1. Executive Committee of the Policy Commission

Subsequent to the Commission's first organizational meeting held October 13, 1966, Chairman Nilson appointed Dr. Mayo, Senator Katz, Mr. Mitchell and Mr. Pollard to serve with him as an Executive Committee.

*Appointed February, 1969.

In May 1968 he named Senator Katz as vice chairman of the Policy Commission.

Upon Mr. Nilson's resignation from the Commission and the appointment by Governor Curtis of Dr. Mayo to the chairmanship, William Haney was elected to fill the vacancy on the Executive Committee.

The principle function of this committee has been to execute the intent of the full Commission in all matters affecting policy, and to guide the project staff in the development of the study.

In addition to regular monthly meetings, the Executive Committee has convened on many other occasions to facilitate the progress of planning.

C. STATEWIDE ADVISORY COMMITTEE

It was the unanimous decision of the Executive Committee and Policy Commission not to create a separate Advisory Committee. Throughout all phases of the planning the full Policy Commission and the Executive Committee havebeen available for consultation and decision making.

D-E. REGIONAL TASK FORCES

Early in the study, the Commission and project staff gave considerable attention to methods of gaining community involvement at the "grass roots" level. It was recognized that the people themselves can best determine their local needs for services and that once they have gained a broad understanding of how these relate to needs in other communities throughout the state, they can provide an invaluable service by generating the support necessary to carry out the program objectives.

Geographical distribution was ensured through a system of six regional task forces, with the regions themselves drawn on the basis of related state planning models, population density, ecological features, transportation flow, referral patterns, and the availability of public and private rehabilitation services to each area.

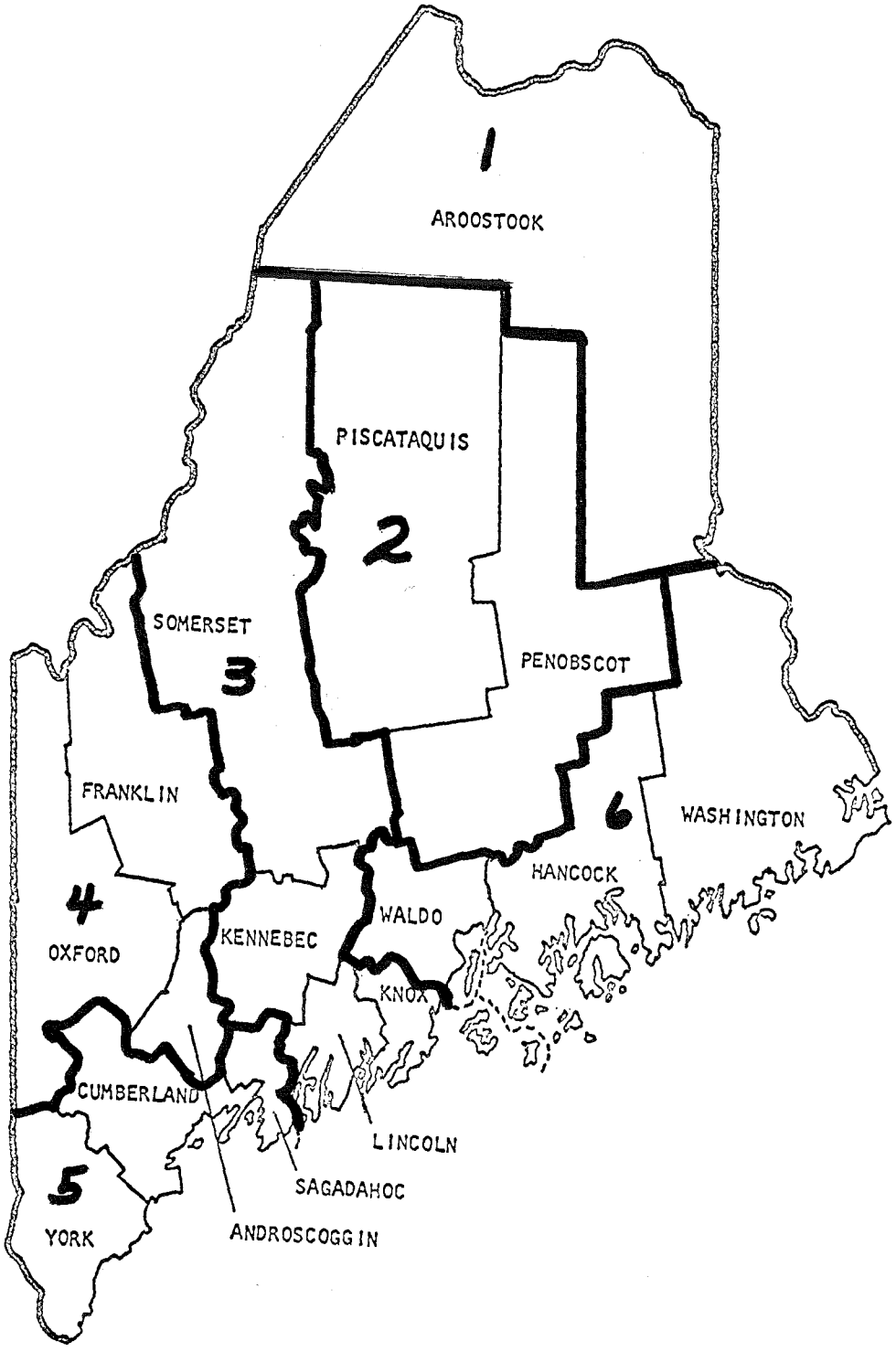
A careful selection was made of an experienced community leader in each of the six regions to serve as a part-time paid coordinator. This person, in turn, assisted the project staff in selecting from 15 to 18 other professional and interested individuals in the region to comprise the citizens task force. These volunteers were chosen to represent a cross section of the population, official and private organizations, and the general public.

Some of the specific functions of the task forces were to identify local needs; survey available services, training facilities and workshops; determine the barriers to the utilization of rehabilitation services and facilities; determine the extent of employment opportunities available to rehabilitated persons; formulate specific recommendations based on their findings; and conduct a statewide study of Employer's Readiness to Hire the Handicapped. The results of the survey can be found in Chapter IV, Sections G-3 and G-4.

Since September 1967 each task force has met at least once every three weeks. They are continuing to play a vital role informing legislators and the general public about the extent of local and statewide rehabilitation needs and the Commission's proposals for meeting these needs.

A map of the six planning areas and a listing of task force members by region will be found on the following pages.

AREA REGIONALIZATION FOR COMMUNITY PLANNING



REGIONAL TASK FORCE MEMBERS

Region 1

Roger Martin, Coordinator
Guidance Director
Madawaska High School
Madawaska

Miss Lorraine Cote, R.N.
Private Duty Nurse
Fort Kent

Peter Freck, Caseworker
Department of Health and Welfare
Caribou

Gregory Freeman, Owner
Seven Up Bottling Company
Presque Isle

Philip Hutcheon, Photographer
Rehabilitated Amputee
Caribou

Robert Johnson, Caseworker
Department of Health and Welfare
Houlton

Miss Ada Knauff, R.N., Supervisor
Public Health Nursing
Caribou

Earl B. Langley, Counselor
Division of Vocational Rehabilitation
Presque Isle

Norman Rogerson, Chairman
Former Legislator
Houlton

Luther L. Lovely, Counselor
Employment Security Commission
Presque Isle

Francis Miller, Personnel Manager
Fraser Paper Mill
Madawaska

Mrs. Caroline Morris
Guidance Director
Ashland High School
Ashland

Mrs. Ruth Mraz, Newspaper Writer
Fort Fairfield

Mrs. Marilyn Plissey, Extension
Agent, University of Maine
Fort Kent

Bert Pratt, Jr., Assistant Director
of Admissions, University of Maine,
Orono

Gerard Rubino, Pastor
Episcopal Church
Presque Isle

Homer Ward, Sr.
Former Legislator
Limestone

Region 2

Mrs. Pauline Briggs, Coordinator
Community Organizer
Bangor

Jerry Cartwright, Ph.D.
Psychologist, Infirmary
University of Maine
Orono

John Cunningham, Chairman
Director, United Community Services
Bangor

Orville Cookson, Assistant Director
Penobscot County Community Action
Bangor

John J. Fahey, Principal
Fourteenth Street School for
Handicapped Children
Bangor

Horace Gordon, Director
Community Action Agency
Dover-Foxcroft

Charles Grant, Ph.D.
Psychologist, Infirmary
University of Maine
Orono

Charles Holt, Extension Agent
University of Maine
Orono

Mrs. Florence F. Hoxie
Housewife
Brownville Junction

Kwan Lee, Pastor
Methodist Church
Brownville Junction

Roland MacLeod, Vice President
Merrill Trust Company
Bangor

Arthur Michaud, Personnel Director
Great Northern Paper Company
East Millinocket

Mrs. Ruth Mitchell, Director
United Cerebral Palsy of
Northeastern Maine
Bangor

Mrs. Sadie R. Mitchell, Counselor
Division of Vocational Rehabilitation
Bangor

John Neff, Pastor
First United Methodist Church
Orono

O.T. Rozelle, Retired Community
Action Director
Dover-Foxcroft

Ray W. Sherman, Counselor
Employment Security Commission
Bangor

Mrs. Charlotte White
State Representative
Guilford

Region 3

Mrs. Dorothy Mills, Coordinator
Community Leader
Belgrade

Mrs. Marilyn Brown
Speech Therapist
Skowhegan School System
Harmony

Mrs. Pauline Buxton
Community Organizer
Waterville

Gray Curtis, Former Director
Division of Vocational Rehabilitation
Augusta

Miss Lorna Dill, R.N.
Psychiatric Nurse
Bureau of Mental Health
Skowhegan

Richard Cleaves, Chairman
Chaplain, Augusta State Hospital
Augusta

Marguerite Dunham, M.D.
Assistant Director, Division of
Maternal and Child Health,
Department of Health and Welfare
Augusta

Mrs. Cathleen Gerrish, R.N.
Camden

Marshall Kearney, Director of
Personnel, C.F. Hathaway Company
Waterville

Ernest E. Martin, Counselor
Division of Vocational Rehabilitation
Augusta

Mrs. Virginia Masse, Extension Agent
University of Maine
Rockland

H.C. Moeller, Pastor
Lutheran Church
Waterville

John C. Mullins, Counselor
Employment Security Commission
Augusta

Robert Pelletier
Businessman
Winthrop

Alex Somerville, Principal
Gardiner Area High School
Gardiner

Miss Mary Sullivan, R.N., Director
Public Health Nursing
Department of Health and Welfare
Augusta

Mary Tracy, M.D., Pediatrician
Lewis Point
Damariscotta

Beverly Trenholm, Director
Bureau of Guidance, Special and
Adult Education, Education Department
Augusta

Roger Truman, Accountant
Rehabilitated Person
Hallowell

Region 4

Clinton Conant, Coordinator
Director, Community Action
for Franklin County
Strong

Edwin B. Coltin, Director
Employee Relations,
Bates Manufacturing Company
Lewiston

Raymond Dow, Supervisor
Division of Family Services
Lewiston

Mrs. Margaret Foster, R.N.
Norway

Arthur Guoin, Extension Agent
University of Maine
Oxford County
South Paris

Harvey Harrington, Counselor
Employment Service Department
Poland Spring Job Corps
Poland Spring

Ross Fearon, Chairman
Director, Special Education Department, Farmington State College
Farmington

Paul Judkins, Director
Leadership Development
Farmington State College
Farmington

Harry Mickalide, Counselor
Employment Security Commission
Lewiston

Mrs. Elsie Morency, Teacher
Rumford

Mrs. Dorothy Morissette, Social Worker
St. Mary's Hospital
Lewiston

Gregory F. Ouellette, Camp Director
Pine Tree Society for Crippled
Children and Adults
Bath

Ben F. Pike, Director
Public Relations
International Paper Company
Chisholm

Mrs. Hazel Smart, Teacher
Rumford

Region 5

Frank Duley, Jr., Coordinator
Guidance Director
Old Orchard Beach High School
Old Orchard Beach

Matthew I. Barron, Director
Portland Welfare Department
Portland

Philip Chandler, Director
Work Adjustment Center
Portland

Harlow Currier, Counselor
Division of Vocational Rehabilitation
Sanford

Miss Mary E. Desmond, Director
Social Service Department
Mercy Hospital
Portland

Mrs. Louise Gibbs, Counselor
Division of Vocational Rehabilitation
Portland

Lawrence Gilbert, Chaplain
Men's Correctional Center
South Windham

Ray Googins, Manager
Youth Opportunity Center
Portland

Charles Guyler, Facilities Specialist
Division of Vocational Rehabilitation
Augusta

William F. Haney, Director
Pine Tree Society for Crippled
Children and Adults
Bath

Arthur Stevens, Counselor
Division of Vocational Rehabilitation, Lewiston

Mrs. Betty White, Secretary
Community Action Council
Strong

Miss Mary G. Worthley, Chairman
Lay Minister
Governor's Advisory Committee on
Mental Health
West Lebanon

Maurice B. Johnson, Counselor
Eye Care and Special Services
Portland

Mrs. Hazel C. Lord
Former Legislator
Portland

John Lorentz, M.D., Director
of Medical Rehabilitation
Maine Medical Center
Portland

Burleigh P. Loveitt, Extension
Agent, Cooperative Extension
Service
University of Maine
Portland

Edward McGeachey, Assistant Director, Maine Medical Center
Portland

Neil D. Michaud, Director
Diocesan Bureau of Human Relations
Portland

Mrs. Agnes Murphy, R.N., School Nurse
Old Orchard Beach

Jerome G. Plante
Rep. for Peter Kyros
Portland

Andrew Walsh, M.D., Director
Medical Rehabilitation Department
Mercy Hospital
Portland

Miss Heloise Withee, Director
Public Health Nursing Association
South Portland

Region 6

Mrs. Ellen Jewett, Coordinator
Registered Nurse
Bucksport

Howard Brooks, Safety Director
St. Regis Paper Company
Bucksport

Herman Carlstrom, Counselor
Division of Vocational Rehabilitation
Bangor

Barrie Cooper, Administrator
Maine Coast Memorial Hospital
Ellsworth

Mrs. Virginia Frame, R.N.
Bar Harbor Public Health Nursing
Bar Harbor

Mrs. Eleanor Gazutou, R.N.
Public Health Nurse, Supervisor
Washington and Hancock Counties,
Columbia Falls

John F. Harriman, Supervisor
Division of Vocational Rehabilitation
Bangor

Angus Humphries, Counselor
Division of Vocational Rehabilitation
Calais

Harvey Kelley, Educator
Belfast

Mrs. Ida M. Long
Home Executive
Belfast

Ralph Long, Guidance Director
Belfast Junior High School
Blind Disabled Person
Belfast

Ronald Schoppee, Chairman
Supervisor, Division of Family
Service
Ellsworth

Robert Ouellette, Counselor
Employment Security Commission
Calais

Burton Payson, Guidance Counselor
Belfast High School
Belfast

Gordon Richardson
State Representative
Stonington

Harold Rosene, M.D.
Orthopedic Surgeon
Ellsworth

Robert Salisbury, Counselor
Employment Security Commission
Ellsworth

Faye Schoppee, Housewife
Ellsworth Falls

Robert Smith, Director
Community Action Agency
Hancock County, Bar Harbor

Willis Spaulding, Pastor
First Baptist Church
Belfast

Mrs. Marion Stackpole, Specialist
Education, Training and Rehabilitation
Machias

Sara Wilson, Extension Agent
University of Maine
Washington County
Jonesboro

F. SUBCONTRACTORS ASSIGNED PLANNING FUNCTIONS

1. Harbridge House, Inc., Boston, Massachusetts

Harbridge House, a leading consultant firm in vocational rehabilitation, was employed by the Commission early in June of 1967 to conduct three research studies:

a. Estimate the demand for vocational rehabilitation services--the number of persons eligible for such services--in 1967 and projected to 1975.

b. Assess the performance of the two state agencies that have primary responsibility for vocational rehabilitation in Maine--the Division of Vocational Rehabilitation in the Department of Education and the Division of Eye Care and Special Services in the Department of Health and Welfare.

c. Describe the need and means for obtaining quantitative data required for vocational rehabilitation planning. This included a method of developing a nonduplicative name list of eligible vocational rehabilitation clients, and also the nature and potential utility of additional data to be drawn from a sample survey of eligible clients known to hospitals and voluntary agencies.

Except where otherwise noted, disability estimates used in this report, particularly in Chapter IV, Sections A and B, are those provided by the Harbridge House studies.

2. Health Facilities Planning Council

Through a contractural arrangement with the Health Facilities Planning Council, a consultant was engaged in June of 1967 to study programs for the occupationally disabled and the disabled aging. Estimates of the numbers of persons in both these categories were included in this consultant's report, together with the recommendations to be found in Chapter IV, Sections C-1 and C-10.

G. INTERAGENCY LIAISON

1. Statewide Plan for Vocational Rehabilitation Facilities and Sheltered Workshops.

Application was made in 1966 by the Division of Vocational Rehabilitation and the Division of Eye Care and Special Services for a planning grant from the Vocational Rehabilitation Administration with which to determine the needs for workshops and rehabilitation facilities, to provide for a continuing program for assessing such needs, and to evaluate activities for their establishment, construction, utilization, development and improvement.

The amount of the grant permitted the hiring of a facilities specialist to coordinate the study, to develop planning objectives closely allied with those of the comprehensive study being conducted by the

Commission, to compile pertinent data, and to prepare and distribute the Facilities and Workshops Plan in accordance with federal requirements. It also defrayed the travel costs of an Advisory Committee whose duties were the following:

a. Make recommendations on services provided by existing rehabilitation facilities and workshops.

b. Assist in the establishment of immediate and long term goals for rehabilitation facility and workshop development according to designated planning areas and to the needs of disability groups.

c. Serve as a source of specialized information

d. Consider standards for existing and new rehabilitation facilities and workshops

e. Consider methods of implementing the final recommendations to solve current needs and potential demands.

Members of this committee and their affiliations are as follows:

Miss Madge R. Ames
Department of Labor and Industry
Augusta

Stanley L. Brown
Division of Vocational Rehabilitation
Augusta

J. Philip Chandler
Work Adjustment Center
Portland

Benjamin Dorsky
Maine Federated Labor Council
Bangor

Ross E. Fearon
Special Education
Farmington State College
Farmington

Charles R. Hagan
Health Facilities Planning Council
Augusta

Robert C. Hawkes
Bangor Regional Speech and
Hearing Center
Bangor

Mrs. Robina M. Hedges
Committee on Problems of the
Mentally Retarded
Augusta

Millard Howard, Special Services
Augusta State Hospital
Augusta

Stanley A. Jones
Employment Security Commission
Augusta

John B. Leet
Bureau of Mental Health
Augusta

John J. Lorentz, M.D.
Maine Medical Center
Portland

George MacDow
Goodwill Industries of Portland
Portland

Charles J. Micoleau
Work Experience and Training Program
Augusta

Michael Murphy
United Community Services
Bangor

Miss Ward E. Murphy
Stevens Training Center
Hallowell

Paul E. Rourke
Division of Eye Care and
Special Services
Augusta

Barry Smith
Pine Tree Society for
Crippled Children and Adults
Bath

Miss Mary M. Sullivan, R.N.
Public Health Nursing
Augusta

Beverly V. Trenholm
Special Education
Department of Education
Augusta

Richard H. Whittemore
Alcoholism Counseling Center
Bangor

Robert O. Wyllie
Bureau of Social Welfare
Department of Health and Welfare
Augusta

In November 1967 the facilities specialist, Charles M. Guyler, submitted a 55-page interim plan to the Commission which was distributed to task forces and other personnel involved in the Commission's planning. In addition, Mr. Guyler met with each task force to discuss the implications of workshop and facilities planning.

The final plan (57 pp) was received by the Commission and distributed in July 1968. It contains:

a. An inventory and evaluation of rehabilitation facilities and workshops in Maine by region.

b. An assessment of needs as seen by the Advisory Committee as well as the Division of Vocational Rehabilitation, Division of Eye Care and Special Services, Committee on Problems of the Mentally Retarded, Mental Health Planning, the Commission's six regional task forces, and the Health Facilities Planning Council.

c. Recommendations and priorities for the proposed development of workshops and facilities.

d. Progress report on cooperative planning with adjacent states for workshops and facilities.

An account of these findings will be found in Chapter IV, Section C-4 of this report.

Advisory Committee members have continued in their appointed positions. They will review and revise the plan at the end of each fiscal year, or more frequently if considered appropriate. Priorities will be reconfirmed or adjusted as needs shift between or within planning areas. Continuing attention will be given to other proposed construction programs such as those of Hill-Burton, Mental Retardation, Mental Health, Health Facilities, and Regional Medical Programs, in order to promote the orderly development of needed facilities and to prevent inefficiency and duplication.

2. Interagency Health Planning.

The project director, Dr. Doran, has served as secretary to the Maine Interagency Health Planning Committee. This committee, composed of state-

wide health planners, reports directly to the Governor. Its purpose is to circumvent duplication of services and to help lay the basis for comprehensive health planning.

3. Planning for Correctional Rehabilitation

In July 1967 a statewide Committee on Correctional Rehabilitation was organized as an adjunct to the Commission on Rehabilitation Needs, with Maine's Director of Corrections, Robert R. Raines, as chairman. Serving with him have been:

Allan Chalmers
Community Rehabilitation Specialist
Kennebunkport

Joseph E.A. Cote, Commissioner
Employment Security Commission
Augusta

John deWinter, Sheriff
Kennebec County
Augusta

Peter C. Doran,Ph.D., Director
Commission on Rehabilitation Needs
Augusta

Lars Henrikson
Deputy Warden for Treatment
Maine State Prison
Thomaston

Philip Johnson, News Director
WCSH Radio-TV
Portland

Elmer L. Mitchell, Director
Division of Vocational Rehabilitation
Augusta

Louis Ploch, Ph.D.
Rural Sociologist
University of Maine
Orono

Joseph Sanders, Ph.D., Chief
Psychological Services
Veterans Administration Hospital
Togus

John J. Shea (Deceased)
Director, Division of
Probation and Parole
Augusta

The committee held monthly meetings, several of them at the three adult and two juvenile institutions, where administrators and treatment personnel discussed their immediate and long range goals, and pointed out specific problem areas in need of attention.

A major accomplishment of the committee has been the development and implementation of a plan for cooperative vocational rehabilitation units at each of the five correctional institutions. The first of these went into operation at the Men's Correctional Center, South Windham, in October, 1967. Since then similar units, administered jointly by the Vocational Rehabilitation Division and the Bureau of Corrections, have been established at the Maine State Prison, Boys Training School and a combined unit for the Women's Correctional Center and Stevens Training School. All are staffed by full time Vocational Rehabilitation counselors working closely with the correctional staff at the respective institutions, with probation-parole officers, and appropriate individuals and agencies in local communities.

The committee's activities and its major findings and proposals are discussed in Chapter IV, Section C-2 of this report.

4. Economic Opportunity Programs

Close liaison with State Office of Economic Opportunity officials and local Community Action Program directors has been maintained by the assistant project director, Mr. LaPointe.

With their assistance he has prepared a report of recommendations which is summarized in Chapter IV, Section C-3.

5. Governor's Committee on Employment of the Handicapped.

The Commission and project staff have coordinated many of their activities with those of the Governor's Committee on Employment of the Handicapped. Chairman of the committee is Joseph E.A. Cote, Maine's Employment Security Commissioner, who is a member of both the Policy Commission and the Correctional Rehabilitation Committee. Mr. Cote has assisted in developing recommendations of the Commission, two of which have been presented for action by the current legislature. One of the bills proposed is to strengthen the Governor's Committee by providing it with a full-time Executive Secretary and staff. The other revises Maine's present architectural barriers law to make it apply to major renovations of existing public buildings.

6. Greater Portland Rehabilitation Interagency Committee

A special study was launched in cooperation with the United Community Services of Portland, and a Greater Portland Rehabilitation Interagency Committee was organized in August 1967. Members were:

Philip Chandler
Work Adjustment Center

Samuel C. Cheraso
Northeast Hearing and
Speech Center

James Culhane
Southwestern Maine Health
Information Center

Arthur DeW. Grant
Arthritis Foundation

William S. French, Maine Chapter
National Multiple Sclerosis Society

William F. Haney
Pine Tree Society for Crippled
Children and Adults

Maurice R. Johnson
United Community Services

Frederick Kosiba
Cumberland County Tuberculosis
Association

Mina Leavitt
Greater Portland Association
for Retarded Children

John J. Lorentz, M.D.
Maine Medical Center

Sister Mary Miguel
Blind Children's Resource Center

George MacDow
Goodwill Industries

Elizabeth Morrison
Cerebral Palsy Center

Carmine Piscopo
Portland Regional Opportunity
Program

Ann Pride
Greater Portland Association for Retarded Children

Brig. James G. Scott
Men's Social Service Center
Salvation Army

Edward Scott
Vocational Rehabilitation Division

William Swett
Maine Institute for the Blind

H. OTHER GROUPS

1. Related Health Planning in Maine was explored through individual consultation with the following specialists:

Alan Bridges, Director
Health Facilities Planning Council, Augusta

Robert Dishman, Ph.D.
Political Scientist
University of New Hampshire
Durham

Dean Fisher, M.D., Commissioner
Department of Health and Welfare
Augusta

Robina Hedges, Secretary
Committee on Problems of the Mentally Retarded
Augusta

John B. Leet, Deputy Director
Bureau of Mental Health
Augusta

John Lorentz, M.D., Director
Medical Rehabilitation
Maine Medical Center
Portland

Leonard Mayo, S.Sc.D.
Professor of Human Development
Colby College
Waterville

William MacDonald, Director
State Economic Plan
Augusta

George Nilson, Field Director
Bingham Associates Fund
Augusta

Niles Perkins, M.D.
Chief of Medical Services
Department of Health and Welfare
Augusta

Louis Ploch, Ph.D.
Rural Sociologist
University of Maine
Orono

James Schoenthaler
State Manpower Coordinator
Office of Economic Opportunity
Augusta

2. Interstate Coordination

Statewide Planning Project staffs from Maine, New Hampshire and Vermont have held a series of meetings on cooperative planning, and discussion is now underway regarding identification of facilities which may be utilized in the future on an interstate regional basis. Facilities specialists are pursuing this concern and reporting to their respective Commissions Development of a feasibility study of a regionally based in-service training program for vocational rehabilitation counselors in Northern New England is also underway.

State planners may now look to the New England Governor's Compact for leadership in creating new interstate program provisions.

3. Insurance Considerations in Rehabilitation Planning

Recognizing that insurance companies and workmen's compensation programs can make a unique contribution to the rehabilitation of the disabled, an Insurance Advisory Committee was organized in August 1967 as a function of the statewide planning effort.

Among its objectives were:

a. To provide the Commission with authoritative information and advice in planning for the rehabilitation of workers who have suffered a physical and/or psychiatric disability.

b. To determine how adequately workers in Maine are covered through insurance programs in the event of disability requiring rehabilitation.

c. To encourage greater communication and cooperation between the private insurance companies and state agencies contributing to the rehabilitation process.

Commission member Charles R. Hagan, a special projects consultant of the Health Facilities Planning Council, was instrumental in establishing this committee which met monthly during the organizational and fact-finding phase of statewide planning. The committee was instrumental in formulating the recommendations which are concerned with insurance programs and the occupationally disabled, presented in Chapter IV, Section C-10. Members also assisted Mr. Hagan in preparing a report for the Commission which dealt with rehabilitation programs for the occupationally disabled in Maine.(19)

Insurance Advisory Committee members are:

William Norman, Chairman
Union Mutual Life Insurance Co.
Portland (3)

Peter C. Doran, Ph.D.
Commission on Rehabilitation Needs
Augusta

Kendall Dunbar
Industrial Accident Commission
Augusta

V.W. Dyer
Liberty Mutual Insurance Company
Portland (1,2)

John Grimes
Travelers Insurance Company
Portland (1,2,3)

Charles R. Hagan
Commission on Rehabilitation Needs
Augusta

John Hamlin
Mutual of Omaha Insurance Company
Portland (3)

H. Douglas Holloway
Division of Vocational Rehabilitation
Portland

Thomas Mussleman
Lumberman Mutual Casualty
Portland (1,2)

John Nichols
Aetna Life and Casulaty
Portland (1,2,3)

Legend 1-Workmen's Compensation
2-Automobile and Public Liability
3-Health and Hospital and Surgical

Harris Plaisted
Prudential Life Insurance Co.
Portland (3)

Andrew C. Walsh, M.D.
Mercy Hospital
Portland

I. PROJECT STAFF

1. Members of the project staff have been its executive director, Peter C. Doran, Ph.D.; assistant project director, Laurence A. LaPointe; administrative secretary, Mrs. Errie C. Hasty; and later in the study an informational and technical writer, E. Richard Bowring, and a clerk-typist, Mrs. Jean Glazier.

As executive director of the Commission, Dr. Doran has had overall responsiblity for the progress of the study. Mr. LaPointe has had special responsiblity for the community aspect of planning and continues to work closely with the regional task forces and special committees. Mr. Bowring's duties are in the area of public information and education through the mass media, as well as the writing and editing of reports and other materials developed by the Commission. Mrs. Hasty is responsible for all office procedures including bookkeeping and office management.

2. Special Consultants

In addition to the six regional task force coordinators, the Commission has utilized consultants with specific background and training in designated program areas.

Kevin C. Baack, as manpower consultant to the Commission from July 7 to September 8, 1967, provided an evaluation of the public and private programs in Maine designed to assist handicapped adults through rehabilitation, vocational training, and placement. His final report, published by the Commission in September of that year, also includes an inventory of disabled Maine citizens eligible for vocational training, retraining, and placement.(4)

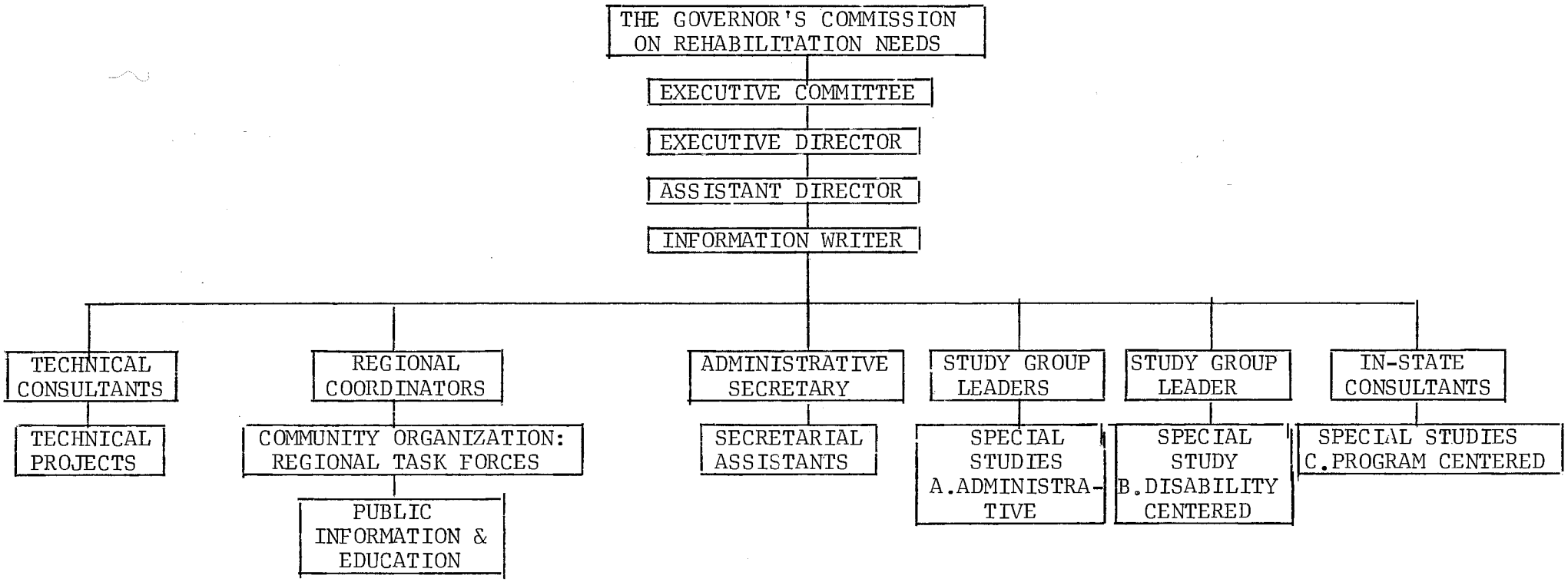
A similar study of rehabilitation programs for handicapped youth, estimates of their number by disability category, and recommendations for the coordination of services for handicapped youth, especially in the areas of prevocational training, was conducted for the Commission by John J. Fahey during a three-month period ending in December 1967.(14)

3. Donated Services in Planning Rehabilitation Research

Francis H. Sleeper, M.D., retired superintendent of the Augusta State Hospital, Commission member, and chairman of its subcommittee on research, contributed his time and expert knowledge in preparing an extensive report on the directions Maine should be taking in the area of rehabilitation research. His recommendations, based upon his experience, a thorough study of Commission reports, and an analysis of over 2,000 abstracts obtained from the University of Wisconsin's Rehabilitation Information Service, are cited in several sections of this report(60).

J. ORGANIZATIONAL CHART
(See next page)

COMMISSION'S ORGANIZATIONAL PLAN
(Feb. 1967 --- June 1969)



CHAPTER III

METHOD OF OPERATION

During February and March 1967, the project staff was hired, an office was set up at 83 Western Avenue, Augusta, and a public information campaign launched. An organizational approach was devised by the staff during March and April which was formally approved by the Executive Committee and full Policy Commission in May.

This organizational blueprint was formulated in terms of specific objectives to be accomplished on a monthly schedule. These were viewed in four successive phases:

Phase I - Organization (Feb. 15 to June 30, 1967)

Phase II - Fact Finding and Evaluation (July 1 to Jan. 31, 1968)

Phase III - Formulating Recommendations (Feb. 1 to Oct. 1, 1968)

*Phase IV - Reporting and Implementing (Oct. 2 to June 30, 1969)

The specific timetables in terms of objectives for Phases I through IV are reproduced on the following pages.

*Special permission was granted by Commissioner Joseph Hunt of the Federal Rehabilitation Administration to extend Maine Planning from February 15 to June 30, 1969.

Specific Timetable for Commission Planning

Phase I - Organization (Feb. to June 1967)

Objectives

1. Establishing Project Staff and Office
2. Developing Public Awareness of the Commission
3. Developing Organizational Plan with Executive Committee
4. Approving Organizational Plan Through Policy Commission
5. Revising Budget in Accordancewith Plan
6. Contracting with Consultants for Technical Projects
7. Selecting Regional Task Force Coordinators

Monthly Schedule:

	1	2	3	4	5	6	7
Feb.	X	X					
Mar.	X	X	X				
Apr.		X	X				
May.		X		X	X	X	
June		X			X	X	X

Phase II - Research: Fact Finding and Evaluation (July 1967 to Jan. 1968)

Objectives:

1. Assessing Disability Needs through:

   a. Consultants
   b. Special Studies
   c. Voluntary Regional Task Forces

2. Organizing Regional Task Forces

3. Submitting First 6 Months Interim Report (Aug. 15, 1967)

4. Setting up Governor's Kickoff (September 1967)

5. Evaluating Public and Private VR Agencies

6. Writing Yearly Report and Applying for Second Year Funds

7. Fact Finding Reports - Due Jan. 31, 1968 from Consultants, Task Forces and Special Studies Chairmen

Monthly Schedule:

	1A	1B	1C	2	3	4	5	6	7
July	X			X					
Aug.	X			X	X				
Sept.	X	X	X			X	X		
Oct.	X	X	X				X		
Nov.	X	X	X				X		
Dec.	X	X					X	X	
Jan.		X					X	X	X

Phase III - Formulating Recommendations (Feb. 1968 to Oct. 1968)

Objectives:

1. Coordinating Administrative Special Studies
2. Analyzing Disability & Program Studies, Technical Reports and Task Force Results
3. Testing Validity of Disability Estimates through Representative Field Sampling
4. Synthesizing and Organizing Findings into Preliminary Recommendations.
5. Considering Preliminary Recommendations with Executive Committee
6. Presenting Major Recommendations to Policy Commission
7. Writing Third Interim Report (Aug. 15, 1968)

Monthly Schedule:

	1	2	3	4	5	6	7
Feb.	X	X					
Mar.	X	X	X				
Apr.	X	X	X	X			
May		X	X	X	X		
June				X	X		
July				X	X		X
Aug.					X	X	X
Sept.						X	
Oct.						X	

Phase IV - Reporting and Implementing (Oct. 1968 to June 1969)

Objectives:

1. Mapping Implementation of Major Recommendations
2. Preparing Final Report of Major Recommendations
3. Drafting Final Project Report and Legislation
4. Revising Final Report for Printing
5. Reporting Project Results to the Citizens of Maine

Monthly Schedule:

	1	2	3	4	5
Oct.	X	X			X
Nov.	X	X			X
Dec.	X		X		X
Jan.			X		X
Feb.			X		X
Mar.			X	X	X
Apr.				X	X
May					X
June					X

A. ORGANIZATION (Feb. 15, 1967 - June 30, 1967)

Development of the plan began with a careful review of prior health planning studies in Maine such as those on mental retardation, health facilities, and mental health, with particular attention to recommendations related to rehabilitation. Information gleaned from these studies and from consultations with key persons who were instrumental in formulating them have served as useful guidelines for the present comprehensive plan. (See Chapter II, Section H) Similar orientation was provided by professional planners and state officials in the assessment of ecological factors relevant to this study.

1. Technical Consultants

The process of determining disability incidence through statistical estimates and assessing agency performance was begun in June 1967 with the signing of a contract with Harbridge House. Other consultant services including special studies consultants Kevin C. Baack, John J. Fahey, and Charles R.Hagan were engaged during the summer of 1967.

2. Regional Task Force Coordinators

Six part-time regional consultants were employed in June 1967 to assist the Planning Commission in the fact finding and implementation phases of the study. (See Chapter II, Sections D and E, for more complete description).

B. RESEARCH: FACT FINDING AND EVALUATION (July 1, 1967-January 31, 1968-See chart on next page)

1. Professional and Technical Consultants

a. Harbridge House

A description of the methods used by Harbridge House in compiling data for their reports on disability incidence and prevalence and on agency performance are discussed in Chapter II, Section F of this report.

b. Kevin C. Baack, in preparing his report entitled Evaluation of Programs in Maine Designed to Assist Handicapped Adults through Rehabilitation, Vocational Training and Placement inventoried estimates and records of those eligible and feasible for such services in the following populations:

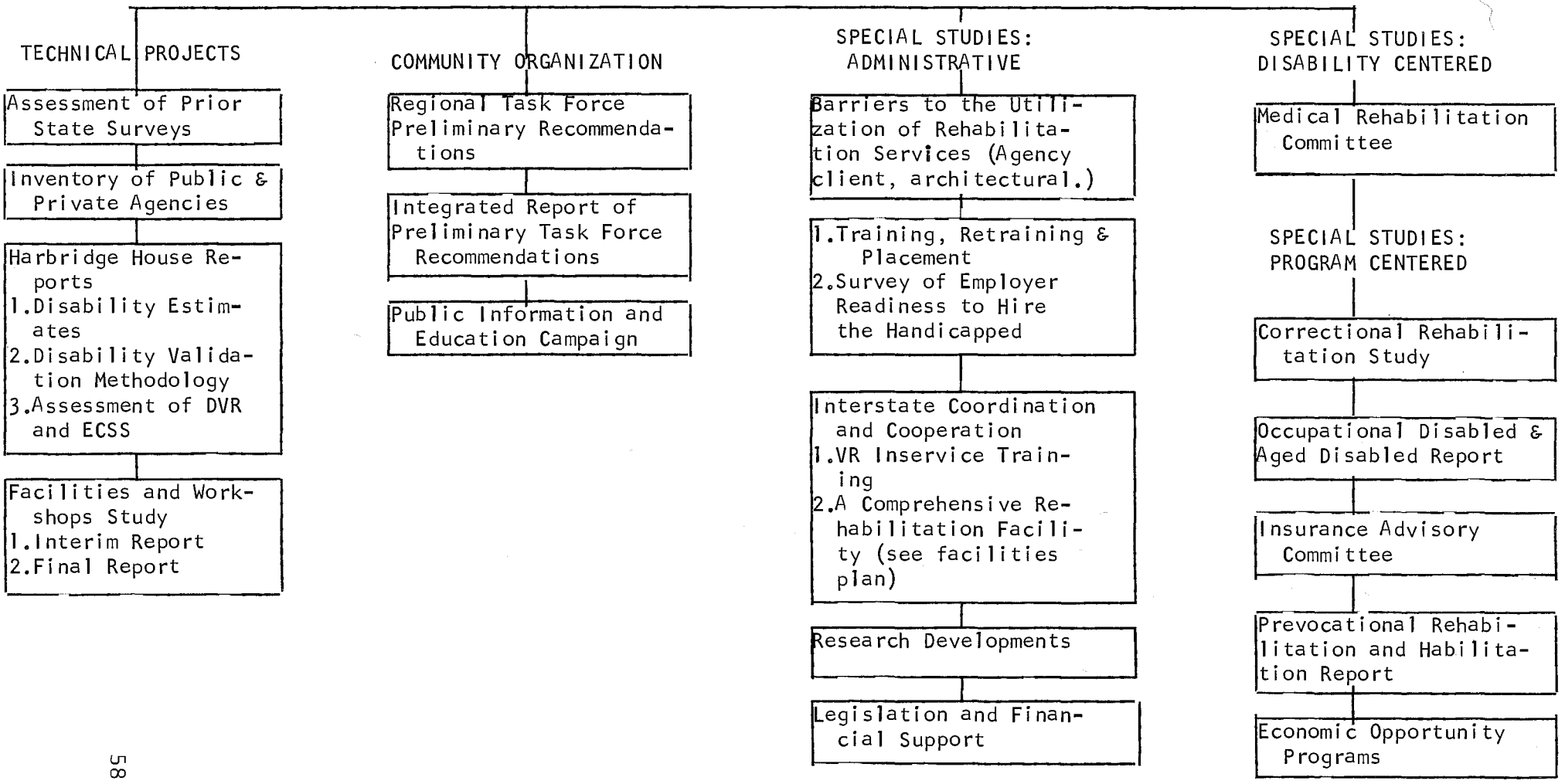
On probation, parole, and in correctional institutions

In state hospitals and outpatients served by area mental health clinics

Enrolled in Manpower Development Training Act courses

Served by the Employment Security Commission, Department of Health and Welfare, Division of Vocational Rehabilitation, Division of Eye Care and Special Services

RESEARCH: FACT FINDING AND EVALUATION
July 1967 to Jan. 31, 1968



His report also contains an assessment of public and private programs which assist disabled citizens in securing suitable employment, and recommendations for manpower development and training of Maine's vocationally handicapped.

Reference is made to these findings and recommendations in Chapter IV Section D.

c. For his report entitled Assessment of Programs in Maine Designed to Provide Assistance to Handicapped Youth through Rehabilitation, Education, and Prevocational Training, John J. Fahey compiled a nonduplicative list of known cases (age 8-18) from the files of five state agencies and the public and private speech and hearing clinics. Because of Maine's lack of a uniform reporting and central data gathering system of handicapping conditions this represented a major accomplishment.

His description and assessment of public and private programs which provide some aspect of needed services to handicapped youth is accompanied by specific recommendations for improving services to all of Maine's handicapped youth with emphasis on sequential programs for habilitation and prevocational preparation.

Both Mr. Baack and Mr. Fahey met with administrators and line personnel of public and private agencies to explain the purposes of their studies, gain greater insight into the many facets of each program, seek ideas and recommendations from service staff as to ways in which their programs and services might be strengthened, and to lay the groundwork for gaining access to essential data.

d. Charles R. Hagan, as special consultant for the Health Facilities Planning Council, prepared reports on Maine's Industrial Disabled and Disabled Aging. He received considerable assistance from members of the Commission's Insurance Advisory Committee, insurance claims managers, representatives of business and industry including members of the Associated Industries of Maine, medical personnel, union officials and the representatives of several government agencies including the Bureau of Labor Statistics, U.S. Department of Labor and Industry, State Department of Labor and Industry, Employment Security Commission, Industrial Accident Commission, and the Division of Vocational Rehabilitation.

Similarly, in preparing his report on the disabled aging, he conferred with numerous specialists to obtain statistical data and other essential information.

2. Regional Task Forces

The six regional task force coordinators employed as part-time consultants by the Commission assisted the project staff in selecting prospective task force members and were responsible for making the initial contacts. This was done by letter and also in person, with the coordinator explaining the purposes of the Commission's planning and the ways in which members would be making a contribution. Other duties

of the coordinator were to appoint the task force chairman, arrange for meetings, write minutes and reports, and ensure that the overall timetable for regional activities was adhered to.

On August 28, 1967, the regional coordinators attended a one-day orientation workshop during which the project staff explained in greater detail the hoped-for outcomes of broad community participation, and the procedures and techniques designed to bring this about. Discussed also at the workshop were plans for the Governor's Kickoff Conference held three weeks later on September 20, 1967. The central theme of the conference was "Community Planning for Vocational Rehabilitation."

In September 1967, regional meetings were begun. The first of the regional task force meetings were informational, with representatives of public and private rehabilitation agencies explaining their programs and particular needs. Similar presentations were made by the consultants to the Commission and persons speaking for the special study committees.

In later meetings, task force members reviewed published materials prepared in connection with the study as these became available. Preliminary estimates supplied by Harbridge House in October 1967 were distributed to the task forces, some of whom chose to use them as guidelines in preparing estimates of disability within their own regions.

Task Force IV prepared and distributed a directory of rehabilitation resources in this three-county area. Regions II and V highlighted medical rehabilitation services and facilities in Maine and prepared a plan for the development of a comprehensive pattern of care utilizing, and building upon, existing medical resources.(See Chapter IV, Section B.)

Members of all task forces informed people in their local communities about the progress of rehabilitation planning by accepting speaking engagements and arranging for other knowledgeable persons to address meetings of local organizations. They also assisted the project staff in arranging for press, radio and television coverage of their activities and in other ways sought to invite public interest and support.

3. Special Study Committees

The organizational plan called for a number of special studies to be conducted by committees and consultants in three general areas designated as Disability Centered, Program Centered, and Administrative.

a. Disability Centered

In the first category, a study was undertaken of medical rehabilitation services and facilities with special attention to their availability, development needs, and capability of providing specialized services required for the successful medical-vocational rehabilitation of clients. Emphasis was also given to the role of medical programs in the prevention as well as the alleviation of physical

and mental impairments.

Largely because of the high concentration of medical and paramedical specialists in the Greater Portland Area, this special study was of particular interest to members of regional Task Force V (Cumberland, York and Sagadahoc Counties). Consequently, it was adopted as a major program of the task force, working through a subcommittee on Preventative and Restorative Services under the chairmanship of John J. Lorentz, M.D., director of the Maine Medical Center's Rehabilitation Department. Other members included Andrew C. Walsh, M.D., director of Rehabilitation Medicine, Mercy Hospital, Portland; Edward McGeachey, M.S.W., assistant director, Maine Medical Center, Portland; and Miss Heloise Withee, R.N., director, Public Health Nursing Association, South Portland.

In the following months the subcommittee, aided by other specialists in the field, made an intensive survey of medical rehabilitation needs and services in Maine and reported their findings and recommendations in a written report which was incorporated in Region V's report of recommendations to the Commission. It features a plan for the distribution and correlation of statewide and regional medical rehabilitation services through a network of existing facilities extending from key centers to "satellite units" such as the community hospitals, nursing homes, and community health services.

b. Program Centered Studies included those on prevocational rehabilitation, programs for the occupationally disabled and disabled aging, coordination of Economic Opportunity Programs with related vocational rehabilitation functions both public and private, and planning for correctional rehabilitation.

Organization of the studies on prevocational rehabilitation, the occupationally disabled and disabled aging and a discussion of the role played by the Commission's Insurance Advisory Committee, have been discussed earlier in this chapter.

(1) Community Action and Other Economic Opportunity Programs

During the summer of 1968 the Commission's assistant project director, Laurence A. LaPointe, former director of the Augusta-Gardiner Area Community Action Program, consulted with a number of persons who have responsibility for administering employment and Economic Opportunity programs. Among these were James Schoenthaler, chairman, Maine Employment Security Commission; Herbert Sperry, executive director, State Office of Economic Opportunity; Clinton Conant, Community Action Program director for Franklin County; Robert Smith, Community Action Program director for Hancock County; supervisors and counselors of the Vocational Rehabilitation Division; and several disadvantaged individuals. Based upon these discussions which were concerned specifically with recommendations for a coordinated approach to rehabilitation utilizing resources available through CAP and other community resources, he prepared a report.(29) This report of recommendations was reviewed and adopted by the Executive Committee; subsequently, copies of it, printed by the Commission and released in September 1968, were distributed to all members of the Commission and its task forces, as well as to Economic Opportunity personnel and interested agencies throughout the state.

(2) Planning for Correctional Rehabilitation

In June 1967, the Commission's executive director and the director of the Bureau of Corrections, Robert R. Raines, selected a group of 12 individuals to serve on a correctional rehabilitation planning committee The Commission took responsibility for recruiting its members and throug out the course of the 12-month study arranged for monthly meetings, supplied members with resource materials, and wrote and distributed reports of the meetings.

Between July 1967 and April 1968 at least one of these regularly scheduled meetings was held in each of the five state correctional institutions. Other sessions focused on the rehabilitation needs of the state probation and parole system and the county jail system.

Following these extensive investigations with correctional administrators throughout the state, the committee developed a framework for its final report, dividing into subcommittees to formulate recommendations in each of the following areas:

---Correctional out-services (pre-parole, community involvement, county jails, etc.) for both youth and adults.

---Correctional in-services (rehabilitation-treatment programs, work release, facilities development, etc.) for both youth and adults

---Public education

---Legislative reform

This report, developed with the assistance of the Commission's infor tional and technical writer, was prepared in the late spring of 1968 and during the ensuing summer was discussed in full by the committee and a number of modifications were made. Following its final approval by the full committee and by the Commission's Executive Committee, it was print by the Commission in September 1968 and copies were forwarded to Governor Curtis, members of the legislature, and all Commission and task force members.(34)

Mr. Raines and the committee members have regarded this report as the first plan for correctional rehabilitation to be developed in Maine and during the current 104th Legislature have been seeking legislative approval of its major recommendations.

c. In the administrative area, a special study committee was organized in the Greater Portland Area to coordinate planning for rehabilitation services of that region. The work of this committee formed a substantial part of the pre-planning for the Special Education Subcommittee of the "Portland West" Model Cities program. In January of 1968 the Greater Portland Interagency Rehabilitation Planning Committee combined formally with the Model Cities Special Education Subcommittee.

Each of the special study committees described in this chapter pursued their fact finding and evaluation activities through January 1968, preparatory to formulating their recommendations and writing final reports for the Commission.

In each instance, however, preliminary reports, both written and verbal, were provided for the task forces and for the use of the project staff in writing newspaper articles and reporting the Commission's progress to the communications media.

4. Public Information

Although during the organizational phase of the statewide planning project the Commission had no public information staff member as such, the executive director and assistant director arranged for and received excellent coverage by newspapers, radio and television of the Commission's purposes, objectives, and the means by which these objectives were to be pursued. Some of the materials developed were:

a. News articles written by the staff and directed to the mass media.

b. Feature stories written by newspaper reporters.

c. Television interviews for statewide educational television, closed and open circuit distribution. The first interview in this series was created at the University of Maine ETV studios, with Dr. Leonard Mayo, the present chairman of the Commission, interviewing Harold Russell, chairman of the President's Committee on Employment of the Handicapped. This 30-minute video tape on the subject "Rehabilitation in Maine" was shown statewide during the first week in October 1967, in conjunction with National Employment of the Handicapped Week. A kinescope of the tape was obtained by the Commission for showing to community groups.

d. Radio Station WTVL interviewed Mr. Russell during his visit to Maine and made a copy of the tape available to the Commission for use in the public information program.

e. Creation of an illustrated brochure describing the Commission and its goals. Entitled "Maine Opens the Door to the Handicapped" it was distributed throughout the state and proved to be an effective introduction to the statewide planning program.

f. Charts and posters illustrating the Commission's organization for planning, regionalization scheme, and location of vocational rehabilitation personnel in relation to planning areas.

Beginning in February 1967, and continuing through each of the successive phases, the project staff was active in holding meetings, taking part in conferences, making visitations, and speaking to various groups. These contacts provided excellent opportunities not only to acquaint Maine people with rehabilitation planning but also to gain feedback regarding goals and directions.

5. Governor's Kickoff Conference for Rehabilitation Planning

More than 300 interested Maine citizens attended the Governor's Conference held September 20, 1967, in Augusta. Gov. Kenneth M. Curtis and Henry Viscardi, Jr., founder of Abilities, Incorporated, Long Island, New York and a member of the President's Committee on Employment of the Handicapped, gave the keynote addresses. Other speakers during the all-day session were Chairman George T. Nilson, Prof. Leonard Mayo, Sen. Bennett D. Katz and Dr. Peter C. Doran.

During the afternoon session meetings were held by the task forces and special study committees.

C. FORMULATING RECOMMENDATIONS (February 1, 1968-October 1, 1968)

1. Regional Task Forces

At a two-day workshop held December 29-30, 1967, in Augusta, coordinators and chairmen met with the project staff to plan the format for reporting. Also at these meetings they shared information about problems and needs peculiar to each individual region, as well as identifying pertinent areas of mutual statewide concern.

Procedures used by the task forces in formulating recommendations varied from one region to another. Some appointed subcommittees to review specific problem areas, develop recommendations pertaining to them, and later to present these recommendations to the full membership for refinement and approval. In others the task force worked together as a group in formulating recommendations.

Coordinators were responsible for ensuring that the report was submitted by the mid-February 1968 deadline, and that it conformed to the agreed-upon format. In some task forces a subcommittee assisted the coordinator in preparing the report; in others the actual writing was done by the coordinator and chairman. The project staff was available at all times to provide help upon request.

From mid-February to early March the six reports were combined into a single document by the project staff. This Integrated Report of Preliminary Recommendations was distributed March 20, 1968, to all Commissio and Task Force members and to each of the consultants and special study committees.(21)

2. Policy Commission Subcommittees

The process of selecting and refining major recommendations began at a meeting of the full Policy Commission on March 27, 1968. At that time a procedure was adopted for evaluating the relative merit of recommendations proposed by task forces, consultants, and special study committees with a view to identifying those key recommendations which might properly serve as the framework of the comprehensive statewide plan. Accordingly, the following subcommittees were appointed:

(1) Organization and Administration of Public Vocational Rehabilitation Services	Leonard W. Mayo, Chairman Charles McEvoy Elmer L. Mitchell C.Owen Pollard
(2) Legislation and Financial Support of Rehabilitation Services	Catherine Carswell, Chairman Bennett D. Katz John A. Platz Norman Rogerson
(3) Vocational Rehabilitation Facilities and Workshops Development	Charles Guyler's Advisory Committee which includes: John J. Lorentz Benjamin Dorsky Charles Hagan (See also Chapter II, Section G-1)
(4) Medical Prevention and Restoration of the Disabled	John Lorentz, Chairman Frederick Hill Barrie Cooper George Sullivan
(5) Barriers to the Utilization of Rehabilitation Services, and Interagency Cooperation	Edmund Wells, Chairman Leo Morency William Gilman Carolyn Lombardi William Haney Donald McAllister
(6) Research Developments	Francis H. Sleeper, Chairman
(7) Public Awareness of Rehabilitation Needs and Services	Philip Johnson, Chairman Hazel Lord Casper Ciarvino
(8) Professional Development of Rehabilitation Personnel	Louis Ploch, Chairman Elaine Gagne
(9) Training, Retraining and Placement of the Handicapped	Louis Benoit, Chairman Joseph Cote Benjamin Dorsky Charles Hagan
(10) Prevention-With Emphasis on Special Education, Prevocational Habilitation and Rehabilitation	Thomas Kane, Chairman Eugene Jorgensen Sister Mary Miguel
(11) Disability Incidence Validation	Leonard Mayo, Chairman Commission and Executive Committee
(12) Correctional Rehabilitation	Robert R. Raines, Chairman and 12-man Committee (See Chapter II, Section G-3)

(13) Occupational Disabled	Charles R. Hagan and Insurance Advisory Committee (See Chapter 11, Section H-3)
(14) Disabled Aging	Charles R. Hagan Andrew C. Walsh

It will be noted that each Commission member served on at least one sub-committee, further, that many specialists who were not Commission members per se took part in this crucial phase of planning. Examples are the Facilities and Correctional Rehabilitation advisory committees (each had three Commission members), and the Insurance Advisory Committee, comprised of representatives of the leading insurance underwriters. Among the resource people utilized by Mr. Johnson, news director of WCSH Radio-TV, Portland, in formulating recommendations for Public Information and Education were Miss Francis Hapgood, editor-columnist, Gannett Newspapers; Ralph Lowe, news director, WABI Radio-TV; and Mrs. Beatrice Chapman, information officer, Department of Health and Welfare.

3. Refinement of Major Recommendations

All subcommittees met on at least two occasions to compare their impressions of the research material developed during the course of planning and to identify recommendations which they believed should receive major emphasis. Some subcommittees went further and proposed original recommendations which had not previously been stated. At the conclusion of its May 29, 1968, all-day meeting, the Policy Commission unanimously agreed to authorize the Executive Committee to prepare a preliminary draft of major recommendations during the summer months in accordance with two criteria: (a) need as judged by those engaged in the planning project and (b) feasiblity of implementation. This draft would then be presented for approval at the September Policy Commission meeting.

During June and July each member of the Executive Committee reveiwed the 165 separate recommendations identified by the Policy Commission. Using a five point rating scale, executive committee members selected the 25 major recommendations and organized them within eight categories. The project staff then compiled a first draft of preliminary major recommendations. Additional refinement was made by the Executive Committee in modifying cross-categories and identifying those recommendations which seemed most feasible for implementation by the incoming 104th Legislature. A July 29 meeting of the Executive Committee resulted in agreement on 25 major recommendations to be presented and discussed in detail with Governor Curtis. In mid-August, a revised copy of the preliminary major recommendations for statewide planning in rehabilitation was completed. Then on August 19, 1968, the Executive Committee and project staff met with the Governor to discuss the preliminary major recommendations during a two and one half hour session. Governor Curtis had received an advance draft and was prepared to review each preliminary major recommendation in detail with the Executive Committee and project staff from the standpoint not only of ultimate objectives but also in terms of immediate priorities and effective courses of action for implementation.

Based upon the deliberations of Governor Curtis and the Executive Committee a draft of 20 preliminary major recommendations was written

and distributed in early September to all Commission and task force members. A series of meetings held by the regional task forces during September produced further suggestions for refinements substantiated by supporting rationale.

4. Policy Commission Modification and Adoption of Major Recommendations

Task Force coordinators and chairmen attended meetings of the full Policy Commission on September 25 and October 3, when the fourth draft of 20 preliminary major recommendations was modified and then officially adopted in final form. As the framework for the comprehensive statewide plan, it was formally presented to Governor Curtis at his Conference on Rehabilitation Needs held October 29, 1968 in Augusta.

5. Public Information

Increasing Awareness - General Techniques

The project staff, assisted by a fulltime public information consultant, has made a continuing effort to report the progress of rehabilitation planning in Maine to the widest possible audience through the media of press, radio and television, and through public appearances. A great many communications specialists in the mass media have aided directly or indirectly by serving on task forces and special committees and in other ways supporting the project since its inception. Their personal interest and cooperation has been an invaluable contribution. Contacts with Commission members, project staff, task forces and study committees through news conferences, coverage of meetings, conferences and other events, preparation and dissemination of feature materials, and generous reporting of Commission activities and findings have served to keep Maine citizens aware and informed.

The task forces continued to assist the Commission in educating and informing the general public laying the groundwork for publication of major recommendations. During the summer months of 1968 they aided the Commission in conducting an employer readiness survey to hire the handicapped. At this time the task forces emphasized the advantages of employing handicapped individuals and the investment returned by removing potential clients from relief rolls and placing them on payrolls. At their suggestion a 15-minute brief summarizing the highlights of the Commission's study was prepared; it stressed the gap between existing services and needs.

Arrangements were made by the six regional task forces to provide speakers to service organizations in each region. Both the project staff and task force members participated in these programs.

During this time, newspaper articles and feature stories were written with a regional rehabilitation emphasis. Some of these were based upon the speaking engagements while others stressed the services available in the regions and the needs detected by task forces.

Task force members participated in several regional and statewide conferences during the spring and summer of 1968. "Grass roots" involvement

contributed significantly to the educational effects of two conferences in particular.

6. Special Events - Jointly Sponsored Conferences

a. Maine Rehabilitation Association - Maine Commission on Rehabilitation Needs.

On May 10, 1968, the Maine Chapter of the National Rehabilitation Association and the Commission held a joint meeting in Augusta at which "Planning for Rehabilitation" was the theme.

The morning session featured presentations by the Executive Committee and project staff concerning accomplishments to date and future goals. Luncheon speakers were two rehabilitated paraplegics, both successful in their chosen fields, and one an active task force member.

The integrated report of preliminary task force recommendations was discussed in an open forum during the afternoon, prefaced by introductory comments from representatives of the six regional task forces. News coverage of this informative conference was excellent.

b. Maine Hospital Association - Maine Rehabilitation Association - Maine Commission on Rehabilitation Needs

During the 1968 annual meeting of the Maine Hospital Association an afternoon session on "Rehabilitation and the General Hospital" was held June 12, 1968, under the co-sponsorship of the Maine Hospital Association, Maine Chapter of the National Rehabilitation Association, and the Commission.

The keynote speaker, Howard A. Rusk, M.D., director of the Institute for Rehabilitation Medicine, New York University Medical Center, was joined later in the afternoon by a reactor panel of four Commission members: Leonard W. Mayo, S.Sc.D., John J. Lorentz, M.D., Andrew C. Walsh, M.D., and Barrie E. Cooper, hospital administrator.

Publicity was arranged by the project staff and full coverage by the media during the session and an advance news conference was obtained. A radio tape of Dr. Rusk's presentation and that of the panelists was made by WTVL commercial radio station, which provided copies to the Commission at no charge.

Immediately prior to this medical rehabilitation session, Dr. Rusk and Dr. Mayo created a television program with Dr. Philip Rice on "Vocational and Medical Rehabilitation" at the University of Maine ETV studios in Orono. The 30-minute program, one in a series on community resources sponsored by the network, was shown statewide early in October of 1968.

c. Social Welfare Conference - Maine Commission on Rehabilitation Needs

Major preliminary recommendations of the Commission were the subject of an all-day session during the annual Maine Social Welfare Conference. Held in September, the morning speaker was Commission Vice-Chairman Bennett D.

Katz, who discussed the major recommendations within the context of comprehensive planning for rehabilitation services.

A panel of Commission and task force members moderated by Senator Katz reacted during the afternoon session from the standpoint of "service providers" and "service consumers." Representing the "providers" were Elmer L. Mitchell, director of the Division of Vocational Rehabilitation, and C. Owen Pollard, director of the Division of Eye Care and Special Services. The "consumers" representatives, both of whom are task force chairmen, were Miss Mary Worthley (Region V), member of the Governor's Advisory Committee on Mental Health, and Ross Fearon (Region IV), director of special education, Farmington State College.

The evening session keynote speaker was Prof. Leonard Mayo, chairman of the Commission and world renowned specialist in social and child welfare. Professor Mayo summarized the Conference proceedings with poignant remarks, his theme being "Having the Knowledge, We Have the Duty!"

D. REPORTING AND IMPLEMENTING

1. Governor's Conference on Rehabilitation Needs

The concluding phase of the statewide planning project was officially launched October 29, 1968, at a public meeting in Augusta attended by some 350 persons. In accepting the Commission's major recommendations, Governor Curtis called attention to those requiring legislative action which he proposed to include in his state program for presentation to the 104th Legislature in January 1969.

Keynote speaker during the morning session was William P. McCahill, executive secretary of the President's Committee on Employment of the Handicapped, who spoke on the topic "Untapped Resources." During his remarks he singled out the Commission's Survey of Employer Readiness to Hire the Handicapped for special commendation. Later he requested and received 200 copies of the Response-Abilities report for national distribution.(57)

Other speakers at the all-day conference were Sen. Katz, who described the significance of the recommendations in his formal presentation to the Governor, and Chairman Mayo, who traced the development of the recommendations and the progress of planning since its beginning in mid-February 1967. Dr. Doran and Mr. LaPointe paid special tribute to the task forces, study committees, and the many hundreds of Maine citizens who have given their active support.

Miss Mary Worthley, chairman of Task Force V, emphasized the need for continuing community involvement and a heightened public awareness of the benefits which accrue from sound rehabilitation practices. In a summary statement, Professor Mayo outlined the steps to be taken in implementing the immediate and long-range goals identified in the statewide plan.

Mr. McCahill and Employment Security Commissioner Joseph E.A. Cote, chairman of the Governor's Committee on Employment of the Handicapped, presented awards to Miss Worthley for her untiring service to Maine's handi-

capped and disadvantaged, and to three Maine citizens who have achieved notable success despite serious physical impediments. Receiving these citations were Miss Carole Manning of Biddeford, Assistant Attorney General Courtland D. Perry II of Augusta, and Robert E. Hawkes, director of the Bangor Regional Speech and Hearing Center.

2. Preparation of Legislative Documents

Financial provisions for implementing several of the Commission's recommendations have been incorporated in the legislative appropriation requests submitted by the respective state departments that would be responsible for administering the proposed new programs. Some of the other recommendations, however, have required the drafting of new legislation by the project director and Executive Committee. Additional assistance has been sought through the state attorney general, the director of the State Legislative Research Committee, officials of the Rehabilitation Services Administration regional and national offices, the executive secretary of the President's Committee on Employment of the Handicapped, and others.

Specific recommendations for which legislation was drafted for action by the 104th Legislature are:

a. A bill to create a functional unit of rehabilitation services within the Department of Health and Welfare having bureau status which would include the Division of Vocational Rehabilitation (heretofore a function of the State Department of Education), Division of Eye Care and Special Services, Division of Alcoholism Services, and other rehabilitation services as deemed advisable.

b. A bill to establish the Governor's Committee on Employment of the Handicapped on a permanent basis and furnish it with a salaried executive secretary and staff.

c. A bill to reorganize and expand the Bureau of Corrections to include the Division of Probation and Parole, a proposed Division of Treatment, and authority to enforce regulations concerning the county jails.

d. A bill to revise the present State Vocational Rehabilitation Act to make it more nearly conform to the recently liberalized federal statutes.

e. A bill to revise the present architectural barriers law by extending its provisions to include major remodeling of existing public buildings.

3. Mobilization of Public Support

It speaks highly of the interest shown by the task forces and their dedication to the total planning function that when they had submitted their report of recommendations, each one expressed a unanimous desire to remain active and to give all possible assistance to the implementation of recommendations. Consequently, the six regional coordinators have been retained as part-time consultants and each task force has continued to meet monthly.

a. "Response-Abilities"-- A Survey of Employer Readiness to Hire the Handicapped.

One of the projects undertaken by the task forces during this phase of the study was a survey of employers' attitudes toward hiring the handicapped, along with an assessment of job openings available to handicapped persons.

A survey questionnaire based on a model developed by Harbridge House and used previously by New Hampshire and Iowa in their statewide planning projects was adopted by the Commission. The Commission staff devised a survey sampling method that promised to yield the necessary information.

First, a master list of over 1400 Maine private employers was compiled, then the list was divided into three categories: small (4-50 employees), medium (51-300) and large (301+). From these a random sample of companies within each task force region yielded a group of 120 employers throughout the state. Fifteen employers were interviewed in five of the regions, and 45 employers in the sixth. In this way broad geographic coverage was obtained, with fairly concentrated sampling in one representative locale.

Each of the employers on the master list received a letter from Governor Curtis explaining the purposes of the survey and asking for his cooperation in the event he was approached for an interview. Interviews were conducted by task force members and by the volunteer coordinator for the employer survey, Charles Hagan.

At the conclusion of each interview, an employer who expressed interest in hiring rehabilitated persons was given a referral form which he could either fill out at once or mail to the Commission later. The employer was asked to check those types of handicapping conditions for whom employment in his particular operation would be feasible and suitable in specific types of jobs. Once collected, these forms were forwarded by the Commission to the Maine Employment Security Commission. Local employment offices, then followed through by assigning counselors to interview the employer-respondents in order to secure actual placements.

Results of the survey, both quantitative and qualitative, were given wide distribution through a report released by the Commission in October 1968 entitled "Response-Abilities."(57) These survey findings are reviewed in Chapter IV, Section G-3 of this report.

b. Task Force Contacts with Legislators

The task forces, in addition to carrying on active public information and education campaigns in their respective planning regions, contacted each of their local representatives to the 104th Legislature to brief them on legislative proposals stemming from the major recommendations. Each task force member met with at least one legislator well in advance of the January 1969 legislative session. Accounts of these personal interviews, by members and legislators alike, have been highly favorable.

c. Increasing Public Awareness of Recommendations

Numerous speaking engagements at meetings of civic and fraternal groups, churches, and both regional and statewide organizations have been arranged by the task forces, with Commission, project staff and task force members sharing in the presentations. There has been great interest reflected in the numerous requests for printed materials and offers of support for legislative proposals by these groups.

Task forces have also arranged for several radio, television and press interviews in which Commission members, project staff, task force representatives and others have been participants.

A number of influential agencies and organizations in the state which have responsibility for leadership and decision making in the field of human services have scheduled special seminars, open forums, panel discussions and other types of programs in which Maine's rehabilitation planning and the recommendations proposed by the Commission have been featured.

(1) Commission recommendations for meeting the rehabilitation needs of the occupationally disabled were the topic of a morning session sponsored by the Maine Industrial Nurses Association during the annual State Safety Conference in Rockland on September 18, 1968. Recommendations were presented by Andrew C. Walsh, M.D., Portland physiatrist and Task Force V member, and discussed further by a panel of specialists, who addressed themselves to "The Industrial Nurse's Role in Rehabilitation."

(2) Progress of the Commission's planning and major recommendations was reviewed during the annual meetings of the Maine Nurses Association October 8, the Maine Council of the Blind October 26, and the Maine Association for Retarded Children on November 1.

(3) The Maine Rehabilitation Association at its annual meeting in Waterville on December 6 presented a "Legislative Preview" of the Commission's major recommendations. Panelists were Commissioner Cote, Employment Security Commission, Dr. Doran and Miss Worthley. Following this presentation the association voted to formally endorse the major recommendations of the Commission.

(4) The Advisory Committee to the Department of Health and Welfare and the Advisory Committee to Medical Care of the Department of Health and Welfare reviewed the major recommendations with Dr. Doran at meetings on December 11 and January 8 respectively. These advisory committees expressed favor with the proposals introduced at the 104th legislative session.

(5) State officers of the Maine Jaycees met with the project staff on December 17 to discuss ways in which the organization could assist in implementing the major recommendations. Plans were developed for a series of open forums at regional Jaycee meetings held December 4 and 5 at Presque Isle (Region I), January 10 at Buxton (Region IV), January 15 at Winslow (Region III)and January 16 at Hampden (Region II). Discussion leaders at the four regional meetings were:

Region I-Dr. Doran, Mr. LaPointe and Task Force I representatives Roger A. Martin, Philip Hutcheon, Earl Langley and Miss Ada Knauff.

Region IV-Dr. Doran and Task Force V representative Maurice Johnson.

Region III-Task Force III representatives Mrs. Dorothy Mills and Roger Truman.

Region II—Task Force VI representative Burton Payson and Mrs. Gordon D. Briggs, Task Force II.

(6) The State Board of Education reviewed the major recommendations at a regular meeting of the Board on December 20 and voted their unanimous endorsement of the proposal to transfer the Division of Vocational Rehabilitation from the Department of Education to the Department of Health and Welfare.

(7) Recommendations requiring legislative action were reviewed by Dr. Doran at a meeting of the Health Council of Maine on January 21.

(8) Endorsements were voted by the Women's Legislative Council and the State Association of Business and Professional Women at meetings in February 1969.

(9) "The Clergyman and Rehabilitation" has been adopted as the annual theme for 1969 by the Maine Association for Pastoral Care following a presentation by Dr. Doran at the Board of Directors meeting in November. Three regional workshops have been scheduled in April for the purpose of clarifying the role of the clergyman in rehabilitation.

CHAPTER IV

FINDINGS AND RECOMMENDATIONS

A. ESTIMATES OF THE PREVALENCE AND INCIDENCE OF HANDICAPPED PERSONS BY CATEGORY PROJECTED TO 1975.

1. Harbridge House Estimates of Demand for Vocational Rehabilitation Services (13)

In light of the emphasis the Commission and its task forces gave to comprehensive planning for total rehabilitation services, it is important to note here that within this broader context, the consulting firm's estimates which appear in succeeding tables of this chapter reflect only a portion of Maine's disabled and disadvantaged persons. They are, however, estimates of utmost important: those handicapped persons eligible for VOCATIONAL rehabilitation services.

What is particularly significant is the large number of eligible clients compared with the number who have previously been identified and served by state-sponsored and funded vocational rehabilitation agencies. Harbridge House states in the opening pages of its report:

> Our estimate of demand for 1967 supports the widespread belief that there is a large unmet need for vocational rehabilitation services. The estimate was drawn on conservative lines, but it indicates that about 50,000 persons in Maine, exclusive of those under the supervision of the Bureaus of Corrections, Probation, and Parole (about 2,000) and an unknown additional number of the socially disadvantaged, are eligible for vocational rehabilitation services. In 1967 the combined caseloads (referrals and active cases) of the Division of Vocational Rehabilitation and the Division of Eye Care and Special Services amounted to about 3,000 clients, of whom about 330 were successfully rehabilitated. Although the figures of 3,000 served and the 50,000 eligible cannot be read literally as a measure of the gap between service and need, they do suggest the orders of magnitude with which the Commission must deal. (13, Part I-1)*

The report presents, for 1967 and projected to 1975, the following estimates:

a. Number of disabled persons, by age group and type of disability.

b. Number of persons eligible for vocational rehabilitation services--that is, disabled, vocationally handicapped, and feasible for vocational rehabilitation--a subgroup of persons both disabled and vocationally handicapped.

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*NOTE: First numeral (13) indicates alphabetical listing of reference as it appears in the Bibliography appended to this report. Second numeral (Part I-1) refers to the page or section of the reference quoted.

c. The distribution of persons in b. above, by age group, type of disability, and geographic location in terms of the Commission's six planning regions.

The estimates are based primarily on secondary sources, a principle one being the National Health Survey sponsored by the U.S. Public Health Service. Materials prepared for the Commission, such as John Fahey's report on disabled youth, were also consulted.

The criteria of eligibility adopted by Harbridge House were those of the federal Vocational Rehabilitation Act prior to 1968: first, a person must be present in the state; second, he must be disabled, third, his disability must constitute a handicap to gainful occupation; and fourth, he must be feasible for rehabilitation. The estimates do not account for persons in institutions or those with other than medically definable disabilities.

Except for the institutionalized, therefore, the quantitative data is intended to reflect the entire population of the state. This group was excluded in order to maintain the highest degree of reliability in the estimates, which were computed largely on the basis of a statistical technique termed a "sample-and-rate" approach.

Instead of a physical count of the number of eligible persons in Maine, the sample-and-rate approach relies on studies that establish percentages, or percentage rates, of pertinent characteristics for other populations. To the extent that the sample population with known rates is representative of another population or sample (such as Maine), the prevalence rates developed for the first sample can be applied to the second sample (Maine). Harbridge House points out in its report, however, that "the sample-and-rate approach produces meaningful results only when the sample population with known rates and the population being analyzed are generally similar." In this stage of computation, type of disability was not considered, and a prime source of data was that provided by the U.S. Census Bureau.

It is important to keep in mind that for purposes of the report, disability was defined as a medically identifiable physical or mental condition. This has been one of three criteria which have determined eligibility for vocational rehabilitation services from the Division of Vocational Rehabilitation and/or the Division of Eye Care and Special Services. The others are: (b) existence of a substantial handicap to employment, and (c) a reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation--i.e., the individual must be "feasible" for service.

The report explains: "Definitions of disability based on socioeconomic characteristics such as illiteracy and poverty involve duplication of counting and a wider margin of error..." it adds, however, that since many of the poor and illiterate are also included in this identification of disability, the prevalence rate of disabled persons in Maine is understated. Consequently, the findings of the subsequent stages are similarly understated.

Estimates of the number of medically disabled persons in Maine in 1967 and 1975, respectively, were calculated by applying a series of prevalence rates of disabled persons based on Health Interview Survey data reported by the National Health Survey.

The "vocationally handicapped" category includes "only these disabled persons severely limited...in their major activity--work, play, school, or housekeeping. Each of these persons may be considered vocationally handicapped if he meets one additional requirement: He must be interested in being gainfully occupied. For example, a retired worker who is disabled would not be considered vocationally handicapped. Thus, in this stage we must introduce the concept of labor-force status." Data from the Bureau of Labor Statistics and the Maine Employment Security Commission were used to determine, by age-group, the labor-force status of disabled persons as (a) unemployed, (b) employed but underemployed because of disability, or (c) not in the labor force. Analysis of the resulting data, cross-correlated by age-group and labor-force status, produced an estimate of the percentage (the prevalence rate) of disabled persons considered vocationally handicapped.

Finally, the estimates of demand for 1967 and 1975 identify those disabled and handicapped persons who are (or will be) feasible for vocational rehabilitation.

"Not all disabled and handicapped persons are feasible," the report explains. "Persons in the general population of the state who are disabled and handicapped may be considered 'feasible,' and thus 'eligible,' for vocational rehabilitation services only if such services may reasonably be expected to render them fit to engage in a gainful occupation."

"We have used the national vocational rehabilitation agency experience to estimate the percentage--the prevalence rate--of disabled and handicapped persons, broken down by age group, type of disability, and geographic location within the state." Applying the final prevalence-rate series to the "vocationally handicapped" data produced the numeric estimates of demand for vocational rehabilitation services in 1967 and 1975. (13, Parts I & II)

The reader is again reminded that the estimates were not intended to provide planning numbers for the diverse special service groups that serve the handicapped and disadvantaged. Rather, they were directed to vocational rehabilitation planning needs, and in particular those of the two major state agencies, the Division of Vocational Rehabilitation and the Division of Eye Care and Special Services, that have responsibility for this functio

It should be noted further that the activities of these two agencies are governed by legal provisions set forth in the state and federal Vocational Rehabilitation Acts.

The ten tables which follow, are prefaced by a brief explanation and have been reproduced directly from the Harbridge House report. They presen the numeric findings of the study of demand for vocational rehabilitation services in Maine for 1967 and 1975--the number of persons in the general population, as defined in the study, who are (or will be) disabled, handicapped, feasible, and therefore eligible for such services.

Tables 1 through 6 deal with various aspects of demand in 1967, while Tables 7 through 10 deal with projections of demand to 1975. Tables 1 through 4,7,8, and 10 deal with statewide patterns of demand, while Tables 5,6, and 9 deal with distribution of demand among the six planning regions in Maine. (The Tables are located on pp. 81-90 inclusive)

Since numbers are rounded off in the calculations, it should be noted that the entries in a table may not add to the totals for that table.

BRIEF EXPLANATION OF HARBRIDGE HOUSE DISABILITY ESTIMATES

Table 1. This table describes the State of Maine in 1967 in terms of the aggregated results of each of the four stages of the analysis--the summation of four stages provides us with low-range, mid-range, and high-range estimates of the demand for rehabilitation services for the state in 1967.

Under the mid-range series, 12.5 percent of the state's total population are disabled. Of the 125,521 persons disabled, 46 percent are handicapped by their disability or disabilities. Of the 58,021 persons who are in the general population, disabled, and handicapped, an estimated 90 percent--or 52,219 persons-are feasible for rehabilitation and therefore constitute the demand for rehabilitation services for the state in 1967, since they meet all four criteria for eligibility for rehabilitation services. Under the low-range series, this number may be as low as 46,851; under the high-range series, demand may be as high as 57,875 persons.

Comparing the low-range and the high-range numbers with the mid-range numbers--the mean--we find that at no point do the extremes vary from the mean by more than 10.8 percent. As a general rule, then, mid-range estimates may be assumed to be accurate within $\pm$ 11 percent.

Table 2. This table presents the detailed findings of Stage II of the analysis--the summation of these findings identifies, by age-group and type of disability (RSA condition category), the mid-range estimate of the number of disabled persons in the general population in Maine in 1967. Many of these persons have more than one disability. The tabulations assign persons to condition categories on the basis of their major or primary disability.

Of the disabled persons in Maine in 1967, 11 percent are younger than 17--mental retardation is the most common primary disability (53 percent) in this age-group; 21 percent are between 17 and 44 years of age--mental retardation is also the most common primary disability (27 percent) in this age-group; 27 percent are between 45 and 64 years of age--orthopedic deformity is the most common primary disability (25 percent) in this age-group; 41 percent are 65 years of age or older--cardiac and circulatory conditions constitute the most common primary disability (26 percent) in this age-group.

Table 3. This table presents the detailed findings of Stage III of the analysis--the summation of these findings identifies, by age-group and type of disability (RSA condition category), the mid-range estimate of the number of disabled persons in the general population who are handicapped by their disabilities. As in Table 2, the tabulations assign persons to condition categories on the basis of their major or primary disability.

All of the 13,541 disabled persons younger than 17 years of age in Maine in 1967 are handicapped. Of the 26,511 disabled persons aged 17 to 44, 57 percent, or 15,130 persons, are handicapped. Of the 34,324 disabled persons aged 45 to 64, 57 percent, or 19,510 persons, are handicapped Only 19 percent --9,840 persons--of the 51,145 disabled persons aged 65 and older can be considered legally handicapped by their disabilities.

Table 4. This table presents the detailed findings of Stage IV, the final stage of the analysis--the summation of these findings identifies, by age-group and type of disability (RSA condition category), the mid-range estimate of the number of disabled and handicapped persons in the general population in Maine in 1967 who are feasible for rehabilitation. The 52,219 persons identified in Stage IV as meeting the four criteria for eligibility for rehabilitation services constitute the demand for such services.

The distribution of eligible persons among the four age-groups indicates a younger age structure than characterizes the disabled (see Table 2). While 23 percent of eligible persons are younger than 17, only 11 percent of disabled persons are in this age-group; 26 percent of the eligible and 21 percent of the disabled are between 17 and 44 years of age; 34 percent of the eligible and 27 percent of the disabled are between 45 and 64 years of age; 17 percent of the eligible and 41 percent of the disabled are 65 years of age or older.

The most common disabling conditions, in terms of RSA condition categories, among eligible persons are mental retardation (23 percent), orthopedic deformity (22 percent), and cardiac and circulatory conditions (16 percent) --these three conditions alone account for the disablement of 61 percent of the persons who are eligible for rehabilitation services.

Table 5. This table described the distribution of the demand for rehabilitation services in Maine in 1967 among the six planning regions. Within each planning region the number of eligible persons in each age-group is tabulated.

The information in Table 5 is particularly important in terms of planning. An effective planning effort to meet the demand for rehabilitation services must consider the geographic distribution of the demand. The prevalence of disabled persons and the prevalence of eligible persons vary from region to region, just as the socioeconomic characteristics of regions (for example, the age structure of the population, the average family income, the average size of the family) vary.

Not surprisingly, since it is Maine's largest region in terms of population, Region V (Cumberland) has the largest number of residents who are eligible for rehabilitation services (32 percent of the state's demand). Region VI (Washington) has the smallest share (9 percent) of the state's demand. In each region except Region I (Aroostook), persons between 45 and 64 years of age represent the largest component of the region's eligible persons.

Table 6. This table describes Region V's demand for rehabilitation services in 1967 in detail in terms of age-groups and RSA condition categories. We have chosen this region as meaningful in these terms because

of the relatively large size of its population and its socioeconomic similarity to the state as a whole. Also, as discussed in connection with Table 5, this region has the largest share (32 percent) of the state's demand for rehabilitation services.

Table 7. This table describes the State of Maine in 1975 in terms of the aggregated results of each of the four stages of the analysis--the summation of the four stages provides us with low-range, mid-range, and high-range estimates of the demand for rehabilitation services for the state in 1975. Except for the planning year--1975 instead of 1967--this table is equivalent to Table 1.

Under the mid-range series, 12.4 percent--133,734 persons--of the state's total population will be disabled in 1975 (the 1967 distribution is 12.5 percent--125,521 persons). As in 1967, 46 percent of the disabled in 1975 will be handicapped by their disability or disabilities. Our data projected to 1975 show the same prevalence rate of feasible persons--an estimated 90 percent of the persons in the general population, disabled, and handicapped--in Maine as in 1967.

Under the mid-range series, the 55,664 persons feasible, and therefore eligible, for rehabilitation services constitute the demand for such services in Maine in 1975. Under the low-range series, this number may be as low as 49,943; under the high-range series, demand may be as high as 61,695 persons.

Table 8. This table presents for 1975, just as Table 4 does for 1967, the detailed findings of Stage IV, the final stage of the analysis--the summation of these findings identifies, by age-group and type of disability (RSA condition category), the mid-range estimate of the number of disabled and handicapped persons in the general population in the state who will be feasible for rehabilitation.

Among the 55,664 persons in Maine who will be eligible for rehabilitation services in 1975, the most common disabling conditions will be mental retardation (24 percent), orthopedic deformity (22 percent), and cardiac and circulatory conditions (16 percent). The predominance of these conditions is almost identical to the 1967 pattern (see Table 4).

The age structures of the 1967 demand and the 1975 demand can be compared as follows:

	1967	1975
Age-Group		
17	23% of demand	23% of demand
17-44	26% of demand	28% of demand
45-64	34% of demand	32% of demand
65+	17% of demand	17% of demand

Table 9. This table describes the distribution of the demand for rehabilitation services in Maine in 1975 among the six planning regions. Within each planning region the number of eligible persons in each age group is tabulated. Except for the planning year-1975 instead of 1967-this table is equivalent to Table 5.

Data from the United States Bureau of the Census used for projecting 1975 populations of the planning regions indicate that the relative mix of socio-economic characteristics typifying each region will remain constant during the next eight years. Thus we assume that the 1975 pattern of distribution of demand for rehabilitation services in Maine among the planning regions--and, within each region, among the age groups will be similar to that of 1967.

Table 10. This table identifies, in terms of a series of mid-range estimates, the number of persons in Maine in each age-group who will be eligible for rehabilitation services in each year of the planning period from 1967 through 1975. Over the eight-year period, persons between 17 and 44 years of age will show the most dramatic growth in number (13 percent), while persons between 45 and 64 years of age will be chacterized by the slowest growth (2 percent).

TABLE 1
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE:

BY COMPONENTS OF ELIGIBILITY, BY RANGE;
STATE OF MAINE, 1967

Component of Eligibility	Range		
	Low-Range	Mid-Range	High-Range
General Population,		1,000,970	
and Disabled,	119,244	125,521	131,796
and Handicapped,	55,119	58,021	60,921
and Feasible (Eligible for Rehabilitation Services)	46,851	52,219	57,875

TABLE 2
PERSONS IN THE GENERAL POPULATION AND DISABLED:
BY RSA CONDITION CATEGORY, BY AGE-GROUP;
STATE OF MAINE, 1967; MID-RANGE

RSA Condition Category	Age-Group <17	17-44	45-64	65+	Total, All Groups
1-- Visual Impairments	302	497	786	3,294	4,879
2-- Hearing Impairments	337	402	314	989	2,042
3-- Orthopedic Deformity or Impairment (Except Amputations)	2,140	6,160	8,605	12,526	29,431
4-- Absence or Amputation of Major & Minor Members	34	152	278	371	835
50- Mental, Psycho- 51- neurotic & Personality 52- Disorders	305	1,434	1,807	1,988	5,534
53- Mental Retardation	7,203	7,103	3,663	852	18,821
60- Other Conditions Resulting From Neoplasms (n.e.c.)	76	352	507	635	1,570
61- Allergic, Endocrine, Metabolic & Nutritional Diseases	353	1,636	1,830	2,522	6,341
62- Diseases of the Blood & Blood-Forming Organs	31	155	292	371	849
63- Other Specified Disorders of the Nervous System	145	273	380	458	1,256
64- Cardiac & Circulatory Conditions	1,151	2,625	6,832	13,281	23,889
65- Respiratory Diseases	206	961	1,400	1,473	4,040
66- Disorders of the Digestive System	263	1,211	2,405	3,400	7,279
67- Conditions of the Genito-Urinary System	194	896	1,093	1,495	3,678
68- Speech Impairments	367	222	285	371	1,245
69- Other Conditions & Impairments (n.e.c.)	434	2,432	3,847	7,119	13,832
Total, All Categories	13,541	26,511	34,324	51,145	125,521

TABLE 3
PERSONS IN THE GENERAL POPULATION,
DISABLED, AND HANDICAPPED:

BY RSA CONDITION CATEGORY, BY AGE-GROUP;
STATE OF MAINE, 1967; MID-RANGE

RSA Condition Category	Age-Group <17	17-44	45-64	65+	Total, All Groups
1-- Visual Impairments	302	284	447	634	1,667
2-- Hearing Impairments	337	229	178	190	934
3-- Orthopedic Deformity or Impairment (Except Amputations)	2,140	3,516	4,891	2,410	12,957
4-- Absence or Amputation of Major & Minor Members	34	87	158	71	350
50- Mental, Psycho- 51- neurotic & Personality 52- Disorders	305	819	1,027	382	2,533
53- Mental Retardation	7,203	4,054	2,082	164	13,503
60- Other Conditions Resulting From Neoplasms (n.e.c.)	76	201	288	122	687
61- Allergic, Endocrine, Metabolic & Nutritional Diseases	353	933	1,040	485	2,811
62- Diseases of the Blood & Blood-Forming Organs	31	89	166	71	357
63- Other Specified Disorders of the Nervous System	145	156	215	88	604
64- Cardiac & Circulatory Conditions	1,151	1,498	3,883	2,555	9,087
65- Respiratory Diseases	206	549	796	283	1,834
66- Disorders of the Digestive System	263	691	1,367	654	2,975
67- Conditions of the Genito-Urinary System	194	512	622	288	1,616
68- Speech Impairments	367	127	162	71	727
69- Other Conditions & Impairments (n.e.c.)	434	1,388	2,187	1,370	5,379
Total, All Categories	13,541	15,130	19,510	9,840	58,021

TABLE 4
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE
(ELIGIBLE FOR REHABILITIATION SERVICES):

BY RSA CONDITION CATEGORY, BY AGE-GROUP:
STATE OF MAINE, 1967; MID-RANGE

RSA Condition Category	Age-Group <17	17-44	45-64	65+	Total, All Groups
1-- Visual Impairments	272	255	402	570	1,500
2-- Hearing Impairments	303	206	160	171	841
3-- Orthopedic Deformity or Impairment (Except Amputations)	1,926	3,164	4,402	2,169	11,661
4-- Absence or Amputation of Major & Minor Members	31	78	142	64	315
50- Mental, Psycho- 51- neurotic & Personality 52- Disorders	274	737	925	344	2,280
53- Mental Retardation	6,483	3,648	1,874	148	12,153
60- Other Conditions Resulting From Neoplasms (n.e.c.)	69	181	259	110	618
61- Allergic, Endocrine, Metabolic & Nutritional Diseases	318	840	936	437	2,531
62- Diseases of the Blood & Blood-Forming Organs	28	80	149	64	321
63- Other Specified Disorders of the Nervous System	131	140	194	79	544
64- Cardiac & Circulatory Conditions	1,036	1,348	3,495	2,300	8,178
65- Respiratory Diseases	185	494	716	255	1,650
66- Disorders of the Digestive System	237	622	1,230	589	2,678
67- Conditions of the Genito-Urinary System	174	460	559	259	1,453
68- Speech Impairments	331	114	146	64	655
69- Other Conditions & Impairments (n.e.c.)	391	1,249	1,968	1,233	4,841
Total, All Categories	12,187	13,617	17,559	8,856	52,219

TABLE 5
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE
(ELIGIBLE FOR REHABILITATION SERVICES):

BY PLANNING REGION, BY AGE-GROUP;
STATE OF MAINE, 1967; MID-RANGE

Planning Region	Age-Group				Total, All Groups
	<17	17-44	45-64	65+	
I. Aroostook	1,565	1,535	1,488	622	5,210
II. Penobscot	1,860	2,028	2,337	1,199	7,424
III. Kennebec	2,114	2,411	3,352	1,807	9,684
IV. Androscoggin	1,884	2,104	2,860	1,418	8,266
V. Cumberland	3,733	4,383	5,882	2,891	16,889
VI. Washington	1,031	1,156	1,640	919	4,746
Total, All Regions	12,187	13,617	17,559	8,856	52,219

TABLE 6
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE
(ELIGIBLE FOR REHABILITATION SERVICES):

BY RSA CONDITION CATEGORY, BY AGE-GROUP;
PLANNING REGION V (CUMBERLAND), 1967; MID-RANGE

RSA Condition Category	Age-Group <17	17-44	45-64	65+	Total, All Groups
1-- Visual Impairments	82	83	135	185	485
2-- Hearing Imapirments	89	66	53	58	266
3-- Orthopedic Deformity or Impairment (Except Amputations)	567	1,030	1,465	708	3,769
4-- Absence or Amputation of Major & Minor Members	11	27	47	20	105
50- Mental, Psycho- 51- neurotic & Personality 52- Disorders	82	241	306	113	742
53- Mental Retardation	2,024	1,122	665	49	3,859
60- Other Conditions Resulting From Neoplasms (n.e.c.)	23	61	88	35	207
61- Allergic, Endocrine, Metabolic & Nutritional Diseases	97	276	312	141	825
62- Diseases of the Blood & Blood-Forming Organs	8	27	47	20	103
63- Other Specified Disorders of the Nervous System	42	44	65	26	176
64- Cardiac & Circulatory Conditions	313	438	1,165	752	2,668
65- Respiratory Diseases	55	162	241	84	543
66- Disorders of the Digestive System	71	206	412	194	883
67- Conditions of the Genito-Urinary System	52	154	188	84	478
68- Speech Impairments	97	35	47	20	200
69- Other Conditions & Impairments (n.e.c.)	120	412	647	403	1,581
Total, All Categories	3,733	4,383	5,882	2,891	16,889

TABLE 7
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE:

BY COMPONENTS OF ELIGIBILITY, BY RANGE;
STATE OF MAINE, 1975

Component of Eligibility	Range		
	Low-Range	Mid-Range	High-Range
General Population,		1,081,000	
and Disabled,	127,047	133,734	140,421
and Handicapped,	58,757	61,849	64,942
and Feasible (Eligible for Rehabilitation Services)	49,943	55,664	61,695

TABLE 8
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE
(ELIGIBLE FOR REHABILITATION SERVICES):

BY RSA CONDITION CATEGORY, BY AGE-GROUP;
STATE OF MAINE, 1975; MID-RANGE

RSA Condition Category	Age-Group <17	17-44	45-64	65+	Total, All Groups
1-- Visual Impairments	284	292	408	606	1,590
2-- Hearing Impairments	309	236	163	182	889
3-- Orthopedic Deformity or Impairment (Except Amputations)	1,968	3,630	4,470	2,303	12,370
4-- Absence or Amputation of Major & Minor Members	33	90	145	68	336
50- Mental, Psycho- 51- neurotic & Personality 52- Disorders	287	851	939	366	2,443
53- Mental Retardation	7,005	3,943	2,025	159	13,132
60- Other Conditions Resulting From Neoplasms (n.e.c.)	72	209	263	117	662
61- Allergic, Endocrine, Metabolic & Nutritional Diseases	334	971	950	464	2,718
62- Diseases of the Blood & Blood-Forming Organs	29	92	151	68	340
63- Other Specified Disorders of the Nervous System	137	162	197	84	580
64- Cardiac & Circulatory Conditions	1,085	1,546	3,548	2,442	8,622
65- Respiratory Diseases	194	571	727	271	1,763
66- Disorders of the Digestive System	248	719	1,249	625	2,840
67- Conditions of the Genito-Urinary System	183	532	568	275	1,558
68- Speech Impairments	340	128	148	68	683
69- Other Conditions & Impairments (n.e.c.)	409	1,444	1,976	1,309	5,139
Total, All Categories	12,916	15,414	17,926	9,408	55,664

TABLE 9
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE
(ELIGIBLE FOR REHABILITATION SERVICES):

BY PLANNING REGION, BY AGE-GROUP;
STATE OF MAINE, 1975; MID-RANGE

Planning Region	Age-Group				Total, All Groups
	<17	17-44	45-64	65+	
I. Aroostook	1,658	1,738	1,519	661	5,576
II. Penobscot	1,971	2,295	2,386	1,274	7,926
III. Kennebec	2,240	2,730	3,422	1,919	10,311
IV. Androscoggin	1,996	2,382	2,920	1,507	8,805
V. Cumberland	3,958	4,961	6,005	3,070	17,994
VI. Washington	1,093	1,308	1,674	976	5,051
Total, All Regions	12,916	15,414	17,926	9,408	55,664

TABLE 10
PERSONS IN THE GENERAL POPULATION,
DISABLED, HANDICAPPED, AND FEASIBLE
(ELIGIBLE FOR REHABILITATION SERVICES):

BY YEAR, BY AGE-GROUP;
STATE OF MAINE, 1967-1975; MID-RANGE

Year	Age-Group				Total, All Groups
	<17	17-44	45-64	65+	
1967	12,187	13,617	17,559	8,856	52,219
1968	12,276	13,830	17,604	8,923	52,633
1969	12,366	14,046	17,650	8,991	53,053
1970	12,456	14,265	17,696	9,059	53,476
1971	12,547	14,488	17,741	9,128	53,904
1972	12,638	14,714	17,787	9,197	54,336
1973	12,731	14,944	17,833	9,267	54,775
1974	12,824	15,177	17,880	9,337	55,218
1975	12,916	15,414	17,926	9,408	55,664

2. Development of a Nonduplicative List of Clients Eligible for Vocational Rehabilitation Service - Harbridge House*

Plans formulated during the organizational phase of the study called for Harbridge House to describe a methodology for validating and field testing the estimates of disability incidence which, as has been stated, are based on research of secondary sources. The underlying purpose of the validation system was to provide a means whereby the Harbridge House estimates could be refined, using local data. It was believed this refinement process would give increased assurance that the estimates were indeed an accurate reflection of vocational rehabilitation need. Specifically proposed was a household survey to be conducted in the Upper Kennebec Valley Region.

However, as the Commission's overall study progressed and the proposed validation of estimates was reexamined, it became evident that the household survey would be impractical in terms of cost and utility for current and future planning. Among the reasons given by a Harbridge House representative at a meeting of the Commission on October 2, 1967, were:

a. Household surveys, to be reliable, must be conducted under the most exacting conditions; hence, it would be costly and difficult to conduct a survey that would provide detailed statistics with high levels of confidence and still be a large enough sample to be considered reliable.

b. Since the estimate of demand does not reflect the actual number of persons receiving vocational rehabilitation service, planning in the near future depends less on the accuracy of the estimate than on the gap between service required and service being provided. So long as this gap remains large, precision in the estimate is not essential.

c. Data on services provided in relation to estimates of demand are difficult to decipher because of duplication of clients among agencies; lack of any uniform system of recordingdata on clients in service, both among agencies and even in some instances within the agency itself; difficulty of access to records, since they are housed in many different locations around the state.

Harbridge House and the Commission concluded that the most urgent need is for the orderly development of a nonduplicative list of persons currently receiving vocational rehabilitation service. Comparison of these known cases with the disability estimates already derived by Harbridge House would give a far better indication of unmet need than a costly validation survey.

The second study by Harbridge House, therefore, was a description of a methodology for developing the nonduplicative name list. In preparing it, the firm not only drew upon its own extensive research ex-

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*Material in this section is abstracted from the Harbridge House study, Data Requirements and Survey Techniques for Vocational Rehabilitation Planning, Harbridge House, Inc., Boston, Massachusetts, February 1968.

perience but also the accomplishments of John Fahey and Kevin Baack, consultants to the Commission during the summer of 1967. A detailed description of the methods used by Mr. Fahey are included in the Harbridge House report because of their effectiveness and because "many of the same techniques should be used in the development of a non-duplicative list of total vocational rehabilitation clients in the state."

Included in the report also are some observations offered to the Harbridge House representative by Mr. Fahey soon after completing his assignment. They are quotedhere directly from the Harbridge House report:

(Mr. Fahey noted that) an investigator performing a study of this nature encounters these problems:

> Data from the various state welfare agencies are not readily available or accessible to outside organizations--either public or private. Access to the data tends to be limited, both because of confidentiality requirements and because of the effort required to compile summary information.
>
> Agency records tend to be scattered and generally incompatible in format and content. Data formats vary from agency to agency and, within many agencies, from geographical area to geographical area.
>
> Because state welfare agencies apparently do not have adequate staff to summarize and analyze statistical information in their own files, investigators must provide their own research staffs. However, some agencies have better summary data than others...
>
> Referral patterns for most clients served by more than one agency generally cannot be tracked, except for those clients serviced by Public Health Nursing District VI where formal referral source records have been maintained. (In agencies using HEW Form R-300, the referral source for each client is required, but disposition of the client, if any, through referral to another agency, may not be available without consulting the case file.)
>
> There is inadequate information on interagency transations and sponsorship of clients by more than one agency as a result of multiple disabilities or multiple rehabilitation needs.
>
> The relationships among state and private welfare agencies is not defined, and there is no specific evidence to suggest how or whether these agencies work together to maximize the use of the state's total public and/or private resources for rehabilitation.

3. Harbridge House Approach

Based on Mr. Fahey's methods, interviews with vocational rehabilitation administrators in Maine, and the firm's own experience with other survey work, Harbridge House recommended a procedure for collecting caseload data and developing a nonduplicative registry. It is understood that this would be a comparatively short-term project (data collection for Mr. Fahey's study required approixmately seven man-weeks, with an additional man-month for analysis of the data and compilation of the final report). A brief outline of the recommended procedure is as follows:

a. A project director should be appointed and given responsibility for the project, which should include also a companion survey of clients of other state agencies eligible for vocational rehabilitation service. A full-time secretary should be engaged at this time.

b. After the planning stage, additional staff should be assigned to the actual collection of data in the proper formats, observing all requirements of confidentiality. Once this phase is completed, these personnel will no longer be needed.

c. Caseload data and the nonduplicative name list would be compiled from the records of rehabilitation agencies serving persons identified as handicapped. It should be gathered on forms that have been precoded for key punch in order to convert the data to a machine processable form. (A proposed form to be used is included in the report.) From the data-collection forms one card will be punched for each client listing and processed by computer to arrange the cards alphabetically with name cards from different agencies adjacent in the stack.

d. Processing and analysis of the data will provide a base from which to compute the gap between current levels of service and estimated needs, to plan future outreach and service activities, and to measure results in terms of altered caseloads, patterns of services, disposition of cases, and so forth.

4. Sampling of Eligible Clients of Other State Agencies

In order to determine the extent to which vocational rehabilitation agencies are not serving the handicapped clients of other state agencies who are eligible for service, a sample of other state agency case records should be analyzed. Harbridge House points out that this information will highlight the opportunities and need for interagency coordination, as well as be useful in planning the expansion of vocational rehabilitation service.

It would not be necessary to develop full lists of all persons served by these agencies, since the objective is to determine the prevalence of vocationally handicapping conditions. The assistance of professional personnel from the Division of Vocational Rehabilitation will be required at this stage to assess the eligibility of an agency client for vocational rehabilitation services. (The suggested size sample to be studied for each agency is indicated in the report). As in the case of the non-dupli-

cative name list, the data gathered would then be converted to data cards for analysis.

In addition to providing information on eligibility by agency as well as distributions of age, disability, and geographical location, analysis of the data would also provide a means, through the client's name, of following up the eligible cases in the sample to verify the need for vocational rehabilitation service.

If the original sample indicates a large proportion of eligible clients, a determination should be made of all the clients of the agencies specified. This could well result in the discovery of large numbers of people for whom plans should be made and services provided.

Recommendations for Determining Extent of Unmet Need

Concurrently with the Harbridge House study, the regional task forces also expressed concern about the large gap between needs and services being provided. One task force prepared disability projections for its own region and found them considerably higher than the preliminary estimates of Harbridge House.

While most felt that it is now difficult to project for the long run until more is known about how adequately current needs are being met, all task forces stressed the importance of more effective reporting and data processing techniques.

One task force reported that "the lack of any uniform system of reporting, and the absence in the state of any central registry of information about clients makes it necessary for each agency to go through much the same process each time a client applies or is referred to a different agency." An efficient reporting and information system "would cut down the time lag, which often extends to several months, between initial processing of a client who has been served by another agency, and his initial acceptance or refusal by the new agency considering him."

All task forces recommended that a procedure be adopted to determine the actual extent of need for rehabilitation services; also, that responsibility for obtaining this information and maintaining it on a continuing basis be vested with the appropriate agency.

On the basis of these observations and those of other study committees and special project consultants, the Commission recommends that:

A NONDUPLICATIVE LIST OF KNOWN HANDICAPPED PERSONS NEEDING REHABILITATION SERVICE SHOULD BE DEVELOPED AND KEPT UP-TO-DATE AS A CONTINUING FUNCTION OF THE MAJOR PUBLIC REHABILITATION SERVICES AGENCY.

The Commission believes that the initial development, as well as the continuance of such a list, using the procedures recommended in the Harbridge House study, should be undertaken by the proposed unit of rehabilitation services described in Section F-3 of this report. The list, therefore, would include uniform data on each of the clients served by the Divisions of Vocational Rehabilitation, Eye Care and Special Services, Alcoholism Services, and any other state rehabilitation functions incorporated in a new administrative structure. Once the appropriate forms and method of reporting have been developed and utilized in preparing the initial list of clients in service, each of these agencies comprising the rehabilitation unit should continue to report to the central registry all new clients, using the standard procedure agreed upon in the early phase of the project.

While it would be the responsiblity of the Department of Health and Welfare to establish and enforce this uniform reporting procedure, it is recommended further that:

ALL OTHER DIVISIONS WITHIN THE DEPARTMENT OF HEALTH AND WELFARE HAVING KNOWLEDGE OF PERSONS IN NEED OF REHABILITATION SERVICE SHOULD ALSO BE REQUIRED TO REPORT THESE CASES TO THE CENTRAL REGISTRY.

Examples of these agencies are Child Health Services, Child Welfare Services, Family Services and related Services of the Bureau of Health. Additionally, it is recommended that:

A UNIFORM REPORTING PROCEDURE SHOULD BE EXTENDED TO ANY OTHER AGENCIES OR INSTITUTIONS, PUBLIC OR PRIVATE, THAT IN THE COURSE OF THEIR WORK ENCOUNTER PERSONS CURRENTLY OR POTENTIALLY IN NEED OF REHABILITATION.

Successful implementation of this more extensive case reporting would require much greater understanding of common objectives and better coordination among state and private resources for rehabilitation than has previously existed. But the many instances of interagency liaison and increasing acceptance of the total rehabilitation concept are convincing indications that such cooperation is by no means unattainable.

State agencies that can be expected to supply this needed information are the Employment Security Commission, Department of Mental Health and Corrections, Department of Education, Industrial Accident Commission, Division of Economic Opportunity, and others. Among the private sources of information are hospitals and the many services and facilities that

serve special groups of handicapped persons, for example, the Pine Tree Society for Crippled Children and Adults, private Cerebral Palsy Centers and Mental Retardation programs.

5. Information and Referral Services for Prospective Clients

It is recognized that many persons who should be receiving some form of rehabilitation service never become known to a public or private agency or organization because they have never applied or been referred. Lack of understanding about what services are available and who is entitled to them is undoubtedly one of the prime reasons, and this may well apply to agencies as well as to individuals. It can be assumed, also, that in the absence of effective referral procedures, a certain number of persons, especially among the socially and economically disadvantaged, are easily put off and become discouraged when their tentative efforts to seek help are met with confusing complexities, red tape, and long delays. Inadequate funds and staff shortages prevent many agencies, both public and private, from "selling" their programs effectively to the general public, and often prevent them from giving individual clients or prospective clients the personal attention that would allay their misapprehensions.

As a means of helping to correct this situation and also to arrive at a more accurate assessment of rehabilitation need, it is recommended that:

INFORMATION AND REFERRAL CENTERS DESIGNED TO GIVE CITIZENS IMMEDIATE AND COMPLETE INFORMATION ABOUT THE FULL RANGE OF REHABILITATION SERVICES AVAILABLE, AND ALSO TO REFER CLIENTS DIRECTLY TO THESE SERVICES, SHOULD BE ESTABLISHED IN STRATEGIC LOCATIONS IN THE STATE.

These centers should function as regional offices of a Central Information and Referral Service, to be operated as a function of the Department of Health and Welfare, which would have overall responsibility for coordinating the statewide system and helping to implement interagency cooperation. Each center should be staffed by knowledgeable persons trained in counseling techniques who are familiar with the broad range of social and rehabilitation services being provided by public and private agencies regionally and statewide.

Through cooperative arrangements with these agencies, the preliminary contact should be made on behalf of the client, to be followed up later with an inquiry about the disposition of each case.

This regional and statewide system is seen as operating in conjunction with the central registry of clients, proposed in the foregoing recommendations, and in association with district level health and welfare offices.

B. DISABILITY GROUPS

Methodological Approach

During the organizational phase of the statewide planning project it was decided that rather than assign task forces or special study committees to particular kinds of physical and mental disabilities, it would be more productive in Maine to adopt a broad view of disability needs within the total context of preventive and restorative services. Accordingly, each disability group received the attention of several consultants and all of the regional task forces.

Basically, disability groupings covered in this study include the 16 categories utilized by Harbridge House in preparing estimates of need.(13) John J. Fahey, in his assessment of programs for handicapped youth, prepared Incidence Tables for 12 separate disability categories based on his nonduplicative name list of 8 to 18-year-old clients being served by various rehabilitation agencies.(14) Subjects enumerated in the tables are identified by age, sex, geographic region, and the agency in whose files they first appeared. (Although several subjects appeared on the rolls of two and sometimes three or more agencies, they are counted only once in the tables). Similarly, Kevin C. Baack presents both actual numbers and estimates of handicapped adults (age 18 up) in a number of different categories.(14) To evaluate job placement of adults by the Employment Security Commission, he grouped rehabilitated applicants within ten categories of disability. And as another example, Francis H. Sleeper, M.D., in his recommendations for research in rehabilitation, addressed himself to the needs of several disability groups including the mentally ill, mentally retarded, sight and hearing impaired, paraplegics and quadriplegics, occupationally disabled, epileptics, elderly disabled, and a number of others.(60) Many of the regional task force recommendations are concerned with programs and services for specific groups of handicapped children and adults, as are those in the plan for rehabilitation facilities and workshops. (18)

However, despite the very evident, and often severely acute needs of many special disability groups--for example, the large numbers of emotionally and behaviorally disturbed children for whom only meager programs of treatment are now being provided--it was felt that the purpose of the overall planning effort would be better served, and that in actual practice more effective and less fragmented results could be obtained, by adherence to the concept of <u>total</u> preventive and restorative service.

This, to repeat, in no way conflicted with a full realization of the specific needs of particular individuals. It did, however, recognize that few handicapped persons have only one problem to cope with. Throughout all phases of the planning project it was acknowledged that disability must be viewed, and treated, as a condition affecting the whole person, emotionally, socially, economically. The individual may require help in solving a variety of problems which together comprise the pattern of disability; therefore, the role of rehabilitation is to provide these kinds of help within the context of a comprehensive structure in which the whole person is, and remains, the focus of attention.

As this report has stated earlier in the words of Professor Leonard W. Mayo, "All rational rehabilitation starts with an attempt to remove the physical or mental source of disability. Therefore, the first goals are medical. Nevertheless, careful attention must be paid to the social and psychological obstacles. Goals in rehabilitation may be interpreted as movement toward more independent living..."(38)

In accordance with this principle, several of the task forces and study groups gave close attention to ways of implementing a pattern of care, regionally and statewide, that would utilize existing resources in the most effective manner, and at the same time provide for their orderly development as contributing elements within a comprehensive structure.

This aspect of rehabilitation planning was of prime interest to regional Task Force V (Cumberland, York, and Sagadahoc Counties), an area having a high concentration of inhabitants (30% of the state's total population) and also by far the largest number of technical rehabilitation services and specialized personnel. For several months a Task Force V subcommittee chaired by John J. Lorentz, M.D., director of medical rehabilitation at Maine Medical Center, Portland, explored the topic in depth. Dr. Lorentz, with his fellow committee members Andrew C. Walsh, M.D., director of medical rehabilitation at Mercy Hospital, Portland, and Miss Heloise Withee, director of the Public Health Nursing Association, South Portland, developed the framework of a comprehensive plan for statewide regionalized medical rehabilitation facilities and services. (55,pp.5-10)

A System of Medical Rehabilitation Services

Essentially, the plan is based on the premise that the many problems obstructing the handicapped persons' potential for personal, social, and economic adjustment quite often require specialized attention which local resources alone are unable to supply.

> The rehabilitation process calls upon many different though related disciplines, each of which is capable of providing some help. When correlated, they form a continuum that is dynamic, flexible, and individual. The need, therefore, is to make the most efficient use of resources currently existing or planned for the future. This requires the breakdown of traditional local barriers, yet not the loss of local identity, through a regional approach to service and a coordinated effort by all members of the rehabilitation "team." (55, p.8)

The elements of the rehabilitation process are defined in the subcommittee report as (1) medical and allied paramedical services, (2) psychosocial services, and (3) vocational and educational services.

Examples of medical services are physical and medical evaluation and consultation, psychological and psychiatric screening, physical, occupational and speech therapy, audiology, recreational therapy, psychiatric treatment, rehabilitative nursing care, and prosthetics and orthotics.

Psychosocial services include personal adjustment counseling, group therapy, behavioral conditioning, social evaluation, social case work, social group work, and non-medical recreational and diversional activities.

Vocational and educational services include vocational evaluation, vocational training, and placement. This last, the report emphasizes, is by no means limited to "vocational placement." Rather, it is to be interpreted in its broadest sense as including placement within educational and learning situations, placement within training situations, and not least, placement within a social framework wherein the individual can function and continue to function at his highest level of competence.

Rehabilitation thus becomes the process of helping each individual to reach and maintain his highest level of independence by means of prevention, modification or circumvention of congenital or acquired impairments. It is necessarily governed by such factors as the availability of medical and paramedical services, transportation, geography, economic considerations, availability and distribution of educational opportunities, and also the means of attracting trained personnel to areas where specialized skills are needed.

In Maine the technical facilities and highly trained personnel needed to conduct programs of comprehensive rehabilitation are in short supply. Consequently, it is of utmost importance to make maximum use of those available or being planned, and to avoid all unnecessary duplication. The plan for regionalized medical rehabilitation services developed by the Task Force V subcommittee (see diagram next page) and modified by other regional task forces, consultants, and special study groups, represents a concerted attempt to realize these objectives. It is therefore, a major recommendation of the Commission that:

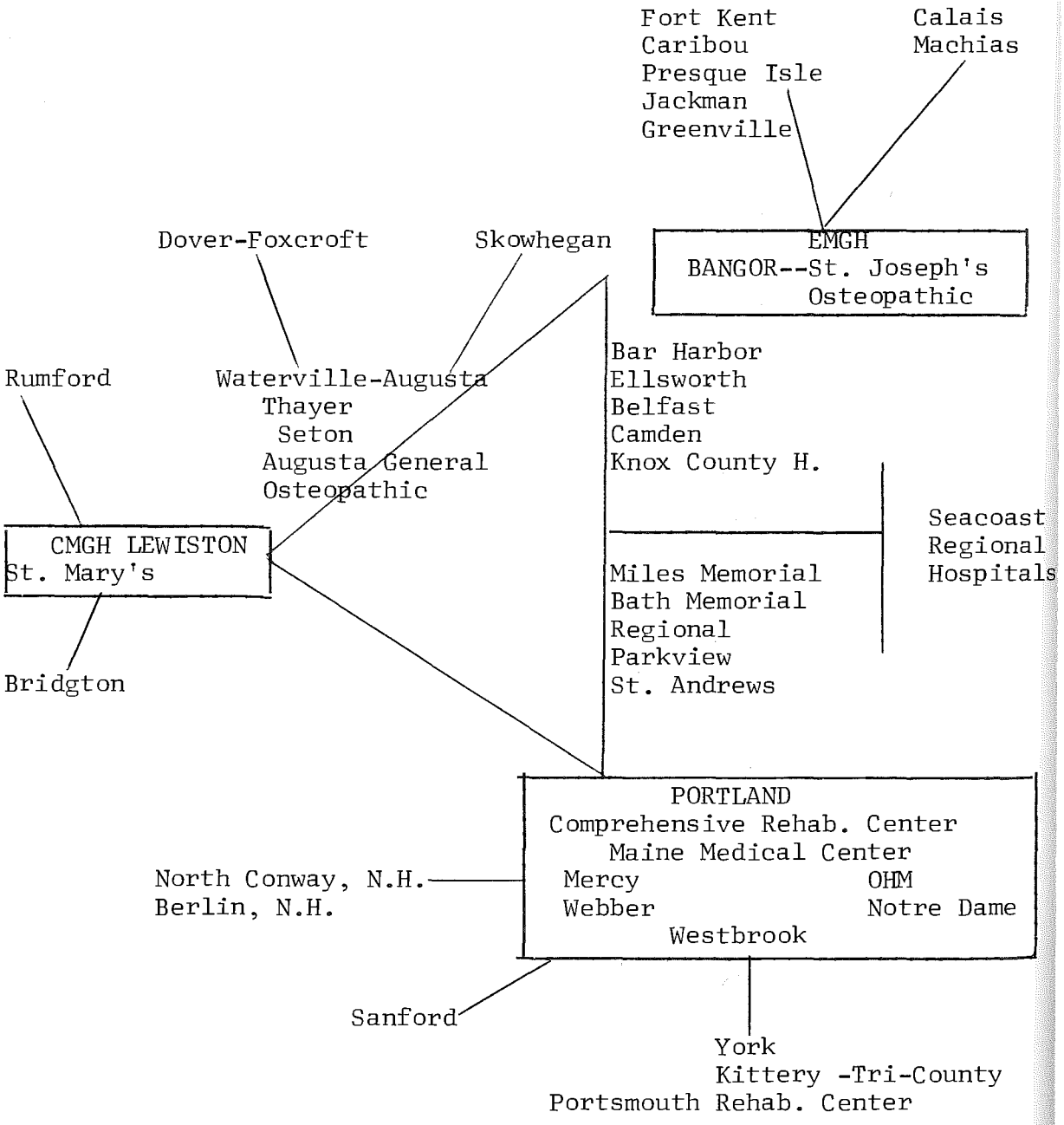
THE PLAN FOR THE ORDERLY DEVELOPEMENT OF A STATEWIDE REGIONALIZED SYSTEM OF COMPREHENSIVE MEDICAL REHABILITATION SERVICES AND FACILITIES THROUGH A COOPERATIVE TEAM APPROACH BE ADOPTED TO GUIDE PRESENT AND FUTURE EXPANSION AND UTILIZATION.

The densely populated Portland area, because of its high demand for services and the presence there of medical facilities such as the Maine Medical Center, Mercy Hospital, Osteopathic Hospital of Maine, and the Webber, Notre Dame, and Westbrook Hospitals with their complement of specialists, technicians and other highly trained personnel, is seen as the hub of a service network extending to all parts of the state. Next geographically is the Bangor region, where the Eastern Maine General, St. Joseph's and Osteopathic Hospitals are located, and which serves a large portion of northeastern Maine including Aroostook County. Other regional centers are the Lewiston-Auburn group of Central Maine General and St. Mary's Hospitals; Waterville-Augusta (Thayer, Seton and Osteopathic Hospitals of Waterville, Augusta General and Gardiner General); and the coastal region (Maine Coast Memorial and other coastal hospitals). From these key points, services should extend to smaller satellite units including the community hospitals, extended care units, and public and private community health services, as dictated by such factors as transportation and topography.

SCHEMATIC DIAGRAM FOR STATEWIDE AND
REGIONAL MEDICAL REHABILITATION SERVICES

Prepared by Task Force 5

Regional Rehabilitation Planning
(not all-inclusive)



A Comprehensive Rehabilitation Center

An integral part of the plan, stated here as a major recommendation of the Commission, is that:

A COMPREHENSIVE REHABILITATION CENTER FOR THE STATE AND REGION (THE LATTER TO INCLUDE NEIGHBORING PORTIONS OF NEW HAMPSHIRE) SHOULD BE DEVELOPED IN CLOSE PROXIMITY TO, IF NOT AN ACTUAL EXTENSION OF A MAJOR MEDICAL FACILITY HAVING A WIDE RANGE OF MEDICAL REHABILITATION SERVICES IN SOUTHERN MAINE.

It should be noted here that this recommendation was also proposed independently by all of the task forces and given major emphasis by five of them. In addition it was given first priority by the facilities advisory committee who, under a separate federal grant, prepared the state Plan for Rehabilitation Facilities and Sheltered Workshops (See Chapter IV, Section E-6). The report of this study group notes: "This is a long term goal but is considered to be the greatest need for the state."

The Region V subcommittee, in their report to the Commission, point out that the basic components of a comprehensive Center already exist within the Greater Portland complex. The Maine Medical Center, for example, is now providing medical, paramedical, psychosocial, and educational services, as well as diagnostic, research, and training programs, (physician, intern, resident, and nurse). Drawing upon these and other medical and allied social service programs in the Greater Portland area, the proposed comprehensive rehabilitation center could extend its sphere of influence to all parts of the state and offer specialized rehabilitation services not available elsewhere in Maine.

While noting the need for a comprehensive rehabilitation center in each New England state, the Northern New England Rehabilitation Facilities specialists have recommended that close attention be given to trends in the development of the Crotched Mountain Foundation in New Hampshire, an existing center, in the event that it seems feasible, in the short term at least, to support a multi-state facility. At the same time, the Maine Rehabilitation Facilities Advisory Committee urged that Maine begin planning for its own comprehensive center without delay.

The center as envisioned by the task forces, facilities planning group and the Region V subcommittee, should be fully equipped and staffed to employ a multidisciplinary approach to each individual patient or client. Once in the process, the client should be treated in all spheres of his disability, progressively or concurrently, as his individual needs dictate. While it is not necessary for all service components to be a single location, there must be careful development of an organization that recognizes the patient as the central theme of its program and gears all of its services to meeting his needs.

Prompt diagnosis and evaluation, medical treatment when indicated, including psychological counseling, fitting prosthetic and orthotic

devices and training patients in their use, along with other adjustment services, should be followed by vocational counseling, training, and placement as defined earlier. The center should be equipped to provide domiciliary care for those who have come for diagnostic evaluation or vocational training and who are not in need of inpatient status in a hospital. They should also include an area in which visiting family members can be housed temporarily, so that social visits are possible and family members can be led to an intelligent understanding of the patient's problems, present and future.

Educational facilities at the center should include training programs for paramedical personnel, physical and occupational therapy aides, home health aides, and others, to permit them to function in the small hospital, extended care unit, nursing home, or within the patient's home itself under the direction and supervision of a trained paramedic who in turn is directed by a physician. There should also be opportunities for physicians in the small community hospitals to acquire the skills in preventive and restorative measures, including prosthetic and orthotic appliances, and the generally accepted medical rehabilitative techniques.

To ensure that the medical rehabilitation needs of Maine citizens everywhere in the state are adequately served, it is also recommended that:

MEDICAL REHABILITATION CENTERS SHOULD BE FURTHER DEVELOPED

AT MAJOR MEDICAL FACILITIES IN CENTRAL, EASTERN AND NORTHERN

MAINE.

These centers should be equipped to offer a continuum of rehabilitation services to patients and clients nearly as complete as those proposed for the comprehensive rehabilitation center in the Greater Portland area. These should include psychiatric examination and referral, physical and occupational therapy, speech and hearing therapy, psychological and psychiatric counseling and treatment, prosthetic and orthotic services, and any others that may be feasible. In addition, through cooperative arrangements with public and private agencies, a full range of social and vocational rehabilitation services should be available at these regional centers.

The Bangor region, because of its geographical location and the large area which it serves, should develop services almost as comprehensive as those described for the Portland area, utilizing existing public and private facilities and enlarging upon them as the needs dictate. The Lewiston-Auburn, Waterville-Augusta, the coastal region, and central Aroostook region should continue expansion of their medical rehabilitation programs (medical evaluation, treatment, referral, physical and occupational therapy, speech and hearing therapy, prosthetic and orthotic services) in an orderly and well-coordinated manner, relating these to existing and projected social services within their respective communities.

COOPERATIVE VOCATIONAL REHABILITATION UNITS SHOULD BE ESTABLISHED AT MAJOR MEDICAL CENTERS IN THE STATE WHICH NOW HAVE MEDICAL REHABILITATION PROGRAMS.

It is to be hoped that each of the major regional medical facilities proposed in the plan for comprehensive medical rehabilitation services will also develop, with the assistance of the appropriate state agencies, supporting vocational, educational and social services to function as necessary adjuncts to what the medical center itself can achieve. An immediate need is for a vocational rehabilitation unit to be established at the Maine Medical Center in Portland, where physical and mental restoration and training programs are now available.

SATELLITE UNITS FORMALLY AFFILIATED WITH THE REGIONAL MEDICAL REHABILITATION CENTERS SHOULD BE ESTABLISHED THROUGH COMMUNITY HOSPITALS, EXTENDED CARE FACILITIES, HOME HEALTH SERVICES AND CLINICS PROVIDING FOR EFFECTIVE REFERRAL AND QUALITY MAINTENANCE OF CHRONIC CONDITIONS. SUCH UNITS WOULD FUNCTION AS EXTENSIONS OF THE REGIONAL PROGRAMS UTILIZING THEIR SPECIALIZED EQUIPMENT AND PERSONNEL.

As extensions of this statewide pattern of care, the Commission further recommends that:

COOPERATIVE ARRANGEMENTS SHOULD BE MADE WITH NEIGHBORING NEW ENGLAND STATES AND CANADA FOR THE SHARING AND JOINT PLANNING OF MEDICAL REHABILITATION SERVICES AND FACILITIES.

These interstate and international compacts can be expected to result in better utilization of facilities and personnel and also lower costs by avoiding expensive duplication. Long distances prevent many people in rural areas from availing themselves of the rehabilitation services they need. Many Aroostook residents, for example, live nearer to Provinces than to another Maine community. From Madawaska to Edmundston, New Brunswick, is only one mile, whereas it is 48 miles to Caribou.

Cooperation on a broad regional basis also has important implications for personnel training, research, and rehabilitation programming which would be far beyond Maine's financial means to provide alone.

1. THE BLIND AND VISUALLY IMPAIRED

Programs for the prevention of blindness and specialized educational and vocational rehabilitation services for visually handicapped children and adults is the responsibility of the Division of Eye Care and Special Services. Its operational approach reflects that of its parent organization, the Maine Department of Health and Welfare, and provides a continuum of services from the time the disability is first identified to the time a client can function independently. Federal standards for "gainful occupation" are interpreted broadly to include independent functioning in the home.

The Division's Vocational Rehabilitation Services unit has an open referral policy that encourages counselors to accept as many referrals as possible, even those for whom rehabilitation potential may appear slight. However, its rate of rehabilitants per counselor man-year is higher than the national and regional averages.(3, Parts VI & VII) At the present time, the unit receives one-fourth of all state funds for vocational rehabilitation allotted.

Although the Division's vocational rehabilitation program has entered a period of expansion, there is still a substantial unmet need for rehabilitation of the visually handicapped. The scarcity of specialized rehabilitation facilities within the state, along with generally low salary levels for counselors and the large areas of sparse population where service is difficult to provide, are recognized obstacles to the rehabilitation of clients. Also, funding of the program is substantially below the level necessary to realize the full available federal matching monies.

In fiscal 1967 a total of $3.1 million would have been available to the two Maine vocational rehabilitation agencies if the legislature had appropriated $776,000 to obtain the federal allocation of $2.3 million in matching funds. Under the arrangement that allows the vocational rehabilitation unit of the Division of Eye Care and Special Services up to 25 percent of the authorized funds, the Division would have had a budget of $776,000, of which $194,000 would have been state funds. As it was, the state appropriated $80,000 for the Division's vocational rehabilitation program, allowing $340,000 in federal funds to lapse.

The quality of service supplied by the Division is indicated by a study of rehabilitants' income and occupation. Of the 85 persons closed rehabilitated in fiscal 1967, 75 had no earned income (including 22 receiving public assistance), and 10 had weekly incomes between $1 and $79 at acceptance. At closure, this same group showed the following income distribution: 37 persons (including 20 receiving public assistance), no earned income; and 48 persons, weekly incomes between $1 and $100. Their approximate collective weekly earnings were $400 before acceptance and $3,080 after rehabilitation. Of the total 85 closed rehabilitated, 5 were holding professional or management positions, 12 clerical or sales, 14 service trades, 2 farming and fishing,

14 industrial, and 38 homemaking, home working, or in sheltered or vending stand operation. Forty-one of the rehabilitants were bilaterally blind at acceptance.

Incidence

One of the recognized sources for the most accurate statistics on blindness and vision problems is Estimated Statistics of Blindness and Vision Problems published by the National Society for the Prevention of Blindess, Inc. (copyright 1966). Present and projected needs of the visually handicapped in Maine are based on this publication, on actual cases receiving service at the present time, and estimates developed by Harbridge House.

Legal Blindness

In Maine there are an estimated 1,850 people who fall within the definition of Legal Blindness defined as visual acuity for distant vision of 20/200 or less in the better eye with best correction; or visual acuity of more than 20/200 if the widest diameter of field of vision subtends an angle no greater than 20 degrees. It is however interesting to note that Maine Statutes define blindness much more broadly in terms of any vision handicap which prevents the individual from performing his usual activities. Based on the first definition above, the estimated prevalence by age groups would be as follows:

Under 20	20-64	65+
185	795	870

Partially Seeing

The partially seeing are defined as persons with a visual acuity greater than 20/200 but not greater than 20/70 in the better eye after correction. This group does not meet the arbitrary definition of Legal Blindness but most of them would meet the Maine Statutes defining blindness and most would need specialized educational and vocational services. It is estimated that there are at least 520 such children in Maine. There are no valid estimates for adults in this category.

School Children Needing Eye Care

The number of children in school in need of eye care is of great concern for the prevention of blindness. In order that school children may achieve in the learning situation they must see properly. Those who cannot see adequately because of an undetected vision problem frequently do not adjust to school and fail to gain the basic education essential to vocational preparation. There are an estimated 65,400 of these children in Maine. Approximately 13,000 of these children are of indigent families who cannot afford adequate eye care even if the condition is detected. (Based on 20% of all Maine families falling below the poverty level and an average of 2 children per family).

Persons Eligible for Vocational Rehabilitation Services Because of a Visual Impairment

Harbridge House in Estimates of Demand for Vocational Rehabilitation Services estimates that there are presently 1,500 people eligible for vocational rehabilitation services because of a visual impairment, and that 1,590 people will be eligible by 1975 based on current eligibility and feasibility factors.

All of the conclusions of the Commission on Rehabilitation Needs concerning lack of services, gaps between service and needs are applicable to the Visually handicapped but some very specific needs should be delineated both in relation to the Harbridge House estimates of incidence and the other assessments of vision problems that are identified above. These special needs are based on the agency's own evaluation of priorities and on surveys conducted by the American Foundation for the Blind in 1965 and 1968.

Some special needs are:

1. The development of more effective detection and screening programs for vision problems and eye disease through:

a. Preschool vision testing programs that reach the vast segment of the preschool population group and the provision of adequate follow-up including financial assistance with the cost of follow-up when indicated,

b. A complete reassessment of the efficiency of present school vision testing programs establishing new standards, proceduresand methods of follow-up, identifying problems based on a coordinated program between Education, Health and Welfare and the ophthalmological and optometric practitioners,

c. Establishment of statewide programs for the detection of glaucoma, cataracts and other eye diseases that if undetected may rob adults of vision.

2. Strengthen services to children and adults whose vision problems significantly interfere with normal childhood development, education, ultimate vocational goals, independent living and self-care through:

a. A strengthened program of services to the preschool child with emphasis on assisting parents to deal constructively and knowledgeably with the seriously visually handicapped child in order that he might develop to his maximum potential and better utilize the subsequent education and vocational services he must receive if he is to become an economically and socially contributing individual.

b. Augmentation of existing specialized staff such as mobility specialist, adult education specialists, educational specialists for visually handicapped children, social caseworkers, rehabilitation counseling personnel and appropriate support personnel to maximize the effectiveness of existing professional services by immediately obtaining:

(1) A social casework unit consisting of a qualified supervisor and a minimum of three social caseworkers.

(2) An additional mobility instructor to insure that this essential service can be available in other than the southern area of the states on a limited basis - without this service blind people are homebound or entirely dependent on others to move about their homes and community.

(3) Two additional adult education specialists in order that people in their own homes, nursing homes, hospitals and institutions can function with greater independence.

(4) Establishment of subprofessional and preprofessional job classifications and authorized positions that will free highly trained professional people to best utilize their skills and to establish more effective methods of outreach, referral and advocacy to and for those who need services.

The following recommendations are based on the agency's own evaluation of needs and priority and on surveys conducted by the American Foundation for the Blind in 1965 and 1968.

COMBINE VOCATIONAL REHABILITATION SERVICES FOR THE BLIND AND VISUALLY IMPAIRED WITH VOCATIONAL REHABILITATION SERVICES FOR ALL OTHER DISABILITY GROUPS WITHIN THE PROPOSED REHABILITATION SERVICES UNIT OF THE DEPARTMENT OF HEALTH AND WELFARE.

DEVELOP MORE EFFECTIVE DETECTION AND SCREENING PROGRAMS FOR VISION PROBLEMS AND EYE DISEASE THROUGH:

A. PRE-SCHOOL VISION TESTING PROGRAMS THAT REACH THE VAST SEGMENT OF THE PRE-SCHOOL POPULATION GROUP, AND THE PROVISION OF ADEQUATE FOLLOW-UP INCLUDING FINANCIAL ASSISTANCE WITH THE COST OF FOLLOW-UP INDICATED,

B. A COMPLETE REASSESSMENT OF THE EFFICIENCY OF PRESENT SCHOOL VISION TESTING PROGRAMS, ESTABLISHING NEW STANDARDS, PROCEDURES, AND METHODS OF FOLLOW-UP ON IDENTIFIED PROBLEMS BASED ON A COORDINATED PROGRAM BETWEEN EDUCATION, HEALTH AND WELFARE, AND THE OPHTHALMOLOGICAL AND OPTOMETRIC PRACTITIONERS,

C. ESTABLISHMENT OF STATEWIDE PROGRAMS FOR THE DETECTION OF GLAUCOMA, CATARACTS AND OTHER EYE DISEASES THAT IF UNDETECTED MAY ROB ADULTS OF VISION.

2. THE DEAF, SPEECH AND HEARING IMPAIRED

Incidence

During the fact finding and evaluation phase of the Commission's statewide planning project, three separate but related estimates concerning the incidence of speech and hearing impairments among the people of Maine were obtained. Each of them point to the need for greatly expanded rehabilitation services to this segment of the population.

--Harbridge House, in its estimates of demand for vocational rehabilitation services, reported that in 1967 there were 841 persons of all ages with hearing impairments serious enough to require vocational or prevocational rehabilitation services, and 655 persons with speech impairments of the same order.

--John Fahey, in preparing a nonduplicative name list of young persons between the ages of 8 and 18 receiving service from rehabilitation agencies, including the speech and hearing clinics, tabulated 326 known cases whose primary condition was a hearing impairment, and 391 known cases where a speech impairment was recorded as the primary disabling condition.

--A Speech and Hearing Subcommittee of the Rehabilitation Facilities and Workshops Advisory Committee submitted recommendations concerning this disability group, together with estimates of incidence and prevalence. This subcommittee was comprised of eight practicing specialists in the treatment of speech and hearing problems. Their estimate of 44,000 persons needing diagnostic and therapeutic assistance for both speech and hearing difficulties is based upon national estimates of speech and hearing incidence and the committee members' first-hand knowledge of the situation prevailing in Maine.

Their method of determining this incidence rate was as follows:

Classification		Population	Incidence
Pre-School:	0-5	150,000	5% or 7,500
School age:	6-16	250,000	10% or 25,000
Adult:	17+	600,000	2% or 12,000
	TOTAL	1,000,000	44,000

The subcommittee pointed out, however, that while the above percentages should be considered as guidelines in determining the extent of rehabilitation need, accurate assessments are impossible without a screening process. They urged in this connection that:

ALL RESPONSIBLE AGENCIES, INCLUDING THE SCHOOLS, SHOULD AID IN THE EARLY DETECTION AND TREATMENT OF SPEECH AND HEARING PROBLEMS, ESPECIALLY AMONG THE PRE-SCHOOL POPULATION.

Some Basic Recommendations for Meeting Immediate and Long Range Goals

The following recommendations were formulated by the subcommittee and presented to the full advisory committee in a special report.* It should be noted, however, that they reflect the thinking of the Commission's regional task forces, as well as that of several other consultants and study groups as expressed in their reports of recommendations.

They are seen as essential, not only for meeting current needs of the speech and hearing handicapped in Maine but also as a means of anticipating and reducing the extent of future needs.

DEVELOP MORE EXTENSIVE PROGRAMS OF SPEECH AND HEARING THERAPY IN THE PUBLIC SCHOOLS. SPECIFICALLY, IT IS RECOMMENDED THAT AT LEAST ONE PUBLIC SCHOOL THERAPIST BE AVAILABLE FOR EVERY 2,000 STUDENTS.

HEARING CONSERVATION CLASSES SHOULD BE CONDUCTED IN PUBLIC SCHOOLS LOCATED AT REGIONAL CENTERS IN THE STATE.

THE STATE VOCATIONAL REHABILITATION AGENCY SHOULD EMPLOY AT LEAST ONE SPECIALLY TRAINED COUNSELOR TO WORK SPECIFICALLY WITH PERSONS WHO HAVE SPEECH AND HEARING IMPAIRMENTS.

Major responsibilities of this specialist should be to (1) coordinate and guide programming at regional, state, and local levels, and to (2) ensure that all persons with speech and hearing impairments eligible for rehabilitation receive appropriate attention including medical treatment, correction, adjustment, and related services.

CLOSER INTERAGENCY LIAISON SHOULD BE ESTABLISHED BETWEEN THE VOCATIONAL REHABILITATION AGENCY AND OTHER PUBLIC AND PRIVATE PROGRAMS WHICH SERVE THE SPEECH AND HEARING HANDICAPPED.

A unified effort leading to comprehensive services to individual clients is essential to avoid unnecessary gaps, lengthy delays, and service duplication.

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*Needs for Speech and Hearing Handicapped of Maine, as Proposed for the Advisory Committee for Rehabilitation Facilities and Workshop Planning, Augusta, March 15, 1968.

One aspect of this unified approach should be the cosponsorship by public and private agencies of an intensive in-service training program for all personnel having direct association with the speech and hearing handicapped. One of the functions of this program should be to facilitate referral, counseling, and disposition of clients.

Regional Needs for Services and Facilities

Facilities and services in Maine which presently serve the speech and hearing needs of clients include:

Governor Baxter State School for the Deaf, Falmouth
Northeast Hearing and Speech Center, Portland
Bangor Regional Speech and Hearing Center, Bangor
Pine Tree Society for Crippled Children and Adults, Bath (which sponsors the Communication Treatment Center in Bath, Speech and Hearing Clinic in Lewiston, and medical rehabilitation services at the Maine Medical Center including a laryngectomy clinic and esophageal voice training,)
Speech and Hearing Clinic, Farmington State College, Farmington
Speech and Hearing Clinic,University of Maine, Orono
Speech and Hearing Department, Pineland Hospital and Training Center, Pownal
Division of Child Health, Department of Health and Welfare,Augusta
Division of Vocational Rehabilitation,Department of Education, Augusta.

In order to meet the needs of all children and adults in Maine who require speech and hearing services, it is recommended that:

CURRENTLY EXISTING SERVICES AND FACILITIES BE DEVELOPED SUFFICIENTLY TO SERVE A GREATLY INCREASED CLIENTELE, AND THAT, ADDITIONALLY, SPEECH AND HEARING CLINICS BE ESTABLISHED OR FURTHER DEVELOPED AT THE SEPARATE INSTITUTIONS WHICH COMPRISE THE UNIVERSITY OF MAINE AND SELECTED PRIVATE COLLEGES.

At the present time, Farmington State College is the only institution of higher learning in Maine which has a full time speech and hearing clinic and offers a bachelor's degree in speech correction. The University of Maine at Orono has a part time speech and hearing clinic, but currently offers no degree program in this field. Potential sites for these clinics are as follows:

Northern Maine Region - Fort Kent State College, Fort Kent
Aroostook State College, Presque Isle

Eastern Maine Region - University of Maine, Orono
Washington State College, Machias

Central Maine Region - Colby College, Waterville
University of Maine, Augusta

Androscoggin Valley Region - Farmington State College, Farmington
Bates College, Lewiston

Southern Maine Region - University of Maine, Portland
Gorham State College, Gorham
Bowdoin College, Brunswick
St. Joseph's College, No. Windham
Nasson College, Springvale

It is to be understood that establishment of a comprehensive network of college-based clinics is considered a long range goal (1975), and that full-scale clinics may not need to be established at all these institutions. However, there is immediate need to train more personnel such as teacher, therapists, and counselors in all rehabilitation fields, including those concerned primarily with the speech and hearing handicapped. In order to implement this, there must be close liaison among public and private agencies, and especially the major medical centers functioning regionally in the key population areas of the state.

MEDICAL REHABILITATION FACILITIES IN THE KEY AREAS IDENTIFIED IN THE COMMISSION'S REGIONAL PLAN FOR COMPREHENSIVE REHABILITATION SERVICES SHOULD BE EQUIPPED TO OFFER MORE EXTENSIVE PROGRAMS OF DIAGNOSIS, EVALUATION, AND TREATMENT FOR THE SPEECH AND HEARING HANDICAPPED. THEY SHOULD ALSO COORDINATE THEIR PROGRAMS CLOSELY WITH THOSE PROPOSED FOR THE UNIVERSITY AND COLLEGES.

Hospital-based programs should be initiated or further developed as follows:

Northern Maine Region - Carey Memorial Hospital, Caribou

Eastern Maine Region - Eastern Maine General Hospital, Bangor
Osteopathic Hospital, Bangor
Maine Coast Memorial Hospital, Ellsworth

Central Maine Region - Thayer Hospital, Waterville
Osteopathic Hospital, Waterville
Augusta General Hospital, Augusta
Veterans Administration Hospital, Togus

Androscoggin Valley - Central Maine General Hospital, Lewiston
St. Mary's Hospital, Lewiston
Rumford Community Hospital, Rumford

Southern Maine Region - Maine Medical Center, Portland
Mercy Hospital, Portland
Osteopathic Hospital, Portland
Brunswick Regional Hospital, Brunswick
Bath Memorial Hospital, Bath
Webber Hospital, Biddeford

The selected facilities listed above are those which the subcommittee to the Rehabilitation Facilities and Workshops Advisory Committee feel are necessary to adequately handle the need on an area-population basis. However, it is realized that not all of them may find it possible to establish full-scale programs, and that, indeed, the regional approach to comprehensive rehabilitation planning can quite possibly result in a fewer, though still adequate, number of facilities. But again, it is essential that services be integrated with state and regional programs for the professional training of speech and hearing personnel, as well as with the activities of the public and private agencies which serve the speech and hearing impaired.

THE MULTIDISCIPLINARY COMPREHENSIVE REHABILITATION CENTER, PROPOSED IN CHAPTER IV, SECTION B, SHOULD BE EQUIPPED TO PROVIDE A WIDE RANGE OF DIAGNOSTIC, EVALUATION, TREATMENT, VOCATIONAL TRAINING, AND PLACEMENT SERVICES TO ALL GROUPS COMPRISING MAINE'S DISABLED POPULATION, INCLUDING THE SPEECH AND HEARING HANDICAPPED.

It should be noted again that the regional plan for comprehensive rehabilitation services, of which the proposed comprehensive center, to be located preferably in the Southern Maine (Greater Portland) area, would function as the hub, is consistent with the overview and regional planning efforts of such groups as Comprehensive Health Planning conducted by the Department of Health and Welfare. The regional areas identified are generally similar, as are the key population centers within these regions where existing medical care facilities should be further developed in an integrated manner and should extend their services through cooperative arrangements to satellite units in outlying areas.

Recommendations for the Governor Baxter School for the Deaf

This special school at Falmouth Foreside is the only one in Maine for the academic and prevocational instruction of children with impaired hearing. (However, seven school districts at the present time are conducting therapy programs in speech and hearing for their pupils. They are Portland, South Portland, Topsham, Bangor, Skowhegan, Rumford, and Westbrook).

The Governor Baxter School accepts children with normal intelligence whose hearing loss is severe enough to make learning at regular school too difficult. It is tax supported and free of charge except for transportation, clothing, medical and dental bills. The educational program extends from subprimary through senior high school. (Last year ten students received high school diplomas.) The secondary curriculum includes a college preparatory course, general education course, and work experience course. Prevocational instruction offered to girls in the high school includes office work, clerical and secretarial practices. There is also a home economics program. Both boys and girls may enroll in the graphic arts program which includes printing techniques, layout, operating offset presses, as well as courses in woodworking and shop experience. Both shops at the school operate full time and the administration has plans for making these programs available not only to the regularly enrolled students but also to persons in the community who are vocationally handicapped because of hearing problems.

THE GOVERNOR BAXTER SCHOOL'S VOCATIONAL AND PREVOCATIONAL PROGRAM SHOULD BE EXPANDED TO INCLUDE TRAINING FOR MORE OCCUPATIONS THAN ARE NOW REPRESENTED.

These should be carefully chosen to conform to present and anticipated labor market demands, but some of the possibilities to be considered are computer technology, with emphasis on repair and maintenance or equipment, keypunching and programming, automotive and industrial mechanics, sewing, tailoring and other trades considered suitable for persons who are deaf and for whom the placement outlook would appear to be good.

VOCATIONAL AND PREVOCATIONAL PROGRAMMING FOR THE SPEECH AND HEARING IMPAIRED, AS FOR ALL DISABILITY GROUPS, SHOULD BE DONE IN CLOSE COOPERATION WITH BUSINESS AND INDUSTRY, THE EMPLOYMENT SECURITY COMMISSION, AND OTHER INDIVIDUALS AND AGENCIES THAT HAVE KNOWLEDGE OF PRESENT AND PROJECTED TRENDS IN THE LABOR MARKET NEEDS.

Insurance companies and banks throughout Southern Maine project manpower needs for personnel with backgrounds in clerical techniques and computer technology. Private industries have expressed a willingness to share in the training of such personnel as well.

At the present time, one of the vocational rehabilitation counselors in the Portland district office spends a considerable amount of time working with students at the Governor Baxter School, assisting the administration in developing immediate or long range vocational and train-

ing plans for students, referring them to other agencies or training centers for further service, and helping to effect successful vocational rehabilitation. Although to date she has had no intensive training in the specialized field of deafness and hearing loss, the Division of Vocational Rehabilitation is making plans for her to receive additional training.

Improved special education and training techniques now being used by instructors and other personnel working with the speech and hearing impaired can be expected to raise the level of employability significantly within the next few years. Also, an increasing number of post-secondary vocational training opportunities are being made available to young people with these disabilities. For example, under the auspices of the Division of Vocational Rehabilitation, selected graduates of Governor Baxter School can receive post-high school training at the American School for the Deaf, Hartford, Connecticut; Gallaudet College, Washington,D.C., or the National Training Institute for the Deaf at the Rochester Institute of Technology. It is recommended that:

INSTITUTIONS RESPONSIBLE FOR TRAINING THE SPEECH AND HEARING IMPAIRED SHOULD TAKE MAXIMUM ADVANTAGE OF FEDERAL SUBSIDIES AVAILABLE FOR PROGRAM DEVELOPMENT, PROCUREMENT OF STAFF, FACILITIES AND EQUIPMENT, RESEARCH ACTIVITIES, ETC., IN ORDER TO CONTINUALLY UPGRADE THE QUALITY OF INSTRUCTION WHICH THEY OFFER AND TO REACH A LARGER NUMBER OF PERSONS IN NEED OF THESE PROGRAMS.

Recommendations for Expanded Services at the Governor Baxter School

There is much to commend in the academic and prevocational curriculum at the Governor Baxter School. From the physical plant to the courses offered, the school staff and the entire program is oriented to the needs of its students. The curriculum is sequential, has scope, and is both challenging and realistic. The staff is competent and well trained. Many extra-curricular activities, such as hiking, swimming and organized team sports, are scheduled. Living and earning skills are taught both formally and informally. Dormitory living is utilized as a means of teaching care of one's personal belongings, cleanliness, cooperation, communication, and other social skills.

Certain aspects of the program, however, need to be strengthened or expanded:

PROVISION SHOULD BE MADE FOR MORE THOROUGH DIFFERENTIAL DIAGNOSIS AND EVALUATION, INCLUDING IMPROVED PSYCHOLOGICAL AND NEUROLOGICAL ASSESSMENT.

Effective vocational rehabilitation and placement of the deaf and hearing impaired depends upon complete evaluative data in order to formulate realistic goals for individual clients. If a truly comprehensive rehabilitation center were to become a reality in Greater Portland, most of these needed diagnostic and evaluation services could be available from that source.

IN ORDER TO PROVIDE CONTINUING DIAGNOSTIC, EVALUATION AND TREATMENT SERVICES AND TO IMPROVE THE OVERALL REHABILITATION PROGRAM, THE GOVERNOR BAXTER SCHOOL SHOULD EMPLOY IMMEDIATELY A FULL-TIME PSYCHOLOGIST, AUDIOLOGIST, AND SCHOOL SOCIAL WORKER.

ADDITIONAL PROGRAMS SHOULD BE INITIATED AT THE SCHOOL FOR (A) CHILDREN OF PRE-SCHOOL AGE AND (B) DEAF AND HEARING IMPAIRED CHILDREN WITH LEARNING DISABILITIES.

The Governor Baxter School now has a preschool parents' institute and plans are being formulated to extend services to this preschool group. Periodic screening for learning disabilities among children with speech and hearing impairments who are enrolled in the primary and elementary grades should also be conducted within the public schools of the state. As a further extension of the above recommendation, testing and evaluation programs for these children (preschoolers and those with learning disabilities) should become a regular function of the regional medical-vocational rehabilitation and the Pine Tree Society's Communication Center.

As part of an accelerated program of training teachers of the deaf throughout the state,

STUDENT TRAINEESHIPS SHOULD BE ESTABLISHED AT THE GOVERNOR BAXTER SCHOOL, UTILIZING FUNDS AVAILABLE FOR THIS PURPOSE FROM FEDERAL SOURCES.

Potential sources are Title VI of the Elementary and Secondary Education Act, and the grants and traineeships administered by the Rehabilitation Services Administration.

3. HEART DISEASE, CANCER AND STROKE

Incidence

In its disability estimates prepared for the Commission, Harbridge House reported that in 1967 Maine had 23,889 persons of all ages impaired by cardiac and circulatory conditions. (13, Table 2) Of all the disability groups listed this was the second highest figure, exceeded only by orthopedic impairments (29,431). Among the population age 65 and over, however, cardiac and circulatory conditions represented the most common primary disability and accounted for 26% of all persons in this age grouping. Conditions resulting from neoplasms totaled 1,570 persons of all ages, but this is not to be construed as the total number of persons disabled by cancer in 1967, since some of these are accounted for under other disability headings.

The estimates change when the additional factors of "vocational handicap" and "feasibility for vocational rehabilitation service" are applied as determinants. In this regrouping, the total number of persons disabled, handicapped, and feasible whose primary disability was a cardiac or circulatory condition was 8,178 for all age groups. (13, Table 4) Those disabled by cancer (but, again, not all) who were also vocationally handicapped and feasible for vocational rehabilitation service were estimated at 618.

It is a well known fact that the span of human life continues to increase dramatically. From 1940 to 1960, for example, the total population of the United States showed a 35.7% increase, while the percentage of those 65 years of age and older increased by 83.3%. In Maine from 1960 to 1965, the 65-and-over population increased more than 4% while that of the younger 18-to-44 group of working age persons declined -0.3%. (69,P.4)

Since it is well known that the incidence of chronic and degenerative diseases accelerates significantly among those aged 65 and older, the increasing number of persons in this population group and their rehabilitation needs have far-reaching implications for the planning of medical care facilities and services.

Equally important, of course, are the needs of younger persons who have been afflicted with cardiopulmonary or circulatory involvements. In the Harbridge House estimates for 1967, there were 6,832 persons between the ages of 45 and 64 disabled by cardiac and circulatory conditions, of whom 3,548 were considered feasible for vocational rehabilitation services. In the 17-to-44 age group there were 2,625 persons so disabled, of whom 1,546 were feasible for these services. In other words, cardiac and circulatory conditions are the third most common primary disability of all persons who are disabled and feasible for vocational rehabilitation, representing 16% of the total for all groups.

Case Finding and Reporting

Before heart disease, cancer, and stroke victims can be provided with rehabilitation services they must first be identified and referred so that a program for their rehabilitation may be prepared and followed.

BETTER REFERRAL SYSTEMS SHOULD BE DEVELOPED IN MAINE TO ASSIST PHYSICIANS AND OTHER MEMBERS OF THE MEDICAL TEAM TO ENLIST THE AID OF BOTH PUBLIC AND PRIVATE HELPING AGENCIES SO THAT THE TOTAL REHABILITATION EFFORT MAY BEGIN AT ONCE AND BE CONTINUED AS APPROPRIATE IN EACH INDIVIDUAL CASE.

While the physician is no doubt the single most important person in the restoration of his patient to more productive living, his efforts can, and in most cases should, be supplemented by those of other professionals who can provide the supportive services necessary for the rehabilitation process to take place. Better referral practices would insure that this vital team approach is more effectively utilized for the patient/client's benefit.

Key Agencies in the Rehabilitation of Clients Disabled by Heart Disease, Cancer or Stroke

A number of public and private organizations now exist in Maine for the planning and delivery of effective medical and restorative services. The following recommendations are directed to this statewide effort and to some of the key agencies responsible for its continuing development.

PLANNING FOR QUALITY MEDICAL AND RESTORATIVE SERVICES SHOULD CONTINUE AS A FUNCTION OF MAINE'S COMPREHENSIVE HEALTH PLANNING.

Overall responsibility for Comprehensive Health Planning in Maine (funded under Public Law 89-749) rests with the State Department of Health and Welfare. This includes planning for improved medical rehabilitation services possible through a partnership of public and private agencies. Regional planning should continue to be an integral part of this statewide program.

THE QUALITY OF MEDICAL AND RESTORATIVE SERVICES TO PERSONS IN MAINE WHO HAVE BEEN STRICKEN BY HEART DISEASE, CANCER, STROKE, OR A RELATED ILLNESS SHOULD CONTINUE TO BE UPGRADED THROUGH THE COOPERATIVE EFFORTS OF MAINE'S REGIONAL MEDICAL PROGRAM, AND THE BUREAUS OF HEALTH AND MEDICAL CARE IN THE DEPARTMENT OF HEALTH AND WELFARE.

The Maine Regional Medical Program is a private non-profit organization (funded under Public Law 89-239) which aids medical facilities and services in the state to upgrade their quality of care in regard to persons afflicted with heart disease, cancer, stroke, or related illnesses. It does this essentially through the funding of educational programs provided through hospitals and other medical agencies to their medical and paramedical personnel. Regional Medical Programs also assist public and

private agencies in planning and organizing for a more effective system of delivering quality medical services.

The Bureau of Medical Care has statewide responsibility for maintaining and improving standards of medical care and also for carrying out the provisions of Title 18 (Medicare) and Title 19 (Medicaid) of the Social Security Act. Medical rehabilitation of patients is an important concern of this Bureau.

Responsibility for improving the quality of public health services in Maine lies with the Bureau of Health and the several functions of which the Bureau is comprised. These include administration and supervision of Public Health Nursing, Child Health Services, Alcoholism Services, Cancer Control, Health Education, Health Facilities Construction Programs, Hospital Licensing, and other related health programs.

Comprehensive Health Planning in Maine with the aid of the Regional Medical Programs have a basic objective of developing a pattern of regional and statewide medical and restorative care which makes the most effective use of limited health manpower and facilities.

PUBLIC AND PRIVATE ACTIVITIES DEVOTED TO THE PROVISION OF IMPROVED MEDICAL AND RESTORATIVE SERVICES TO HEART, CANCER, AND STROKE VICTIMS SHOULD BE PLANNED, SYSTEMATICALLY AND IN PARTNERSHIP, FOR THE COMPLETE RESTORATION OF THE INDIVIDUAL INTO THE LIFE OF THE COMMUNITY, UTILIZING ALL APPROPRIATE SERVICES AVAILABLE.

A Rehabilitation Institute

In the absence of a medical school, Maine is faced with serious limitations to the formal preparation of medical rehabilitation personnel. For the primary purpose of upgrading existing personnel it is recommended that regional medical centers join with institutions of higher learning in the sponsorship of periodic institutes, workshops and seminars.

For example, a summer institute focusing upon medical rehabilitation techniques could be offered in Central Maine to physicians, nurses, physical therapists and rehabilitation counselors. Sponsorship could be worked out jointly between Colby College, the Dean Medical Education Center, area hosptials and Regional Medical Programs. Colby College in Waterville has traditionally opened its doors during the summer months to professional medical groups for institutes of this type.

4. MENTAL HEALTH

In Maine, responsibility for the direction of mental health programs in the state institutions and also the promotion and guidance of community-based mental health programs rests with the Bureau of Mental Health in the Department of Mental Health and Corrections. The law also provides the Department with authority and funds to promote the expansion of mental health services in existence or initiated by communities.

In accordance with the Maine Comprehensive Mental Health Plan, developed during the course of a two-year planning project which was completed in 1965, the state now has five mental health center service areas, each with its own governing board. Within these geographic regions is at least one major mental health center as well as affiliated programs. The mental health center concept reflects the belief that all available manpower, private or public, should be so organized to give maximum assistance to the Center's functions.

Some clinics in the state operate as part of existing hospital services. Others have been developed outside the general hospital. The composite of services in each region represent an attempt to provide comprehensive mental health services to all of the persons living in the area. Accordingly, regional programs have been structured to help solve the psychosocial problems of children and adults through diagnosis, treatment, guidance, counseling and education. Medical services provided by physicians are available as well as the services of trained social workers.

A serious shortcoming of these programs, however, is the scant attention given to the vocational and prevocational adjustment of those who come to the centers for treatment. It is the feeling of this Commission that regional mental health programs could and should be strengthened by including this important vocational rehabilitation function. Specifically, the Commission recommends that:

VOCATIONAL REHABILITATION COUNSELORS SHOULD BE ASSIGNED TO EACH OF THE REGIONAL MENTAL HEALTH CENTERS TO FUNCTIONS AS A MEMBER OF THE EVALUATION AND TREATMENT TEAM.

This is already being done in the Lewiston-Auburn area, where a vocational rehabilitation counselor employed by the Division of Vocational Rehabilitation works half-time at the Child and Family Mental Health Center and half-time at the Bliss Rehabilitation Center located at Pineland Hospital in Pownal.

Similar cooperative programs should be established in the other four mental health center areas, with vocational rehabilitation counselors working with selected clients while they are undergoing evaluation and/or in therapy and providing follow-up services after they complete their program in the Center. Counselors should attend staff meetings and participate fully in decisions regarding appropriate treatment and rehabilitation services for each of these clients, thus ensuring that evaluation, counseling, and placement services provided by vocational rehabilitation personnel become an integral part of the total treatment and rehabilitation process.

In addition, his serving on the regional team would help the counselor to recruit the necessary mental health services on behalf of clients who have been referred to the district Vocational Rehabilitation office. The Commission recommends also that:

FULL TIME COOPERATIVE VOCATIONAL REHABILITATION UNITS BE ESTABLISHED AT THE STATE HOSPITALS IN BANGOR AND AUGUSTA.

Cooperative vocational rehabilitation units, co-sponsored by the Bureau of Mental Health and the state office of public rehabilitation services, should be established and function in the same way as the cooperative units now in operation at the state correctional institutions. As in the correctional centers, the proposed cooperative units should employ initially a full-time vocational rehabilitation counselor and clerk-stenographers. It is anticipated that as the caseload expands, the services of an additional field counselor would also be required. The units should be so structured that patients in residence and those attending the outpatient clinics located at each of the hospitals will both be served. Financing of the units would be on an in-kind matching basis, as are those in the correctional institutions, with the state's share of the funding being in the form of in-kind services and facilities provided by the institutions and the Department of Mental Health and Corrections.

In order to implement the above recommendation, it is recommended that:

THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS IDENTIFY THE IN-KIND MATCHING POTENTIAL OF CURRENT REHABILITATION SERVICES AT THE TWO STATE HOSPITALS AS THE FIRST STEP IN QUALIFYING FOR FEDERAL VOCATIONAL REHABILITATION FUNDS.

At the present time Maine's mental health institutions carry on programs of vocational therapy which have not been recognized as such. The state hospitals and Pineland Hospital and Training Center utilize work activity as part of the therapy programs to help prepare patients for their re-entry into the community. This type of service, including on-the-job instruction, should be identified and priced so that available federal funds may be applied for and obtained.

Additionally, it is recommended that:

THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS EMPLOY A FULL-TIME VOCATIONAL REHABILITATION SPECIALIST TO SERVE ALL THE STATE INSTITUTIONS AND CLINIC CENTERS. THIS CENTRAL OFFICE STAFF POSITION SHOULD ALSO HAVE A CLOSE LIAISON RELATIONSHIP WITH THE STATE OFFICE OF PUBLIC REHABILITATION SERVICES.

5. MENTAL RETARDATION

Definition

As defined by the American Association on Mental Deficiency, mental retardation may be considered as "sub-average general intellectual functioning which originates in the development and is associated with the impairment of adaptive behavior." Within this definition are the impairments which occur in the development of self-help skills during early childhood, learning difficulties experienced in preschool and school years, and the social adjustment problems occurring at these times which may be carried over into the adult years.

Among the environmental influences experienced in early childhood which may contribute to retardation is the deprivation of healthy and normal emotional and intellectual stimulation necessary for learning and psychosocial development to proceed normally. In the families of the very poor, the cultural impoverishment which prevents children from having the normal experiences of childhood may well lead to permanent retardation.

Emotional and/or behavioral dysfunction exhibited by a child is often interpreted mistakenly as evidence of mental retardation. And in fact the circumstances responsible for producing disturbed forms of behavior may also be causative factors in producing some degree of retardation.

> The demands of society or the community are not the same in every culture. Therefore, mental retardation as a concept becomes operationally meaningful only when it is defined in a particular cultural context...Even within our own society these societal or cultural demands vary with the age of the individual. Society as a whole does little to assess the intellectual or social achievements of the preschool child. However, the school-age individual in our culture is evaluated very critically in terms of academic and social accomplishment. In later life, the intellectual inadequacy again may be less evident if social adjustment meets minimal demands. Numerous surveys directed toward determining the frequency and magnitude of the problem have revealed that the number of persons reported as retarded is highest during the school years. Less than one-fifth as many children in the age group 0-4 were reported by these surveys as were reported in the age group 10-14. Similarly, one-fourth as many persons in the age group 20 and over were identified as mentally retarded as in the age group 10-14. Of striking significance is the fact that more than half of the individuals considered retarded during adolescence are no longer so identified in adulthood...Experience has shown that virtually all children with IQs below 70 on most tests standardized nationally have significant difficulties in learning and in making a successful adaption to their social environment. (62, P-3)

For our present purposes, however, and in order to place the problem of mental retardation within the context of prevocational and vocational habilitation and rehabilitation, it is enough to recognize three degrees of retardation: educable, trainable, and severely retarded. The educable retarded child may be considered to be one who, with special educational

services, testing, evaluation, and prevocational experiences, can usually be prepared through further vocational services to become a self-sustaining member of the community. The trainable child needs a school experience tailored to his limitations which will train him to care for his personal needs, adjust to situations outside the home, and sometimes do simple repetitive tasks or domestic chores. He requires community class work throughout his school years, sheltered workshops, and young adult activity programs. Through intensive training and adjustment programs tailored to his individual needs, he may in some instances become self-supporting, but this is not always a realistic goal. The severely retarded need constant care and supervision throughout their lives. Some may require a day-care center environment, and others residential care.

The Commission's recommendations are directed to these three groups in accordance with the age of the individual. Of first importance, however, is the need to prevent <u>any</u> degree of mental retardation from occurring.

<u>Prevention</u>

Many public and private services exist for the prevention and amelioration of these problems. Examples are the medical care given to mothers during the prenatal period; PKU screening of newborn infants to detect faulty metabolism which leads to mental retardation; postnatal medical care including nutrition, education, immunization, etc.

Together with the Maine Committee on Problems of the Mentally Retarded, the Commission recommends that:

CONTINUING EMPHASIS BE GIVEN BY PUBLIC AND PRIVATE AGENCIES, ORGANIZATIONS AND INSTITUTIONS TO MINIMIZING PREMATURE BIRTHS, BIRTH INJURIES, EARLY CHILDHOOD DEFICIENCIES AND DISEASES WHICH CAUSE MENTAL RETARDATION THROUGH THE CONTINUING DEVELOPMENT OF PRENATAL, OBSTETRICAL, AND PEDIATRIC SERVICES.

ALL PROVISIONS OF THE ECONOMIC OPPORTUNITY ACT RELATING TO MEDICAL, PSYCHOLOGICAL, EDUCATIONAL, AND SOCIAL SERVICES TO CHILDREN OF IMPOVERISHED FAMILIES IN MAINE SHOULD BE ADEQUATELY SUPPORTED AND FULLY IMPLEMENTED.

PUBLIC INFORMATION SYSTEMS DEVELOPED COOPERATIVELY THROUGH THE HEALTH EDUCATION ACTIVITIES OF THE DEPARTMENTS OF EDUCATION AND WELFARE SHOULD BE IMPLEMENTED TO ACQUAINT PROSPECTIVE PARENTS, PARENTS, GUARDIANS AND THE GENERAL PUBLIC WITH THE NATURE OF

MENTAL RETARDATION, ITS CAUSES, AND HOW IT CAN BE PREVENTED.

Incidence and Prevalence

Harbridge House, in its report to the Commission discussed in the previous section, (13, Table 2) estimated that in 1967 there were 18,821 mentally retarded persons in Maine. Of these 7,203 were under 17 years of age, 7,103 between the ages of 17 and 44, and 3,663 between the ages of 45 and 64. It is important to note that according to this tabulation, mental retardation represents by far the most common primary disability in the under-17 age group (53%). By further analysis, the consulting firm estimated that 12,153 mentally retarded individuals are eligible for vocational or prevocational rehabilitation services.

Of this total 6,483 are under 17 years of age, 3,648 are between the ages of 17 and 44, and 1,874 between 45 and 64. Again, mental retardation looms as the most common disabling condition, constituting 23% of the total number of persons in Maine both eligible and feasible for vocational or prevocational rehabilitation services.

Since mental retardation is not accounted for by any of the 40 National Health Survey categories, the firm made use of other sources in order to arrive at these prevalence rates. Of the several studies reporting quantitative rates of prevalence, Harbridge House judged the methodology utilized by the State of California in preparing similar estimates as the most useful (64) not only because of the breadth of its sample, but also for the similarity of its operational aspects to those of the National Health Survey. The following comments from the California study reflect its philosophical approach:

> In estimating the number of retarded persons, different definitions and different cut-off points should be used at various stages of the individual's life...That is, to plan and provide services for the mentally retarded of California, it is necessary to think of those who present problems, rather than those who may be classified as retarded on a theoretical basis.
>
> While this approach reduces the number called retarded in their adult years, it also has the effect of increasing the totals in the age range of the school child, and even more so in the preschool years...

Other researchers, Harbridge House points out, have also stated that "there is no meaning to be derived from any over-all prevalence figures which mix age groups." The Harbridge House report quotes one of these as follows:

> In spite of any tendency to regard mental retardation as a lifelong unalterable condition, the prevalence varies at different ages...
>
> Children reported as retarded by responsible agencies occur in markedly varying frequencies in different age, sex, color, and neighborhood populations. These facts indicate that "mental

> retardation' is not a fixed characteristic of individual children, but a complex set of manifestations of some children's relationship with their immediate environment. (17, pp. 702-707)

Similarly, a survey prepared under the auspices of the U.S. Department of Health, Education, and Welfare included this observation:

> No comprehensive survey of the number of mentally retarded in a community has ever been undertaken using satisfactory techniques of identification. The most common figure cited, one based on expert opinion, is three percent of the total population. Two other factors must be borne in mind in considering prevalence: (1) the percentages of identified mental retardates vary dramatically as a function of age, and (2) prevalence figures vary markedly as a function of the socioeconomic level of community or neighborhood. The percentage of identified mental retardates increases gradually from birth to age six, jumps significantly at the age of school entry and continues to rise, reaching a peak in the 14-16 year age period. The prevalence then drops rather dramatically from age 16 on.
>
> The high prevalence of identified mental retardation among school age persons is probably a function of the facts that: (1) schools are the only community agency having access to, and the means to assess, all persons in the population belonging to a particular age group, and (2) schools, in their academic expectations, apply a more rigorous standard of adaptive behavior than demanded either of the preschool or adult age groups. The prevalence of mental retardation will be found to be considerably greater than three percent among the lowest socioeconomic levels (for example, census tract areas with median income levels of $3,000 or less per annum) while neighborhoods or communities characterized by high incomes and education levels will often have prevalences of less than one percent. Consequently, any estimation of the total prevalence of mental retardation in a given community must involve consideration of factors such as the socioeconomic and age distribution. (61, pp. 14-15)

This latter observation was noted by the task forces and the Commission as a whole in their consideration of the needs of the actual--and potential-mentally retarded population in Maine, and led to one Commission recommendation which is also a recommendation of the Maine Committee on Problems of the Mentally Retarded (49) that:

ADEQUATE EVALUATION AND SCREENING FOR CHILDREN WHO MAY BE ELIGIBLE

FOR SPECIAL SCHOOLING SHOULD BE PROVIDED EITHER AT REGIONAL MENTAL

HEALTH CLINICS OR BY STATE EMPLOYED PSYCHOLOGISTS.

The Commission recommends further, that since programs operated under provisions of the Economic Opportunity Act such as Head Start and VISTA, through the several regional Community Action Programs, provide a means

both of locating children of preschool age suffering from economic, social, and cultural deprivation, and also of helping to alleviate these conditions, that:

PUBLIC AND PRIVATE AGENCIES CONCERNED SPECIFICALLY WITH THE PROBLEMS OF THE MENTALLY RETARDED AND THEIR FAMILIES SHOULD ESTABLISH MORE EFFECTIVE TWO-WAY WORKING RELATIONSHIPS WITH COMMUNITY ACTION AND OTHER APPROPRIATE ECONOMIC OPPORTUNITY PROGRAMS LOCALLY AND STATEWIDE.

Some Considerations in Estimating Future Needs of the Retarded

The shortage of existing facilities and services for the retarded in Maine is so acute, as the Maine Committee on Problems of the Mentally Retarded has pointed out, that priority should be given to those already identified who need service now. At the same time, the Commission believes that before services can be planned and implemented most effectively, it is important to know how many persons in the state are retarded, to what degree, and where they live.

Since, with the exception of congenital impairments, mental retardation is to be viewed as essentially a cultural phenomenon in which certain individuals, largely because of early environmental influences, are prevented from rising to the expectations of an increasingly complex and demanding society, there is every reason to believe that the incidence of mental retardation will increase as these demands and complexities become compounded. Attempts to predict the extent of future demand for preventative and rehabilitative services in the area of mental retardation must therefore take this fact of culturally induced retardation into account.

In attempts to illustrate the increasing demands of the modern educational program, for example, pictures are often used showing a small child standing beside the towering stack of books that he will be expected to assimilate in the course of his immediate academic career. If his preschool experiences fail to prepare him adequately for these demands, however, it is little wonder if he soon becomes overwhelmed and defeated.

Similarly in the area of vocational preparation, as job requirements become more demanding and skilled jobs increasingly difficult to perform, the number of those who lack the preparation for them, largely because they have fallen somewhere by the wayside, will increase in proportion.

Undetected emotional and behavioral disorders further compound the problems attendent to steady educational growth. Despite the mounting attack on poverty and its consequences, it seems highly unlikely that the life style imposed on the economically and culturally deprived will change at the same rate as the burgeoning affluent segment of our society.

Dr. Leonard W. Mayo, as chairman of the President's Panel on Mental Retardation, stated in the panel's report in October 1962:

> As our competitive society becomes more complex and fast moving, the demands for intellectual capacity and for adaptability increase. Thus in an age of automation, individuals with minimal skills and abilities become doubly handicapped. Not only do they face an increasingly competitive society, but, hampered as they are, they must keep pace with people of increasingly higher capacities. Thus, they become easily submerged by the vicissitudes which others can surmount. (46, p.9)

Poverty as It Relates to Mental Retardation Incidence

Because of the relatively high incidence of poverty in Maine compared with national averages, it is conceivable that the prevalence of mental retardation for all degrees approaches or even exceeds the 30,000 estimate derived from the 3% statistic. The Maine Office of Economic Opportunity reports (69, pp. 4-5) that in 1967, one in five Maine families lived in economic poverty, with well over 50,000 families subsisting on cash incomes of less than $2,500 a year. The percentages varied greatly among counties; 30% of the families in Washington County had cash incomes of less than $2,500; Aroostook, 24%, and Cumberland, 14%.

However, the report calls attention to the fact that "percentages may be deceiving since larger actual numbers of poor families may live in the so-called 'rich counties.'" Cumberland, with 19% of the state's entire population, had 8,022 families with under $2,500 income; Aroostook, (11%) 6,370 families; and Washington, (3%) 2,973 families. These are important factors that must be given close attention when developing a comprehensive plan for mental retardation services and facilities, and the Mental Retardation Facilities Construction Plan (42) takes them into account. It is of interest additionally that Maine, with 41% of its families receiving less than $4,000 a year, has by far the largest percentage of this group among the New England states. (69, pp.4-5)

The Need for Service Continuity Through Existing Facilities

No attempt will be made to discuss the Mental Retardation Facilities Construction Plan at this point, except to note that it was given careful study and served to help guide the development of the Plan for Rehabilitation Facilities and Workshops prepared in conjunction with the Commission's study project. (18) It should be pointed out here, however, that each of these planning efforts have advocated: (1) that existing facilities and other resources be encouraged to expand their services and adapt them to meeting current needs before new facilities and services are established, and (2) that whenever possible the mentally retarded be served routinely, along with other segments of the population, at existing or planned centers providing diagnostic, evaluation, therapeutic, social, vocational and placement services, so that a continuity of services is ensured.

THE REGIONAL MENTAL HEALTH CLINICS AND SATELLITE CLINICS OPERATING IN AREAS OUTSIDE THE CENTERS OF POPULATION SHOULD BE EQUIPPED AND STAFFED TO EXTEND EVALUATION, DIAGNOSTIC AND COUNSELING SERVICE, AS

WELL AS SERVICES RELATED TO VOCATIONAL REHABILITATION AND PLACEMENT, TO ALL MENTALLY RETARDED PERSONS WITHIN THEIR SPHERE OF INFLUENCE. THESE CLINICS SHOULD ASSUME THE RESPONSIBILITY FOR REFERRING CLIENTS TO THE APPROPRIATE MEDICAL, SPEECH, HEARING, EDUCATIONAL AND OTHER SERVICES WHICH MAY BE NEEDED.

A key recommendation of the Maine Committee on Problems of the Mentall Retarded was for the development of evaluation and adjustment services at Pineland Hospital and Training Center. This recommendation was partially accomplished in May 1968 with the opening of a new facility at Pineland known as the Bliss Rehabilitation Center. A counselor from the Division of Vocational Rehabilitation has been assigned to the Center on a half-time basis, where he works with the staff as a member of the rehabilitation team. In this way a comprehensive, multidisciplinary approach has been achieved. But because of limited staff, the number of clients served during the past year has been much smaller than the Center was designed to accomodate.

The Committee on Problems of the Mentally Retarded recommended also that Pineland provide direct counseling to families and schools, with appropriate and realistic proposals for treatment and related services as required by the individual child. It was felt that in many cases such counseling would permit the retarded child to be kept at home in the community as an alternative to residential care in the institution. Pineland is attempting to provide this service at the present time, but again is severely limited in the number of staff hours which it can devote to this much-needed activity.

Until clinics are established in geographic areas where such services are not currently available, it is recommended that:

THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS' TRAVELING PSYCHIATRIC CLINIC, WHICH PRESENTLY SERVES CLIENTS OF THE DEPARTMENT OF HEALTH AND WELFARE, BE MAINTAINED.

Special Education Programs for Retarded Children

The Maine statutes governing educational programs for handicapped children specify that in the event these programs cannot be adequately provided through the usual facilities and services of the public schools, the administrative unit must provide funds for attendance at a public or private class, school, center, trainable association, or other program approved by the Commissioner of Education. The law requires that the sending unit pay the receiving unit the actual per pupil cost incurred in the operation of the program. This financial support of the local school system aids materially in the development of community programs for retardates which were established originally by associations of parents and friends of retarded children.

Community classes can provide not only training for school-age children but, in some cases, community sheltered workshops or activity programs for older retardates who are unable to work independently in the community, and day-care centers for retarded children who need supervised group activity. More community day schools, workshops, and activity programs for trainable retarded children and young adults are needed throughout the state. In all but the most sparsely populated areas, they should be within daily commuting distance of the child's home.

The development of these, however, and of training centers having supervised residential facilities where children can live in five days a week, should be developed in accordance with the Maine Committee's comprehensive plan for programs and facilities.

Secondary School Programs for the Retarded

Nearly everywhere in the state, education and training programs for the retarded are fragmented and without sequence. This is especially true of programs for educable retardates of high school age, for whom little is now being provided. The state currently has some 127 elementary and junior high classes for educables, but only 9 secondary school classes.

John Fahey, in studying programs for handicapped children and youth, (14, p.45) noted that "many communities are excluding their retarded children from school at age 16. With the expectations for a 'normal' or 'average' child to stay in school until he finishes the twelfth grade (about 18 years of age) and the state law mandating that students stay in school until age 17, one fails to see how the practice of excluding retardates earlier than other children persists." (A sequential program for prevocational training for the educable mentally retarded child from primary through senior high school is included in this consultant's report.)

The Commission feels strongly that school administrative units should accept their full responsibility for both educable and trainable retardates of high school age and recommends that:

WHENEVER FEASIBLE, SCHOOL ADMINISTRATIVE UNITS SHOULD DEVELOP THEIR OWN PROGRAMS OF INSTRUCTION FOR EDUCABLE RETARDATES AT THE SECONDARY SCHOOL LEVEL. THEY SHOULD ALSO AID IN THE DEVELOPMENT AND ADMINISTRATION OF TRAINING, GROUP ACTIVITY, AND SHELTERED WORKSHOPS FOR TRAINABLE RETARDATES.

While the private schools such as the Work Adjustment Center in Portland and the Occupational Training Center in Lewiston have an important role and should be given a high priority in the further development of facilities and programs for the mentally retarded, they alone cannot adequately serve the education and training needs of teenage and young adult retardates.

It is further recommended that program planning for the retarded should include:

DEVELOPMENT AT THE AREA VOCATIONAL AND TECHNICAL HIGH SCHOOLS OF SEQUENTIAL ACADEMIC AND VOCATIONAL TRAINING PROGRAMS FOR EDUCABLE RETARDATES.

Emphasis in these programs should be on providing a full range of services to evaluate the student's work performance, train him in fundamental skills, and bring him to a level of job readiness required for successful employment. Services should include personal counseling, concentrated attention on both work and life adjustment, vocational counseling, placement, and follow-up. It is anticipated that some schools would need also to provide domiciliary care for students who are unable to commute from home. These regional programs should utilize a variety of resources including the services of vocational rehabilitation counselors and social caseworkers specially trained in mental retardation.

Sheltered Workshops for the Trainable Retarded

Sheltered workshops for low educable and trainable retardates have much to offer both the trainee and the community when competitive employment appears to be a dim or unattainable goal. To the extent that it may serve as a substitute for institutionalization, the amount of money saved per trainee is substantial, and also offers the trainee an opportunity to assume a useful role. Additionally, workshops provide an excellent opportunity for observing and evaluating work performance, thus helping vocational rehabilitation counselors and others to judge readiness for employment in the competitive labor market. Further development of these workshops and training facilities and the establishment of additional ones in selected areas of the state is recommended. (See Section C-4 of this Chapter.)

A COMPREHENSIVE WORK ADJUSTMENT AND TRAINING PROGRAM, TOGETHER WITH A SHELTERED WORKSHOP FOR BOTH TEMPORARY AND TERMINAL EMPLOYMENT SHOULD BE ESTABLISHED IN CONJUNCTION WITH PINELAND HOSPITAL AND TRAINING CENTER IN POWNAL.

This workshop facility with a sustained training program should provide domiciliary care for its own clients and for those working in nearby industries such as the Hillcrest Poultry Plant in Lewiston.

FACILITIES PROVIDING LONG-TERM SHELTERED EMPLOYMENT FOR OLDER RETARDED WORKERS SHOULD BE DEVELOPED IN CONJUNCTION WITH COMMUNITY PROGRAMS FOR THE TRAINABLE AND SHOULD BE SUPPORTED BY A COMBINATION OF STATE AND LOCAL FUNDS.

DOMICILIARY CARE SHOULD BE PROVIDED AT CERTAIN OF THESE CENTERS FOR CLIENTS WHO ARE NOT ABLE TO COMMUTE DAILY FROM HOME.

IN ALL SHELTERED WORKSHOP SITUATIONS, RETARDATES EMPLOYED SHOULD RECEIVE ADEQUATE FINANCIAL REMUNERATION FOR THEIR WORK.

Bureau of Mental Retardation

In the past, a disproportionate share of responsibility for the development, support, and functioning of local and regional programs for the retarded has rested with the voluntary organizations of parents and friends. These groups have operated at a high level of success and are to be greatly commended for their efforts. However, a unified approach to meeting the needs of the mentally retarded regionally and statewide requires that all available resources public and private be coordinated in such a way that they are utilized as effectively as possible. Accordingly, it is recommended that:

THE BUREAU OF MENTAL RETARDATION APPROVED BY THE 103rd LEGISLATURE BE ADEQUATELY FUNDED AND STAFFED WITH A DIRECTOR, ASSISTANT DIRECTOR, AND OTHER CENTRAL OFFICE EMPLOYEES IN ORDER TO PROVIDE THE PROFESSIONAL SUPERVISION AND ADMINISTRATION NEEDED FOR THE DEVELOPMENT OF COORDINATED MENTAL RETARDATION PROGRAMS THROUGHOUT THE STATE.

Functioning in a close liaison capacity with the Department of Education, Bureaus of Mental Health and Corrections, Department of Health and Welfare, state and local voluntary associations, and other public and private agencies, the Bureau of Mental Retardation should have primary responsibility for ensuring that the objectives of Maine's comprehensive planning for mental retardation are achieved. One of the Bureau's prime functions should be to assist in establishing and maintaining communication with all agencies serving the retarded.

Staff Development

As noted earlier, Maine has a serious shortage of trained specialists in all areas of rehabilitation. It is urged that:

ALL FEDERAL FUNDS AVAILABLE BE USED TO INCREASE THE STATE'S PROFESSIONAL MANPOWER IN THE FIELDS OF SPECIAL EDUCATION, PSYCHOLOGY, SOCIAL WORK, AND ALLIED DISCIPLINES.

Some federal funds are available to State Departments of Education and to universities and colleges for traineeships and scholarships for teachers of the mentally retarded. These should be utilized to the fullest and supplemented with state scholarships for professionals seeking specialized training.

Job Placement of the Mentally Retarded

Some of the problems encountered by agencies seeking to place mentally handicapped clients in suitable occupations are graphically illustrated by a survey conducted in 1967 by the Division of Vocational Rehabilitation. A consultant employed for this purpose surveyed all municipal, state, and federal activities and installations and identified some 1,200 civil service positions considered to be suitable and within the capabilities of persons with some degree of mental retardation.

To be "certified" for such employment, the candidate was required to demonstrate: (1) the ability to meet the work requirements, (2) the necessary physical qualifications, (3) the capacity to get to and from the job and the needed punctuality and reliability in work attendance, and (4) the social adaptability requisite to develop appropriate relationships with co-workers and supervisors.

The immediate objective of the project was to place as many retarded persons as possible in suitable public employment. The long-range goal, which would follow if the immediate goal had been achieved, was to improve the image of the mentally retarded as potential employees. Neither objective was accomplished. At the end of the project only 20 mentally retarded clients of Vocational Rehabilitation were "certified" as work-ready and realistic prospects for placement, and only one was placed in a civil service (federal) job. (After the project had been terminated, one other candidate was subsequently employed in a federal position, and four other federal and municipal placements were pending. It should be noted additionally that federal institutions in Maine that employ the largest numbers of personnel, i.e., the air bases and other military areas, were under orders at this time to reduce staff. If this had not been so the federal response would undoubtedly have been more favorable.)

The consultant responsible for conducting the project concluded that "under the conditions that now prevail, public employment of the retarded in Maine is not currently feasible."

These findings, however, should be contrasted with those of a statewide survey of 120 private employers conducted a year later by the Commission on Rehabilitation Needs. (See Chapter III, Section D-3a and Chapter IV, Section G- 3&4) Employers or their representatives interviewed personally by task force members in the Commission's six planning regions were asked to fill out a referral form if they had job openings available for handicapped workers and if they wished to have applicants referred to them by the Employment Security Commission. Thirty-two firms (27%) did so, and the referrals were subsequently made.

The form listed 13 categories of potentially limiting conditions, of which "limited learning capacity" (I.Q. 53-75) was one. Some of the firms indicated all 13 categories and others did not fill out this part of the form. Of the 25 firms that responded to the item, "Interested in hiring handicapped as follows--", 22 indicated that they wished to have candidates with limited learning capacity referred. The only other "disability" category receiving more responses (25) were applicants with a speech impairment.

During the interview the employer was asked if he would hire a person with one or more of the "disabling" conditions if he should have a job opening and if the applicant had the necessary skills. Of the 120 employers interviewed, 102 said that they definitely would hire a person with limited learning capacity if he could handle the work. Fifty-four said they already have such persons working for them. In other words, more than half (53%) of the firms that have operations in their plants that can be performed by mentally retarded persons are hiring them at the present time, and nearly half (45%) of all the employers surveyed have mentally retarded workers on their payrolls.

These findings are particularly interesting when one considers that the earlier survey was undertaken partly to "improve the image of the mentally retarded as potential employees and thus to increase their opportunities for employment in private business and industry."

It is apparent that many more private employers have had experience in hiring and retaining mentally retarded workers than was formerly realized, and that on the basis of these experiences they have continued the practice. Despite the federal government's stated policy of hiring the handicapped, it would appear also that in Maine at least, government officials have had little such experience, at least as far as the mentally retarded are concerned, and that in the absence of a precedent, their opinions concerning the "feasibility" of hiring the mentally retarded are considerably more pessimistic than those of private employers. This relunctance, it would seem, is even more deeply entrenched in the thinking of municipal and state hiring officials, if there is any significance in the fact that the only two placements secured in the earlier survey were in federal installations.

A fairly self-evident conclusion is that state-sponsored programs dedicated to creating a favorable climate for the employment of mentally retarded workers would do well to begin "at home." If proponents are needed to convince state hiring officials that the mentally retarded, when suitably placed, make good workers, then undoubtedly a great many private employers and personnel managers can be found who would be willing to bear out the fact.

Research Directions for Employment of the Retarded

The Commission's survey results should perhaps be qualified by other research findings to the effect that when job opportunities are plentiful, some of these jobs are found to be suitable for the mentally retarded and such persons are hired. Yet when these opportunities dwindle off and the labor market tightens, these same jobs are considered too difficult for the retarded to perform. Hence, the "last hired, first fired" principle applies, and job training programs should set their sights accordingly.

Rather than attempt to train the retarded for an "occupation", therefore, it would seem much more realistic to focus on readiness for general employment and on the basic skills necessary to perform a variety of task's within the individual's range of competence. Training programs should also refine their techniques of sorting out those who have the potential ability to learn, can adapt to change, acquire necessary skills and job performance attributes, and conduct themselves in a responsible manner. These techniques

would aid vocational rehabilitation counselors and others in planning suitable training programs and to place applicants in jobs with the expectation of better than chance success.

While it remains a basic fact that here in Maine, suitable job opportunities for the retarded have never been adequately explored, and the concerted type of vocational and life adjustment programs geared to the total needs of the retardate have yet to be developed, there will still be those for whom vocational status will be unattainable. The sheltered workshop, with its provisions for terminal employment, has a distinct contribution to make in this area and should be exploited as a valuable community resource.

Research Needs in the Field of Mental Retardation

Dr. Leonard W. Mayo, Commission chairman and vice chairman of the President's Committees on Mental Retardation and Employment of the Handicapped, has pointed out (39, pp. 53-61) that necessary research in this area cannot be left to the federal government alone. The states must encourage research by public and private institutions of higher learning, and by institutions for the retarded.

Diagnostic and preventive services need to be expanded, and steps should be taken to protect the public from the known and suspected causes of retardation.

Responsibility for coordination should be clearly and unequivocally designated to state and local authorities for the planning and development of services. Specifically, the Commission recommends that:

THE BUREAU OF MENTAL RETARDATION SHOULD ASSUME THE PRINCIPLE LEADERSHIP ROLE IN PROMOTING AND COORDINATING MENTAL RETARDATION RESEARCH IN THE STATE.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act has important provisions for the development of research facilities and programs, grants to state education agencies and institutions of higher learning to extend and strengthen programs for training teachers of the mentally retarded and other handicapped children, and also grants for research and demonstration projects. (See Section F-5 of Chapter IV)

A much greater attempt should be made here in the state to avail ourselves of these available resources and to utilize them to the fullest advantage.

6. THE SOCIALLY AND CULTURALLY DISADVANTAGED

Throughout the Commission's tenure it has been constantly recognized that Maine's many thousands of disadvantaged individuals and their deep-seated cultural, social, and economic problems have serious implications for the planning, funding, staffing, and delivery of every kind of rehabilitation service. Their plight is reflected in all of the standard disability categories which are subsumed within the traditional definitions of physically and mentally disabling conditions. The fact that many disadvantaged persons are not known to any of the rehabilitation and social services agencies because they have never applied or been referred adds another dimension to this challenge.

Outreach

Outreach has not previously been considered a function which public rehabilitation agencies are expected to perform, though most of them have done a certain amount of this voluntarily. Since congressional enactment of the 1968 Amendments to the federal Vocational Rehabilitation Act, however, times have changed and agencies can no longer merely open their doors and wait for clients to come to them. Hereafter an important function of state VR agencies will be to send counselors into areas where the disadvantaged live, seek them out, and arrange for appropriate diagnostic, evaluation and work adjustment service.

This expanded concept of rehabilitation practice as an integrated process which treats the whole person in his total environmental milieu has long been recognized as essential within a democracy where all citizens have equal right under the law. Official recognition, however, has evolved slowly and legal provisions for its implementation are of only recent date.

Liberalization of Vocational Rehabilitation Laws

The 1968 Amendments authorizing vocational evaluation and work adjustment services for the disadvantaged, are the newest national expression of a greatly accelerating concern, stressed by the public through their lawmakers, that our available human resources be utilized to the fullest and that every handicapped individual be helped to realize his potentialities. Public concern for salvaging the handicapped first came to light in 1920, when Congress passed the Smith-Fess Act establishing the vocational rehabilitation program. It made slow progress at first; when the federal-state program was adopted in Maine the following year, the Division of Vocational Rehabilitation, created within the Department of Education to carry out the provisions of the Act, served only a small number of clients with very evident physical handicaps.

Modifications of the federal law occurred in 1943 and 1954, extending eligibility to the mentally handicapped. These were duly reflected at the state level. A new impetus was given the program in 1965, partly because of Congressional and executive leadership and a public aroused to the dangers of poverty, deprivation and wasted human lives. A major reason, however, was that the federal-state programs had been able by that time to demonstrate their success. Vocational rehabilitation had shown historically and statistically that the public was getting its money's worth in the form of reproductive, contributing, taxpaying citizens.

In 1965 the federal amendments recognized the needs of the psychosocially disabled, defined as those whose employability is seriously jeopardized by medically definable emotional and/or behavioral disorders resulting from educational, cultural, environmental, or related causes.

Then, most recently, the 1968 VRA amendments extended to any disadvantaged individual, defined as one who is seriously limited in his ability to secure or retain appropriate employment by reason of physical or mental disability, youth, advanced age, low educational attainment, ethnic or cultural factors, prison or delinquency records, or any condition which constitutes a barrier to his employment. (70)

Following upon this federal initiative--but at least equally important, as a means of implementing the philosophy which has guided the statewide rehabilitation planning project from the start--the Commission directed its Executive Committee and project staff to draft a proposed legislative document, amending the State Vocational Rehabilitation Act to make it conform to the new federal statute. The procedure followed in carrying out this directive is described in some detail in Chapter III of this report.

Accordingly, the Commission adopted the following as a basic major recommendation:

THAT THE VOCATIONAL REHABILITATION ACT OF THIS STATE BE REVISED IN CONFORMANCE WITH THE AMENDED FEDERAL STATUTES TO PERMIT VOCATIONAL REHABILITATION SERVICES TO BE EXTENDED TO ALL VOCATIONALLY DISADVANTAGED INDIVIDUALS.

The proposed revision defining eligibility and types of services to be provided follows the federal model closely; some of these provisions are presented here to give the reader an indication of their purpose and scope: (1, pp. 2-3)

"Rehabilitation services" are defined as "including but not limited to vocational rehabilitation services," and the provision of "evaluation and work adjustment services for purposes of the Federal Vocational Rehabilitation Act and Social Security Act and acts amendatory thereof and additional thereto."

"Disadvantaged individual" is defined as: (a) any individual who has a physical or mental disability which constitutes a substantial handicap to employment, but which is of such nature that vocational rehabilitation services may reasonably be expected to render him fit to engage in a gainful occupation; any individual who has a physical or mental disability for whom vocational rehabilitation services are necessary for the purposes of determining rehabilitation potential (physical or mental disability defined as a condition which limits, contributes to limiting, or, if not corrected, will probably result in limiting his activities or functions,) and (b) individuals disadvantaged by reason of their youth or advanced age, low educational attainments, ethnic or cultural factors, prison or delinquency records, or other conditions, and (c) members of their families when the provision

of rehabilitation services to family members is necessary for the rehabilitation of an individual described in (a) or (b).

"Evaluation and work adjustment services" include, as appropriate in each case, such services as:

a. A preliminary diagnostic study to determine that the individual is disadvantaged, has an employment handicap, and that services are needed;

b. A diagnostic study consisting of a comprehensive evaluation of pertinent medical, psychological, vocational, educational, cultural, social and environmental factors which bear on the individual's handicap to employment and rehabilitation potential;

c. Services to appraise the individual's patterns of work behavior and ability to acquire occupational skills, and to develop work attitudes, work habits, work tolerances and social and behavior patterns suitable for successful job performance, including the utilization of work, simulated or real, to assess and develop the individual's capacities to perform adequately in a work environment;

d. Any other goods or services provided to a disadvantaged individual, determined in accordance with federal regulations to be necessary for, and which are provided for the purpose of, ascertaining the nature of the handicap to employment and whether it may reasonable be expected the individual can benefit from vocational rehabilitation services or other services available to disadvantaged individuals;

e. Outreach, referral and advocacy. According to E.B. Whitten, executive director of the National Rehabilitation Association: (70) "The term advocacy (in the federal amendment) has never before appeared in rehabilitation legislation. It is interpreted to mean that the evaluation and work adjustment agency will not be content to provide the evaluation services and send the individual on his way with a simple referral." Discussing the implications of the federal amendment for the training of personnel and the delivery of services, Whitten notes: "Physically and mentally handicapped individuals are...as a rule, also poor people; over one-half of those who come to the agencies have no income at all when they apply for services, and over 90 per cent have incomes at time of referral below what is commonly referred to as a poverty level." He adds that the agencies will be called upon to serve many more such persons than they have in the past.

In preparing the revised state vocational rehabilitation law and urging its adoption by the 104th Legislature, the Commission was fully aware that here in Maine particularly, large numbers of socially and culturally disadvantaged persons will be found who have never before been considered for rehabilitation service. While it is known that one out of five Maine families lives in economic poverty (well over 50,000 families have cash incomes of less than $2,500 a year), and that the national averages of chronic impairments apply to the Maine disadvantaged, only a few of these persons are receiving the services they need.

Many, as we have said, are not aware of what services exist, or that they might qualify. Some, based on past experiences or those of relatives and friends, are apprehensive about what they might be letting themselves in for. Still others have lost hope that anything will or can be done for

them. In attempting to satisfy the outreach and advocacy requirements of the new amendment, rehabilitation personnel in Maine will quite likely find themselves burdened with a much greater number of hard-core cases who seem to resist treatment, apparently lack motivation, and whose life styles are alarmingly different from their own.

At the same time, practical considerations will continue to exert much the same influence as in the past. Staff shortages and inadequate funds will impose the necessity of screening out those whose prognosis is poor and concentrating on clients who show evidence of benefitting from the services available. The outreach and advocacy provisions will, however, reveal the magnitude of unmet need and give rehabilitation planners some clearly defined goals--however distant--on which to set their sights. It will at least set the stage for some additional rehabilitation to take place, provided agencies and clients are able to communicate sufficiently to establish realistic objectives.

Finally, one of the amendment's most challenging implications is its legal mandate for more effective and systematic referral patterns and follow-up of clients. This will necessitate a much greater degree of communication and cooperation among state, federal, and voluntary agencies, particularly welfare and manpower agencies, and the private organizations which heretofore have operated more or less independently in seeking to provide services and facilities for the handicapped and disadvantaged.

Coordinating Rehabilitation Services to the Disadvantaged

One of the Commission's special studies, developed by the project staff involved a close look at programs now existing in Maine for the rehabilitation of disadvantaged individuals and recommendations for their improvement through effective interagency liaison. (29) Essentially, the report advocates an interagency approach on the part of all rehabilitation, welfare, and manpower programs, and indicates some of the ways in which this can be implemented, particularly by the state office of public rehabilitation services and the state and local Economic Opportunity programs. Since in a great many instances the target population of these activities is the same, it is essential to the effectiveness of these programs that staff adopt a unified approach and attempt to reach this population in all areas of their need.

Specific recommendations pertaining to this closer interagency liaison (first specified in the above-mentioned report and later adopted by the Commission) are discussed in Section C-3 of this Chapter along with a description of Economic Opportunity programs now operating in Maine. Commission recommendations addressed to the rehabilitation needs of rural disabled and disabled youth are to found in Sections C-7 and C-9.

C. PROGRAMS

1. THE AGING

Older Americans Act

Public concern for the increasingly complex and difficult problems encountered by the aging was reflected at the federal level with the passage in 1965 of the Older Americans Act which, among other provisions, created an Administration on Aging.

The major thrust of the Act is that it requires states to develop programs for the aging and makes federal funds available to the states for this purpose. Through Title III of the Act, funds may be obtained for community programs. Title IV authorizes funds for demonstration and research, and Title V for the development of training programs.

Services for Aging Unit

In Maine, the implementation of these provisions is the responsibility of the Services for Aging Unit in the Division of Family Services, Department of Health and Welfare. Essentially, the purposes of this unit are to develop and implement programs, particularly those provided for in Title III of the federal Act, through its own initiative and in cooperation with other programs that serve the aging such as old age assistance and medical care services provided by the Department of Health and Welfare and Community Action Programs. It seeks to promote research and demonstration activities relevant to the problems of aging and to develop educational programs both for the aging and among the general public. Overall responsibility for the conduct of the Unit's activities and other state programs for the elderly rests with the Governor's Committee on Aging.

As of November 1, 1968, the Services for Aging Unit has assisted in the organizing and funding of 60 senior citizens multipurpose centers operated by 15 funded agencies. These included service clubs, Community Action Programs, municipal government, county organizations and many more. Volunteers donated some 150,000 hours to these projects and upwards of 17,800 persons of retirement age and beyond were served.

These and other Older American projects sponsored by the Services for Aging Unit are providing many kinds of services through paid staff of the agencies involved assisted by some 950 volunteers. At the present time 60 Senior Centers are operating in the state. A partial listing of services and the numbers of persons receiving them as of November 1, 1968, was presented as follows in the Unit's regular October monthly report:

Service	Persons Serviced
Homemaker/Home Health Aid	286
Home Maintenance, Visitations, Reassurance	1,469
Protective Services	199
Meal Services	1,760
Health Services	1,574
Information and Referral	11,066
Employment Referral	308
Transportation	4,744
Adult Education	1,161
Counseling	913
Recreation and Leisure Time	15,779

The same report notes that the federal government contributed $119,885 toward the cost of the above programs. An equal amount was identified in the form of local in-kind matching resources, and the state contributed $7,280 to defray the cost of administrative services.

Another of the Unit's activities has been to provide technical assistance on low cost housing and on social services in housing projects. These have been implemented primarily through the Housing Subcommittee of the Citizens Advisory Committee to the Bureau of Social Welfare and to the Governor's Citizens Advisory Committee on Housing. In the latter instance, for example, Unit staff members assisted the Advisory Committee in preparing a substantial portion of the Housing in Maine report issued in December 1968 by the Executive Department. (20)

The Unit provides technical consulting services and other forms of assistance to communities, to regional planning efforts, and to a large number of public and private organizations and agencies.

Background for Recommendations

The number of Maine residents over 65 continues to increase steadily at the same time that the state's working age population continues to decline. In 1964, with 11.1% of the state's total population over 65 years of age, Maine had the sixth highest aging population in the nation. (69, p.3) By July 1, 1966, this percentage had increased to 11.3%, with 111,000 persons in the over 65 group.

--In 1960 Maine had 28,572 families whose head was over 65. More than half of these families had incomes of less than $3,000. More than 30% of this group had incomes less than $2,000.

--Maine in 1966 had 121,791 old age and survivors benefits paid. The average monthly benefit was $87.

--In 1966 some 9,346 disability insurance benefits were paid. The average monthly benefit was $85.

Some elderly persons draw benefits under Social Security and some have retirement benefits or investment income. Many, however, depend on relatives or welfare for subsistence. In 1966 Maine had 10,000 persons receiving Old Age Assistance.

Additionally, the Services for the Aging Unit points out that four-fifths of our population over 65 have one or more chronic disabling conditions. The elderly poor often look upon curable conditions as incurable because of lack of funds or lack of health knowledge.

Survey of Disabled Aging in Maine

During the course of the Commission's statewide study project, a special consultant, Charles R. Hagan, was engaged by the Health Facilities Planning Council of Maine to prepare a report concerning the problems of the state's disabled aging and how effectively these problems are being met. (19, pp. 16-24) Mr. Hagan's frame of reference encompassed not only aging persons afflicted with a physical or mental disability but also those for whom aging itself constitutes a major vocational handicap. He emphasized that a single purpose of rehabilitation for all age groups in this category would be unrealistic and disappointing. In his discussion he quoted a statement by Deputy Commissioner Bernard E. Nash, federal Administration on Aging, in an address given at Northeastern University in Boston, November 1967:

> ...The mental image of an aging person is usually one of very advanced years. In reality, our programs must recognize aging as a process and must have an impact early in that process. Most agencies are now recognizing that planning must take place beginning at age 45. This calls for different types of planning and programming at different stages of the aging process. (44, p.121)

Because of today's hiring practices which favor younger men and women and often require applicants to pass a standard physical examination regardless of the position for which the applicant is being considered, the consultant adopted the U.S. Department of Labor's definition of aging as persons age 45 or older. In actuality, however, from the standpoint of employment, this imposed handicap upon older persons attempting to compete in the current labor market may well be experienced at age 40 or in some instances even younger.

Based upon observations made by this consultant as well as by several of the regional task forces and responsible state and federal agencies, the Commission has adopted the recommendation that:

PUBLIC AND PRIVATE EMPLOYERS, UNION OFFICIALS, GROUP MEDICAL PROGRAMS, AND OTHER CONCERNED AGENCIES AND INDIVIDUALS SHOULD BE ENCOURAGED TO REVIEW AND REVISE THEIR CURRENT POLICIES REGARDING THE HIRING OF OLDER WORKERS.

In 1967 Congress enacted legislation which prohibits discrimination against workers between the ages of 40 and 65. It became effective in mid-1968. The law is modified by two provisions: Employers are not required to open benefit plans to new employees in that age group, and in some instances employers may deny employment to applicants past the age of 40 if age is a bonafide reason for hiring younger people.

The consultant noted in his report that "the results and effects of this law can best be judged in time by the Employment Security Commission, and it remains to be seen in what ways it is circumvented. It may be that when a person over 40 applies for a job there just aren't any openings that day. Further, he could fail to pass the pre-employment physical." In this regard, the Commission recommends that:

EMPLOYERS SHOULD REVIEW AND REVISE THEIR STANDARDS OF ELIGIBILITY FOR GROUP MEDICAL COVERAGE WHICH FAVOR YOUNGER MEN AND WOMEN. PHYSICAL REQUIREMENTS BOTH FOR EMPLOYMENT AND FOR MEDICAL COVERAGE UNDER GROUP INSURANCE PROGRAMS SHOULD CORRESPOND TO THE DEMANDS OF THE PARTICULAR JOB, REGARDLESS OF THE APPLICANT'S AGE.

The State Department of Labor and Industry and the Employment Security Commission should periodically remind private employers, unions, and others about the federal legislation prohibiting discrimination against workers over 40 and study any loopholes found to exist. At least equally important, public agencies with responsibilities for hiring should be especially mindful of this legislation and its purpose, and subject their hiring practices to continuing scrutiny so that prejudicial practices, no matter how unintentional, are not tolerated.

Vocationally Handicapped Women

A great many women, often in their 40's and 50's but sometimes even younger, find themselves in the job market without adequate vocational skills, insurance benefits, or other financial and marketable resources.

SPECIAL PROGRAMS SHOULD BE PROVIDED FOR VOCATIONALLY HANDICAPPED WOMEN TO INCLUDE, BUT NOT BE LIMITED TO, PERSONAL AND VOCATIONAL COUNSELING, JOB TRAINING, FINANCIAL ASSISTANCE WHEN REQUIRED, AND ON-THE-JOB PLACEMENT AND EVALUATION.

This will necessarily be a cooperative effort by several agencies working in concert. Among them should be the state office of public rehabilitation services, family services, Employment Security Commission, and Community Action Programs.

Disabled Older Workers

Estimates developed by the Maine Department of Health and Welfare for July 1965 indicate that 196,279 persons out of Maine's 993,000 total population (19.7%) were in the 45-64 age range. Of these, an estimated 9,314 (5%) were classified as disabled and eligible for rehabilitation. However, in fiscal 1966 only 160 persons in the 45-64 age group who were identified by the Employment Security Commission as handicapped were placed in jobs by the Employment Security Commission offices. (66 or 41.4% of this group were placed by a single office.)

Since that time there has been a concerted effort on the part of the Employment Security Commission, the Division of Vocational Rehabilitation, the Governor's Committee on Employment of the Handicapped and numerous other agencies to secure more placements of handicapped workers. This cooperative endeavor has achieved a certain measure of success. However, the need is still great and the Rehabilitation Commission has proposed several recommendations which it believes will help close the gap and match a far greater number of handicapped workers with suitable jobs. These recommendations are discussed in detail in Chapter IV, Section G-3 of this report.

It is evident that when age itself is not the primary vocational handicap but rather an identifiable physical, mental, emotional, educational, or social impairment (in by far the majority of cases the disability is a combination of these) the handicapping conditions must be reduced to the point where employment becomes possible. This, as we have emphasized, requires an integrated approach by many different rehabilitation and social services. At the same time, employers are indispensable agents in this team process (to understate the matter) and their degree of participation, in the final analysis, will be the determining factor.

The Retirement Years

Mandatory retirement at age 65 affects nearly all workers in Maine, as elsewhere, who are not self-employed. Many persons welcome retirement, but these are almost invariably the ones who have planned for it and can be secure in the knowledge that their income from whatever sources will be sufficient to meet their needs. There are others, as we have noted, who have no such security. It is essential for many reasons that able-bodied, experienced, and skilled workers who have reached the age of 65 be permitted to continue working if they wish to, and especially if they need to in order to live above a bare subsistence level.

EMPLOYERS SHOULD REVIEW THEIR MANDATORY AGE 65 RETIREMENT POLICIES

WITH A VIEW TO ADOPTING MORE PERMISSIVE RETIREMENT POLICIES SUCH

AS VOLUNTARY RETIREMENT AND/OR MANDATORY RETIREMENT AT A LATER AGE.

The present system dates back many years, when the unemployment rate was high. With today's accelerated production demands and consequent low rate of unemployment, the cutoff point between productivity and idleness has become arbitrary and artificial. More permissive retirement policies would not only have a salutary effect on employees in many ways; they would enable companies to keep their skilled workers, reduce training costs, and effect economic savings. Equally important, they would reduce the need for welfare payments to persons who "unexpectedly" find themselves unemployed and without the means or the opportunity to remain independent and self-supporting.

Simply toting up one's years is not an adequate measure of usefulness. As Dr. Irving S. Wright of Cornell Medical College has pointed out:

> Science has extended life and potential usefulness. But society, the company, the union, the retirement plan arbitrarily ends a man's working days when he reaches 65. For those who want to quit and pursue longstanding dreams of leisure and other activities, society's plan is fine. But society should concern itself with those who do not want to enjoy a life of idleness. (19, p.18)

In many instances, community programs are trying to bring contentment and a sense of purpose to healthy, mentally alert, highly capable men and women whose real desire is to continue working. And as we have said, many of these persons need to do so for financial reasons. A concerted effort should be made to utilize the abilities of men and women over 65 so that the community can benefit from their contribution and these persons themselves may maintain their dignity and independence.

A number of agencies public and private are concerned with this problem, and it is anticipated that a strengthened Governor's Committee on Employment of the Handicapped as well as the state office of rehabilitation services and specialized programs such as the Services for the Aging, can help to effect a coordinated approach. Specifically it is recommended that:

PERSONS OVER 65 WHO WISH TO CONTINUE WORKING PART TIME SHOULD HAVE OPPORTUNITIES TO DO SO. PROGRAMS SHOULD BE DEVELOPED FOR LOCATING AND/OR CREATING PART TIME PAYING JOBS FOR RETIRED PERSONS AND ALSO FOR LOCATING SUCH PERSONS AND, WHERE NECESSARY, PROVIDING THE ADJUSTMENT SERVICES THAT WILL ENABLE THEM TO MEET THE JOB REQUIREMENTS.

These adjustment services might include, among others, personal and job counseling, orientation, and transportation to and from training and work.

There is particular need for Foster Grandparents services in children's day care centers and Head Start programs. It would be especially desirable to employ greater numbers of retired men and women as part-time foster grandparents in Head Start and similar programs sponsored by community councils. Frequently children of the very poor have only limited opportunities to establish wholesome person-to-person contacts with males in the family situation. The contributions that "grandfatherly" retired men can make to the emotional growth and development of these children is considerable.

Sustaining and Life Enrichment Programs for the Elderly

As noted earlier, there are now 60 Senior Centers being funded in Maine under the Older Americans Act. Complementing these is the relatively new "Outreach" program, also funded under Title III of the Act, which utilizes a number of Senior Service Corps made up of retired citizens in the community who are paid for the amount of time they put in. Their primary function is to seek out elderly persons who are unaware or in any case are not availing themselves of community services to which they are entitled. This program is now well under way and is being further developed with assistance

from the Services for Aging Unit. The Commission endorses this activity and recommends that:

THE "OUTREACH" PROGRAM OF THE SENIOR SERVICE CORPS SHOULD BE EXPANDED AND GIVEN ADEQUATE SUPPORT THROUGH COMBINED PUBLIC AND PRIVATE FUNDING.

In conjunction with the programs now in operation, as well as in parts of the state where they have not yet been established, it is recommended that:

TITLE III ACTIVITIES OF THE OLDER AMERICANS ACT SHOULD INCLUDE A TRANSPORTATION PROGRAM SIMILAR TO "PROGRESS ON WHEELS" FOR RECRUITING VOLUNTEER DRIVERS WHO CAN TRANSPORT ELDERLY PERSONS TO MEDICAL, EDUCATIONAL, AND SOCIAL SERVICES, AND TO PART TIME JOBS.

A federal grant to be used in developing this program is being prepared by Services for Aging.

Geriatric Rehabilitation

The population inventory prepared by the Department of Health and Welfare for July 1965 estimated that of the 108,062 persons in Maine at that time who were 65 and over, 15,262 or 14% were in some way disabled. These estimates provided by the supervisor of Services for Aging were grouped as follows:

Nursing Homes	6.0%	6,550
Housebound	6.0	6,550
Leave Home with help	2.0	2,162
		15,262

The estimates do not indicate how many of the disabled elderly were receiving care in general hospitals. It is felt, however, that many elderly persons now hospitalized could be as well cared for, and in fact would show marked improvement, if they were to have their rehabilitation needs met in an extended care facility equipped to provide the therapeutic and other ameliorative services required.

As Task Force IV pointed out in its report of recommendations to the Commission: "We recognize that there have been steady improvements in medical services to the elderly, but we would like to think that they have other interests and needs outside the purely medical area. It would seem to this task force that social services, including recreation and other opportunities to establish good human relationships are of great importance at this time." (54, p.11)

The Region V Task Force, in its plan for comprehensive medical rehabilitation services on a regionalized statewide basis, noted: "Geriatric rehabilitation is an area which demands special consideration and greater emphasis. In recent years there has been a marked increase in the numbers of elderly people. Longevity has resulted in increased morbidity rates, which in turn has caused overcrowding in hospitals and an ever increasing demand for hospital beds.

A new philosophy and approach to this phenomenon is crucial if we are to prevent the functional efficiency of the acute hospital system from being seriously compromised." (55, p.8)

Accordingly, as stated in the plan for comprehensive medical rehabilitation services, the Commission recommends that:

EXTENDED CARE FACILITIES SHOULD BE SURVEYED AND AN ATTEMPT MADE TO IMPROVE DOMICILIARY HEALTH CARE SERVICES ON A REGIONAL BASIS WITH SPECIALLY DESIGNATED EXTENDED CARE UNITS, STRATEGICALLY LOCATED IN THE MAJOR AREAS SPECIFIED IN THE PLAN, FUNCTIONING AS ASSESSMENT AND REHABILITATION CARE UNITS."

APPROPRIATE STATE AND VOLUNTARY PERSONNEL SHOULD BE RECRUITED AND TRAINED TO CLEARLY UNDERSTAND THE DOMICILIARY NEEDS OF THE GERIATRIC PATIENT AND JOIN TEGETHER IN THE PROVISION OF THESE SERVICES, AGAIN FUNCTIONING IN A TEAM SPIRIT.

IN REGIONAL MEDICAL PROGRAM DEVELOPMENT, HOME HEALTH SERVICES FOR THE ELDERLY SHOULD BE EXTENDED FROM THE MEDICAL CARE CENTERS THROUGH THE AFFILIATED REGIONALIZED HOME HEALTH SERVICES IN AREAS WHERE THESE EXIST OR ARE BEING PLANNED.

2. CORRECTIONAL REHABILITATION

Committee on Correctional Rehabilitation

An assessment of the extent of rehabilitation now going on in the state's correctional institutions and development of an immediate and long term plan for its improvement were the dual purposes of a 12-member committee organized as an adjunct to the Commission in June 1967. A detailed discussion of the formation and method of operation of this committee appears in Chapter III, (Planning for Correctional Rehabilitation). Briefly, a year-long series of regular monthly meetings interspersed with informally scheduled work sessions culminated in September 1968 with the publication by the Commission of the Committee's findings and report of recommendations. (34)

The Commission believes that the Committee on Correctional Rehabilitation is best qualified to plan for and execute the implementation of recommendations essential to meeting the needs of handicapped offenders, and that careful consideration should be given to all details of the more than 70 recommendations which comprise the substance of the report. The following, therefore, are to be understood as recommendations of the Committee on Correctional Rehabilitation:

Administrative Reform

REORGANIZE AND EXPAND THE BUREAU OF CORRECTIONS IN ACCORDANCE WITH LEGISLATION INTRODUCED IN THE 104TH LEGISLATURE.

This legislation which the committee helped to formulate is aimed at improving the efficiency and effectiveness of the Bureau of Corrections by including within it the Division of Probation and Parole, and a proposed Division of Treatment to administer educational, vocational, and treatment programs in the state correctional institutions. It also gives the director of corrections authority to enforce certain regulations concerning the county jails.

The Committee believes that enactment of this legislation will help to strengthen treatment programs and provide a more viable administrative structure for the effective coordination of correctional rehabilitation services.

THE COURTS SHOULD SENTENCE OFFENDERS INITIALLY TO THE BUREAU OF CORRECTIONS INSTEAD OF TO STATE CORRECTIONAL INSTITUTIONS.

The current practice which authorizes the Court to sentence offenders to certain institutions for a stated length of time should be discontinued in favor of sentencing both adult and juvenile offenders to the Bureau of Corrections. A Bureau Classification Committee should then determine, on the basis of a complete work-up of each individual developed by a diagnostic team of specialists, which institution he should be assigned to and insure that a program leading to his rehabilitation and successful return to society is carried out.

To implement the previous recommendation, it is urged that:

TWO RECEPTION, DIAGNOSTIC, AND EVALUATION CENTER$, ONE FOR JUVENILE OFFENDERS, THE OTHER FOR ADULT MALES SHOULD BE AUTHORIZED AND FUNDED BY THE 104TH LEGISLATURE.

The purpose of both these centers should be to arrive at a complete assessment of the individual's underlying problems, verify his handicapping conditions, supply short term therapeutic treatment, and prepare a long term plan for his rehabilitation and eventual release. They should be staffed by a team of rehabilitation specialists including a physician, psychologist, social workers, therapists, vocational rehabilitation counselor, as well as additional correctional personnel. On the basis of full individual assessment, the Classification Committee should then authorize the treatment plan to be put into effect and assume overall responsibility for ensuring that it is followed.

Boosting Institutional Rehabilitation Services:

REHABILITATION PROGRAMS AVAILABLE IN THE CORRECTIONAL INSTITUTIONS SHOULD INCLUDE PERSONAL COUNSELING, SOCIAL CASE WORK, AND OTHER PSYCHOLOGICAL AND ADJUSTMENT SERVICES, AS WELL AS MORE INTENSIVE VOCATIONAL REHABILITATION SERVICES.

Treatment personnel are in scant supply in all correctional facilities, state, county, and municipal. Before our corrections system can become truly rehabilitative, citizens must be prepared to expend as much for preventive, treatment and community adjustment services as they now do for law enforcement and custodial confinement.

Shift in Philosophy

A COMPREHENSIVE PHILOSOPHY OF CORRECTIONAL REHABILITATION SHOULD BE ADOPTED BY ALL TREATMENT AND CUSTODIAL PERSONNEL TO GUIDE THE COURSE OF PRESENT AND FUTURE PROGRAM DEVELOPMENT.

The main thrust of this philosophy should be towards rehabilitative as opposed to restrictively custodial methods of handling public offenders. Punitive sentencing, including "longer sentences for more serious crimes," should give way to the rehabilitative approach implicit in individual diagnosis and periodic evaluation of offenders. Wider us of indeterminate sentences should be adopted. Release should be contingent upon progress and prognosis, not upon an arbitrary date set earlier by an individual who, in most cases, is unable to prejudge with absolute accuracy. For all but a few, release should be granted when the individual has demonstrated by measurable changes in his attitudes and behavior that rehabilitation has been successful. Further, when it can be seen that rehabilitation is

taking place and that change is in a favorable direction, every effort should be made to encourage this achievement. Those who have made sufficient progress and are ready should be tried on probation or parole, or given an opportunity to take part in a work release program.

Indeterminate sentencing necessarily requires continuing evaluation of the inmate's progress. It is not meaningful when scant opportunities for change are provided, and when little provision has been made for treatment personnel to assist offenders in reaching therapeutic goals and in preparing for socially acceptable, productive lives in the free community.

Community Involvement in Correctional Rehabilitation

MUCH GREATER EMPHASIS SHOULD BE GIVEN TO WINNING PUBLIC ACCEPTANCE OF THE REHABILITATED EX-OFFENDER THROUGH (1) PROGRAMS TO INFORM CITIZENS OF THE NEED FOR CORRECTIONAL REHABILITATION AND ITS BENEFITS, AND (2) PROGRAMS THAT PERMIT AND ENCOURAGE THE ACTIVE PARTICIPATION OF CITIZENS IN THE COMMUNITY REINTERGRATION OF EX-OFFENDERS.

CONTRIBUTIONS OF THE MANY SUPPORTIVE AGENCIES AND INDIVIDUALS CAPABLE OF PROVIDING NEEDED SOCIAL SERVICES TO POTENTIAL, PRESENT, AND EX-OFFENDERS SHOULD BE IDENTIFIED BY CORRECTIONAL, EMPLOYMENT, AND VOCATIONAL REHABILITATION PERSONNEL AND THE COOPERATION OF THESE AGENCIES AND INDIVIDUALS SHOULD BE ENLISTED.

Experience of some states and the findings of a number of research projects have indicated that the successful reintegration of the ex-offender into the community is determined in large part by his acceptance into non-authoritarian, non-punitive community-based programs in which the individual is allowed to share in decision making. Community programs can often bring about a greater degree of rehabilitation than those restricted to an institutional setting.

As ways of implementing the above general recommendations, it is further urged that:

A BODY OF KNOWLEDGEABLE LAY CITIZENS SHOULD BE APPOINTED TO SERVE AS AN ADVISORY COMMITTEE TO THE BUREAU OF CORRECTIONS.

AN EFFECTIVE PUBLIC INFORMATION PROGRAM SHOULD BE ESTABLISHED IN THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS.

COMMUNITY VOLUNTEERS SHOULD BE RECRUITED AND TRAINED TO ASSIST IN ALL APPROPRIATE PHASES OF THE CORRECTIONAL PROCESS, PARTICULARLY THE PROBATION-PAROLE EFFORT.

Although correctional officials have been cautious in seeking the active participation of lay citizens in their rehabilitation programs, there is evidence that the general public is gaining a better understanding of these programs and that--in theory, at least--they support them. To give one example, in a national public opinion survey conducted in 1967 for the Joint Commission on Correctional Manpower and Training, 7 out of 10 persons interviewed (72% of the survey sample) expressed the view that rehabilitation, instead of "punishment" (7%) or "protecting society" (12%) should be a correctional system's primary goal. However, only 48% believed that today this actually is the primary emphasis in our courts and institutions. (48)

As a means of promoting more effective community involvement within a structured plan of operation, the correctional rehabilitation committee proposed that:

THE BUREAU OF CORRECTIONS, IN COOPERATION WITH OTHER RESPONSIBLE PUBLIC AND PRIVATE AGENCIES, SHOULD EXPLORE THE FEASIBILITY OF A PROJECT, TO BE ADMINISTERED BY THE BUREAU, WHICH WOULD ENCOURAGE LOCAL COMMUNITIES TO ASSIST MATERIALLY IN THE REHABILITATION OF THEIR OWN PUBLIC OFFENDERS.

The model of this proposed plan originated in Massachusetts, where local communities helped to defray the costs of the program through voluntary donations and some 800 lay citizens in 168 communities took responsibility (usually in teams) for the reintegration of individual ex-offenders upon the latters' return to the community. Churches and other community groups recruited volunteers and sponsored certain aspects of individual local projects. Many individuals and groups planned and coordinated these efforts which contributed in a uniform way to the statewide project.

A Planned Program of Public Information and Education

Regarding the recommendation for an ongoing program of public information and education, the committee noted that among its objectives should be:

1. Encouraging more citizens to extra-time involvement in correctional rehabilitation,

2. Promoting incentive programs among employers and community groups to generate more employment opportunities for ex-offenders, and

3. Stimulating public interest in the preventive aspects of correctional rehabilitation, especially those which pertain to young people.

In this connection, another statistical finding of the national public opinion survey mentioned earlier in this chapter is of interest: Despite the fact that most people feel that corrections should place more emphasis on rehabilitating the offender than on punishing him, only a third of the persons interviewed were willing to see taxes raised to pay for better correctional rehabilitation programs. This reluctance, however, is substantially modified by the additional survey finding that, in terms of priority of increased federal spending, funds to combat juvenile delinquency rank next in line behind aid to schools.

Commenting on the need for better communication and wider public support, the Joint Commission on Correctional Manpower and Training stated:

> A good deal of the present lack of public interest and legislative support may well be ascribed to the failure of corrections to show how public funds have been invested and what the returns have been in men, women and youngsters returned to the free community to lead useful lives.
>
> Typically, corrections comes to public notice only in times of crises, like a prison riot. This would not be the case if corrections maintained at least a speaking acquaintance with the public, as successful schools and hospitals have learned to do.
>
> But public support must also come in forms other than appropriations. Corrections cannot achieve its potential unless citizens are willing to take responsibility for helping to further the reintegration of offenders into society...A society that wants to prevent recidivism must see to it that all its institutions are concerned with assisting the offender to enter, and stay within, the main currents of its political, economic and social life. And correctional leaders must assume responsibility for bringing these facts home to the public. (48, pp. 24-25)

Need for a Pre-Release Center:

A PRE-RELEASE CENTER FOR ADULT MALE OFFENDERS, SHOULD BE ESTABLISHED AND LOCATED PREFERABLY IN THE SOUTHERN MAINE AREA.

A number of states, including South Carolina and Colorado, have demonstrated that the de-socializing effects of confinement can be considerably lessened when a unified effort is made to "de-chamber" inmates who are approaching release or parole. Concerning the need for such a facility, one of the committee members noted: "We do a great deal in our Maine institutions to make people institutionalized, but practically nothing to prepare them for the life they will be expected to live in the community. All we do is open the gates and let them out."

The return to society can be especially traumatic for those who have been confined for any length of time. There is urgent need, therefore,

for a pre-release center, situated away from the grounds of both the adult male institutions, where total emphasis would be on preparing the men socially, educationally, and vocationally for the life they are about to enter. Social casework and personal and vocational counseling should be provided, as well as informational programs that cover such aspects of community adjustment as budgets and financing, legal rights, kinds of help available from social agencies, family relationships, employment opportunities and what employers look for when they interview job applicants, getting along with people on the job, and similar discussion topics. Inmates enrolled in the cooperative vocational rehabilitation units should also receive complete social, psychological, and vocational evaluation during this period, and placement efforts should be made on behalf of all inmates requiring this service.

States that have pre-release centers of this kind report excellent results, and cite the exceptionally high level of enthusiasm and cooperation shown by public and private agencies, businessmen, lawyers, prospective employers, and many other community representatives.

Halfway Houses

EXPAND THE HALFWAY HOUSE PROGRAM FOR YOUNG PEOPLE AND ADULTS, MALE AND FEMALE, WHO HAVE JUST BEEN RELEASED FROM A CORRECTIONAL INSTITUTION OR ARE ON PROBATION OR PAROLE, AND WHO (PARTICULARLY IF THE INDIVIDUAL HAS NO ONE SUITABLE TO TURN TO IN THE COMMUNITY) NEED OR CAN BENEFIT FROM THIS EXPERIENCE.

As this recommendation implies, it is envisioned that residing at a Halfway House could be a condition of probation as well as part of the aftercare of parole or entrustment. Essentially, the halfway house experience provides an opportunity for reasonably supervised, therapeutic living in a homelike environment which has strong ties with the surrounding community. This, in fact, is one of its strengths; it is the nearest thing to being totally and independently within a community, yet provides the supportive environment necessary for the development of the attitudes, behaviors, and skills which self-sufficient living in the community requires. Many of the residents would be spending their working hours in the community outside and would pay their room and board and personal bills the same as anyone else. The halfway house not only provides a valuable adjustment service; it is much less costly and far more effective than an institutional setting for properly selected individuals.

Rehabilitation of Alcoholic Offenders

ESTABLISH INTENSIVE TREATMENT CENTERS AT THE AUGUSTA AND BANGOR STATE HOSPITALS FOR THE DETOXIFICATION, EVALUATION, AND REHABILITATION OF CONFIRMED ALCOHOLIC OFFENDERS.

Statistics pointing to the relationship between chronic alcoholism and public offense leave no doubt that until society steps up its efforts to provide better treatment for persons afflicted with this disease, the crime rate will continue to soar. It is significant that by far the greatest number of convictions are for intoxication (quite often after previous court appearances for the same offense) and for crimes committed while under the influence. To cite only one example, Miss Ward E. Murphy, superintendent of Stevens School and the Women's Correctional Center, has noted: "The major problem of almost all of the more mature inmates now at the Women's Correctional Center is that of drinking too much. Most of the offenses are related directly to drinking, or crimes committed while under the influence of alcohol..." (43, p.15)

The treatment centers should adopt a team approach to helping the alcoholic offender solve his complex problems and become reinstated as a productive member of society. This team approach will require the coordinated efforts of many public and private agencies and individuals, and will call especially for close ties with the Bureau of Mental Health and the Division of Alcoholism Services.

Cooperative Vocational Rehabilitation Units

At this writing, Maine is the only New England state to have cooperative vocational rehabilitation units either currently operational or soon to become so, in all of its state correctional institutions. Establishment of the proposed Reception, Diagnostic, and Evaluation Centers could aid these programs enormously by providing comprehensive information about, and a treatment plan for, offenders before their commitment to an institution. If profiles and treatment plans were available to rehabilitation counselors and treatment personnel at the time the individual inmate is received, his treatment program could begin at once, thereby not only accelerating it, but greatly enhancing its effectiveness. These are both important factors, especially when it is remembered that the average length of stay at the Men's Correctional Center, for example, (where a cooperative unit has been functioning since October 1967) is only about six months. The precommitment diagnostic and evaluation service would provide rehabilitation and treatment personnel at the correctional institutions with these detailed profile and treatment plans, thus permitting them to devote all their efforts to achieving the highest level of rehabilitation possible within the time limits imposed.

It is significant also in this regard that the liberalized federal Vocational Rehabilitation Act and the proposed revision of the state Vocational Rehabilitation Act will entitle many more persons than formerly to the rehabilitation benefits offered by these cooperative units. Consequently, the services of vocational rehabilitation counselors and the institution's affiliated treatment personnel will need to be utilized with maximum efficiency if all eligible clients are to be adequately served.

Because of the unquestioned value to be realized from these vocational rehabilitation programs and the opportunities they offer public offenders to become taxpayers instead of tax consumers, it is strongly recommended that:

VOCATIONAL REHABILITATION PROGRAMS AND FACILITIES AT THE CORRECTIONAL INSTITUTIONS BE SUPPORTED IN A WAY THAT WILL PERMIT THEIR NECESSARY EXPANSION, AND FURTHER, THAT A SPECIALIST BE EMPLOYED WITH FULL TIME RESPONSIBILITY FOR THEIR COORDINATION AND PROGRAMMING.

Probation-Parole Services

At any one time, Maine has more than 2,500 men, women and youth on probation or parole from the state-operated institutions alone. The officers responsible for supervising these persons and effecting their reintegration into society are faced with manifold problems, not the least of which are too-large case loads, long hours, and low pay. Yet probation-parole services, because of their community orientation, can be a most effective rehabilitation tool and also a comparatively economical one. In 1967 the average per capita cost of maintaing a prisoner at Thomaston was $2,327. The state's average per capita costs for its probationers-parolees, on the other hand, was only $168, or one-thirteenth the cost of incarceration. This differential is a factor which should be seriously considered when planning an economical and effective program of corrections Since probation-parole activities are community-based, the foregoing discussion pertaining to community resources is particularly applicable to these vitally important needs:

PROBATION-PAROLE OFFICERS SHOULD HAVE ACCESS TO SUFFICIENT CASE SERVICE FUNDS TO MEET THE REHABILITATION NEEDS OF THEIR CLIENTS.

THERE IS IMMEDIATE NEED FOR AT LEAST FOUR MORE OFFICERS, TWO MEN AND TWO WOMEN, FOR GENERAL SUPERVISION AND COMMUNITY ADJUSTMENT.

BECAUSE OF THE DIFFICULTY ENCOUNTERED IN FINDING JOBS FOR PROBATIONERS AND PAROLEES, DISTRICT OFFICES IN PORTLAND, AUGUSTA AND BANGOR SHOULD INCLUDE ON THEIR STAFFS AT LEAST ONE PROBATION-PAROLE OFFICER WITH PRIME RESPONSIBILITY FOR ESTABLISHING CONTACTS LEADING TO JOB PLACEMENT THROUGH THE EMPLOYMENT SECURITY COMMISSION, MAKING FULL USE OF EVALUATION, TRAINING, PLACEMENT AND FOLLOW-UP SERVICES.

AN OFFICER SHOULD BE EMPLOYED BY THE CENTRAL PROBATION-PAROLE OFFICE WITH RESPONSIBILITY FOR RESEARCH AND PERSONNEL TRAINING.

Before and After-Care for Juveniles

With more than 500 juveniles on probation or entrustment at all times, it is clear that these services must be strengthened.

AT LEAST ONE OFFICER, WITH RESPONSIBILITY FOR JUVENILES ONLY, SHOULD BE ASSIGNED TO EACH OF THE FOLLOWING AREAS: LEWISTON-AUBURN: AUGUSTA-WATERVILLE: BANGOR-BREWER-OLD TOWN: AND AROOSTOOK COUNTY.

IT CANNOT BE OVERLY STRESSED THAT MORE COMPREHENSIVE AFTER-CARE SERVICES MUST BE AVAILABLE TO BOTH GIRLS AND BOYS, WITH THE SAME PROVISIONS, BY THE SAME AGENCY, BEING FURNISHED TO BOTH.

Supervised Treatment Within the Community Setting

One of the major benefits of the proposed Diagnostic and Evaluation Centers is that they would permit a large number of adult and juvenile offenders to be placed in a supervised probation program consisting of needed rehabilitation services within the community, hence giving the courts or the Bureau of Corrections an additional alternative to the traditional choice between costly incarceration or standard probation.

As Miss Murphy points out in her report: At the present time there are too many admissions to our juvenile institutions which could have been successfully treated in the community. The initial diagnostic work-up of a committed child could avoid actual commission to a training center if it were not necessary. (Institutional care is by far the most expensive form of treatment possible.) (43, p.14)

MORE EMPHASIS SHOULD BE GIVEN TO THE DEVELOPMENT OF SUPERVISED TREATMENT PROGRAMS WITHIN THE COMMUNITY, AND CONVICTED OFFENDERS SHOULD HAVE ACCESS TO THE VOCATIONAL, EDUCATIONAL, PSYCHOLOGICAL, MEDICAL, SOCIAL, AND PSYCHIATRIC SERVICES NECESSARY FOR THEIR REHABILITATION.

Female Offenders

The following recommendations concerning female offenders were developed by the committee and legislation has been introduced in the 104th Legislature to implement them:

THE WOMEN'S CORRECTIONAL CENTER AND THE STEVENS SCHOOL SHOULD BE MERGED ON A SINGLE CAMPUS.

WOMEN SENTENCED TO THE MAINE STATE PRISON SHOULD BE PROVIDED FOR UNDER AN INTERSTATE COMPACT.

1. A single female correctional center would require adequate separation of girls and young women from the more mature, the tractable from the problem case, and careful screening prior to decision making regarding treatment plans and housing.

With personnel costs making up about three-fourths of these institution's budget requests, the proposed merger would help to avoid duplication. A number of services such as plant maintenance, purchasing, business office operation, stores, laundry, and overall administration could be provided at less expense by a single facility. It is recognized, however, that the combined facility is feasible only to the extent that it results in improved rehabilitation services.

2. For many years now, the state prison in Thomaston has had no accomodations for women and those who receive prison sentences are committed to the Women's Correctional Center. (Legislation permitting this transfer was enacted in the 1930's) Fewer than 7% of admissions to the Center are State Prison sentences and it is felt that this group can best be provided for under an interstate compact. The proposed transfer to a more adequate facility would effect savings for the state, and enhance the feasibility of a combined correctional unit.

The County Jails

The committee's report cites the fact that while the state institutions have adopted reforms which justify to some extent the use of the term "correctional", the county jails have remained just what they have always been, holding agencies and little else. There are no jails which offer rehabilitation programs. Reasons given for this include: (1) the small inmate population, (2) short sentences, and (3) uncertain length of stay. (Records for the Cumberland County Jail, for example, indicate that in 1967, 83% of the sentences were for one month or less, 87% were for two months or less, and 91% for three months or less. In York County, where the percentages were similar, only 13 of 146 sentenced prisoners were held for longer than three months. Many persons sentenced to the county jails are being held in lieu of bail, which in many cases is raised within a few days.) (34, p.15)

A high percentage of these commitments are individuals who have been sentenced previously for other offenses, often within the same year. The committee noted that "although the jail records do not state this specifically, it is known that of the more than 9,500 persons committed during 1967, a large percentage represented multiple commitments of probably many individuals...A reasonable estimate would be from one-half to two-thirds of the total, or from 4,700 to 6,270 persons. (34, p.3)

Considering the social problems which this situation engenders--the expense to the taxpayers and the fact that the earning ability and social adjustment of most of these persons is seriously curtailed by mental, physical, emotional, educational and socioeconomic handicaps--it is clear that rehabilitation efforts on behalf of this group are sorely needed. There is not much comfort in knowing that the most seriously limited of these individuals, through their repeatedly anti-social behabior, will eventually be sentenced to an institution where planned rehabilitation programs are now being developed; it would seem to be much the wiser course to apply rehabilitation measures before the situation becomes that acute. If the county jail is often the road leading to the correctional institution, it would be more profitable to see it also as the road leading back to society.

Among the committee's recommendations for improving the correctional status of the county jail system were the following:

GREATER USE SHOULD BE MADE OF THE WORK RELEASE STATUTE ENACTED BY THE 103RD LEGISLATURE.

It is recognized that sheriffs are handicapped in making good use of the work release provisions in several ways, not the least being the necessity to utilize inmate labor to reduce maintenance costs and lack of time to make contacts with potential employers. Further, it is apt to be those who least need rehabilitation, who have already acquired marketable skills, that are selected to participate in work release. Much more attention should be given to finding ways in which work release can contribute to the rehabilitation of vocationally handicapped inmates.

FAMILY AND JOB COUNSELING, SOCIAL CASEWORK SERVICES, REFERRAL TO AGENCIES FOR ADJUSTMENT, TRAINING, AND PLACEMENT, AND SIMILAR KINDS OF ASSISTANCE SHOULD BE AVAILABLE TO COUNTY JAIL INMATES BEGINNING DURING THE PERIOD OF CONFINEMENT AND CONTINUING AFTER RELEASE.

ATTENTION SHOULD BE GIVEN TO DEVELOPING COMMUNITY (VOLUNTEER) PROGRAMS DESIGNED TO HELP COUNTY JAIL INMATES SURMOUNT THEIR PERSONAL AND VOCATIONAL PROBLEMS AND TO PREVENT FURTHER RECURRENCE OF ANTISOCIAL BEHAVIOR.

A Regional County Jail System

With few exceptions, counties spend the barest minimum to maintain their jails, including the physical plant. Most of them (there are 14, with two serving two counties each) are so small that it is impossible to operate them properly or efficiently. Also, as we have noted, the cost of treatment programs for so small an inmate population, if it were to be included as part of the overall operating expense, would be prohibitive.

It is recommended, therefore, both in the interest of economy and the rehabilitation of offenders, that:

SERIOUS CONSIDERATION SHOULD BE GIVEN TO ESTABLISHING A STATE-WIDE SYSTEM OF REGIONAL JAILS.

The committee noted that the average daily cost per man in the four largest jails, which have an average daily count of 207, is $3.56, compared with $6.24 per man per day in the remaining ten, which have an average daily count of 111.

TRANSFER AND OTHER RECIPROCAL WORKING AGREEMENTS DESIGNED TO PROMOTE THE REHABILITATION OF INMATES SHOULD BE ARRANGED BETWEEN THE REGIONAL JAILS AND OTHER STATE INSTITUTIONS AND SERVICES.

Vocational, medical, or educational needs of individual inmates could in many instances be met by transferring the individual to a facility where he could receive the benefits of an already established program such as medical or psychiatric care, a work release program, sheltered workshop or halfway house.

3. ECONOMIC OPPORTUNITY PROGRAMS

The report on Economic Opportunity programs in Maine which contribute to the rehabilitation of the state's handicapped poor (29) is referred to previously in Section B-6, of this chapter. The following discussion of several of the more comprehensive services being operated by Maine's 16 Community Action programs and related projects which have been developed primarily under the auspices of the Economic Opportunity Act is taken from that report. It will be noted that most of these programs have a strong emphasis on overall family betterment, seeking first to identify the needs of impoverished families and then help them to develop a strategy for meeting family needs. Detailed discussion of services designed especially to aid disabled and other disadvantaged youth, including those sponsored by Economic Opportunity funds, will be found in Section C-7 of this chapter.

Representative Area Services (Family Centered)

a. Family Services Program (Franklin County Community Action, Strong, Maine). This program represents a concentrated attack on the causes of poverty in Franklin County and an attempt to upgrade the poverty-stricken by offering a wide range of family services. Included are adult education, vocational training, Neighborhood Youth Corps, Head Start, VISTA volunteers, a psychologist, and other components such as a babysitting service, family planning clinics, and home economics instructor.

b. Family Betterment Program (Central Community Council Office of Economic Opportunity, Dover-Foxcroft). An attempt to strike at the causes of poverty in Piscataquis County through education programs aimed at improving employability and economic and health conditions. Service extends to all ages, but is particularly geared to creating possibilities for employment and self-sufficiency.

c. Multi-Purpose Centers (Central Aroostook Action Program, Presque Isle). Four centers serve not only as educational and referral agencies but also as coordinating facilities for a number of component projects. These include a Work Experience program, area school for handicapped children, Neighborhood Youth Corps out-of-school program, senior citizens' program, manpower coordinator, social workers, and home economist. Recipients of services are encouraged to determine needs, with strong emphasis on manpower training programs.

d. Outreach (Androscoggin County Task Force on Social Action, Auburn). Emphasis here is on rural families, to provide opportunities and skills necessary for unemployed and underemployed rural residents to find employment that will enable them to move beyond a survival type of existence. The program is comprehensive, including recruitment, obtaining referrals for and coordinating with Neighborhood Youth Corps, Job Corps, basic adult education, vocational rehabilitation, Farmers Home Administration, Small Business Administration, all social service agencies, health agencies, and mental health agencies in the county.

e. Rural Outreach (Hancock County Opportunity Council, Ellsworth). Three offices staffed by volunteers and open five days a week on a half-day basis provide employment and training opportunities as well as an

extension of services to remote areas. Included are VISTA, Neighborhood Youth Corps, Upward Bound. Referrals are made to appropriate social service agencies.

f. Homemaker Services (Knox County Community Action Committee, Rockland). Seeks to reach the low income and disadvantaged families to encourage them to utilize more effectively the education, social welfare, vocational and cultural services available to them. It includes a homemaker supervisor and six homemakers. Individual conferences and group meetings are regularly scheduled.

g. New Channels (Merrymeeting Community Action, Bath). Three community workers, each having two assistants, chart the channels between those who need to be shown ways in which they can help. The prime objective is to bring resources to bear upon problems. Included are a citizens information center, transportation pools, on-the-job training, Apprenticeship Training, Manpower Training, Neighborhood Youth Corps, youth recreation, housing, and other components.

h. Community Aide (Penobscot Committee on Community Action, Bangor). Recruits, trains, and finds employment for low income persons who have been unable to find their proper level of employment. Job-oriented training, counseling, and placement, as well as adult basic education, are utilized. Trainees make group visits to industries and local businesses, and are briefed in other ways as to skills, requirements, and educational needs in reference to various kinds of employment opportunities.

The above is by no means intended as an exhaustive list of Community Action programs now under way in the state, but, rather, as an indication of how they are attempting to utilize community resources as a means of contributing to the total rehabilitation of needy persons in their respective regions.

Training and Employment Opportunities Available Through Economic Opportunity Programs

It will be evident from the brief descriptions of some typical family centered rehabilitation services that the majority of them have a strong vocational emphasis. Some other examples (and again, by no means an exhaustive list) of Economic Opportunity programs that can provide employment, or assist in finding employment for disadvantaged individuals including rehabilitated clients of the state office of public rehabilitation services are as follows:

a. Teacher Aides. Of the 16 Community Action programs in Maine, all have summer Head Start programs and all but one (Washington County) have year-around Head Start. All of them employ low income persons as teacher aides as well as in other areas of employment.

b. Community Aides. A Senior Service Corps, administered jointly by the Services of the Aging Unit in the Department of Health and Welfare and the State Office of Economic Opportunity, employ older citizens to perform a variety of duties including identification of disadvantaged elderly persons in the community, recruitment, transportation, and related

functions. Funds are provided through the Office of Economic Opportunity. Men and women in the program are paid $1.60 an hour and work 20 hours a week. A similar program co-sponsored by these two agencies employs disadvantaged persons over 55 years of age as aides in regional Community Action programs. Their salaries are paid by the Community Action office for which they work.

c. Training and Placement Programs for Mothers of Dependent Children. A training and placement program for mothers receiving Aid to Dependent Children in Cumberland, York, Knox, Androscoggin and Oxford Counties was recently conducted by the Office of Economic Opportunity in partnership with the Employment Security Commission and the Department of Health and Welfare. It is expected that these programs will continue to be scheduled.

d. Training and Placement Programs for Disadvantaged Youth. Examples of these are the Rural Youth Corps, Neighborhood Youth Corps, Upward Bound, as well as the Apprenticeship Training and Manpower Development and Training activities which are incorporated into many of the local Community Action Programs. (These programs for youth are discussed separately in Section C-9 of this chapter.

e. Information and Referral Assistance. VISTA volunteers, whose job is to seek out and give assistance to indigent families and individuals, are a primary source of information about handicapped and other disadvantaged persons in the community. They often make the initial contact, then bring these persons to the attention of agencies that can offer them the types of services they need. Maine now has 25 VISTA volunteers in the following locations:

Acadia Job Corps Center, Bar Harbor (2)
Augusta-Gardiner Area Community Council, Augusta (2)
Franklin County Community Action, Strong (1)
Northern Kennebec Valley Community Action Council, Waterville (2)
Occupational Training Center, Lewiston (3) (One is a speech therapist)
Old Town Indian Reservation, Old Town (2)
Oxford County Economic Opportunity Division, Norway (3)
Passamaquoddy Indian Reservation, Princeton (2)
Pleasant Point Indian Reservation (2)
Poland Spring Job Corps Center (1)
Portland Regional Opportunity Program (PROP), Portland (5)

Recommendations for Interagency Liaison with Economic Opportunity Programs

As already noted in Section B-6 of this chapter, the 1968 amendments to the federal Vocational Rehabilitation Act now authorize diagnostic and evaluation services to persons vocationally handicapped as a result of educational, cultural, environmental, and economic causes. As a result of these liberalized federal-state provisions, vocational and other rehabilitation agencies will find that an increasing percentage of their clients are those in this newly-accepted disability category. The great majority of them will be persons receiving, or at least entitled to receive, services available to the community under provisions of the Economic Opportunity Act.

To ensure that state and federal funds expended on these rehabilitation and social service programs are utilized with maximum economy and efficiency and that they contribute significantly to the rehabilitation process, it is recommended that:

CLOSE LIAISON BE ESTABLISHED AND MAINTAINED BETWEEN STATE AND LOCAL ECONOMIC OPPORTUNITY PROGRAMS AND THE STATE REHABILITATION AGENCY IN ORDER THAT A FUNCTIONAL SYSTEM OF IDENTIFICATION, REFERRAL, AND FOLLOW-UP BE IMPLEMENTED AS AN ESSENTIAL ASPECT IN THE REHABILITATION OF THESE CLIENTS.

Formal working agreements should be drawn up as a matter of standard procedure, with rehabilitation counselors taking responsibility for ensuring that disadvantaged persons who come to their attention are informed of Economic Opportunity programs which can help them and that these persons are brought to the attention of program directors, Head Start teachers, VISTA volunteers, and other Economic Opportunity and Community Action personnel. Similar working relationships should be adopted by these personnel in regard to services available through the state rehabilitation agency.

In view of the potential usefulness of VISTA volunteers in the total rehabilitation process, it is recommended further that:

VISTA PROJECT DIRECTORS SHOULD ASSIST THEIR VOLUNTEERS IN BECOMING FAMILIAR WITH SERVICES PROVIDED BY THE PUBLIC REHABILITATION AGENCY AND SHOULD ENCOURAGE THEM TO REPORT ALL CASES WHOM THEY BELIEVE MAY BE ELIGIBLE TO THE REHABILITATION COUNSELORS IN THEIR REGION.

In reviewing Economic Opportunity programs as they relate to other public rehabilitation services, the Commission noted that:

> Good cooperation and some degree of coordination appears to exist at the top administrative level among the Divisions of Vocational Rehabilitation and Eye Care and Special Services, the Employment Security Commission, Department of Health and Welfare, Bureau of Apprenticeship and Training, and Department of Education (Neighborhood Youth Corps, Special Education of Handicapped Children, Manpower Development and Training, Bureau of Vocational and Technical Education.)
>
> There is some question, however, if this filters down to the lower echelons; in other words, though good relations exist administratively, it is felt that a better definition of working policies among these agencies on the functional, local level, utilizing standardized working procedures and the team approach to solving individual and family problems, would greatly enhance the total rehabilitation effort. (29, p. 7)

Accordingly, it is recommended that:

DEFINITIONS OF SERVICE SHOULD BE EXPANDED AND A TEAM APPROACH TO THE TOTAL REHABILITATION OF DISADVANTAGED CLIENTS SHOULD BE ADOPTED BY ALL SERVICE AGENCIES THAT CAN CONTRIBUTE TO THE REHABILITATION PROCESS.

Specifically, the Commission recommends that:

REGIONAL EMPLOYMENT OFFICES SHOULD ADOPT A SYSTEMATIC APPROACH TO INFORMING LOCAL REHABILITATION COUNSELORS, COMMUNITY ACTION DIRECTORS, AND SIMILAR PERSONNEL ABOUT POTENTIALLY ELIGIBLE INDIVIDUALS WHO ARE CLEARLY DISADVANTAGED AND WHO HAVE COME TO THEM SEEKING EMPLOYMENT ASSISTANCE.

Nearly all unemployed or underemployed persons seek help from their local employment offices before turning to other sources for aid. This is probably because these offices are better known and more visible and because they have less stigma of dependency associated with them.

Employment interviewers can quite easily ascertain the applicant's level of skills, present earning capacity, educational attainment, domestic problems, apparent disabilities, and other factors which might entitle the individual to rehabilitation and Community Action program benefits.

It is expected, also, that the Governor's Committee on Employment of the Handicapped, if revitalized and funded in accordance with the Commission's recommendation, can make a valuable contribution to the identification, referral, rehabilitation, and job placement of the vocationally disadvantaged in Maine.

4. FACILITIES AND WORKSHOPS

Throughout the planning period close coordination was maintained between the facilities and workshop project and the comprehensive statewide planning conducted by the Commission on Rehabilitation Needs. The Commission's executive director attended all Facilities Advisory Committee meetings; similarly, the facilities project director discussed his group's activities and findings at meeting of the Commission's task forces. The executive secretary of the Committee on Problems of the Mentally Retarded, the state mental health planner, and the executive director of the Health Facilities Planning Council are among the members of the Facilities Advisory Committee.

As an essential first step to developing recommendations, an inventory was made of workshops and rehabilitation facilities in Maine and of certain facilities outside the state which are currently used by public rehabilitation agencies.

The state was divided into five areas following the regional boundaries adopted by the Maine Committee on Problems of the Mentally Retarded. Each has a population center in which most rehabilitation facilities are located. These centers are also the transportation hubs for each area.

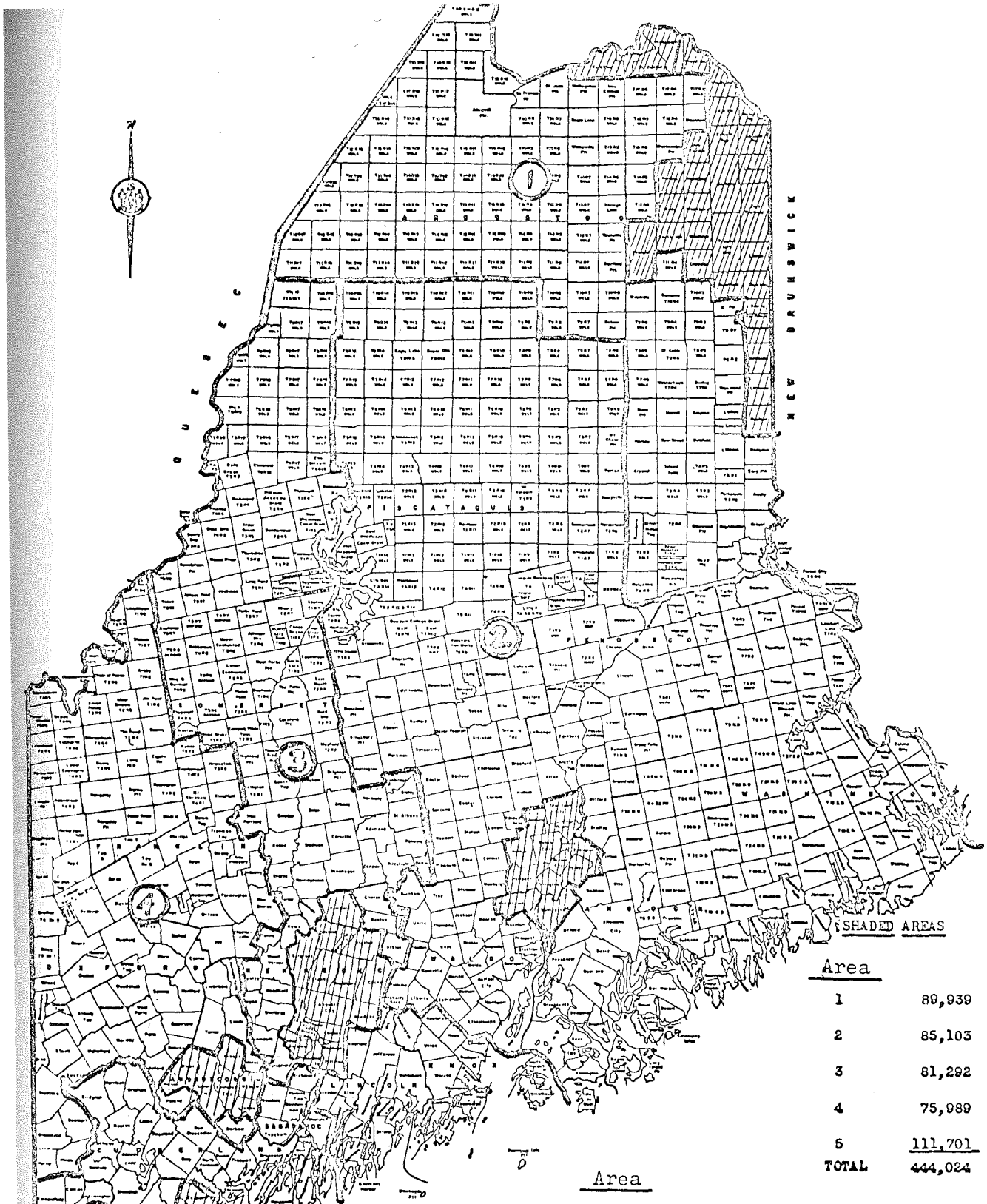
An evaluation, also by planning area, follows, together with a comparison between the inventory and present facility utilization. Needs for workshop and rehabilitation facility service, as seen by the Division of Vocational Rehabilitation, Division of Eye Care and Special Services, Committee on Problems of the Mentally Retarded, Mental Health Planning, needs for hospital rehabilitation facilities presented by the Health Facilities Planning Council, and the reports of task forces and special committees of the Commission on Rehabilitation Needs are outlined and discussed in a separate section of the Facilities Plan. (18, pp. 42-48)

From a review of these documents, verbal presentations at Facilities Advisory Committee meetings by representatives of the Commission, its task forces, and by personnel of the state rehabilitation agencies, as well as other knowledgeable persons, Committee members developed their own recommendations. These were subsequently reviewed by the full Facilities Advisory Committee, and priorities were established.

Listed as Priority One are those which the Committee believes are needed immediately and should be implemented during fiscal 1969. No further attempt is made within this priority grouping to designate any one need as having a higher priority than another.

Priorities 2 through 4 are those which should be developed by 1975. More exact time scheduling is considered to be of little value at this time: "If during fiscal 1969 the needs expressed as Priority 1 have been fulfilled, a more exact time schedule can be arrived at, based upon the experience gained during that period of time." (18, p. 48)

Since the recommendations presented in the Plan for Rehabilitation Facilities and Workshops were developed as an integral part of the statewide comprehensive planning project and with the full participation of the Commission and are so stated in this report. A map of the planning areas, (together with a list of existing facilities and a summary of recommendations and priorities) appears on the following pages.



SHADED AREAS

Area	
1	89,939
2	85,103
3	81,292
4	75,989
5	111,701
TOTAL	444,024

Population Estimates by County
July 1, 1963
STATE OF MAINE 982,000

Area	Cty. Code	County	1963 Population
1	02	Aroos.	104,300
2	11	Pis.	17,600
	10	Pen.	127,400
	15	Wash.	32,100
	05	Han.	32,600
	14	Waldo	22,800
		Total	232,700
3	13	Som.	40,300
	06	Ken.	89,000
	08	Linc.	18,700
	07	Knox	29,400
		Total	177,400
4	04	Frank.	20,300
	09	Oxford	44,000
	01	Andros.	89,800
		Total	154,100
5	03	Cumber.	187,700
	12	Sagad.	22,700
	16	York	103,100
		Total	313,500

REHABILITATION FACILITIES AND WORKSHOPS PLAN

S U M M A R Y

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Medical Rehabilitation Services presently available.

Area 1.- Presque Isle

Cary Memorial Hospital	Physical therapy	Caribou

Area 2.--Bangor

Eastern Maine General Hospital	Amputee clinic, Physical therapy	Bangor
Maine Coast Memorial Hospital	Physical therapy	Ellsworth
J. A. Taylor Osteopathic Hospital	Physical therapy	Bangor

Area 3.- Augusta

Augusta General Hospital	Physical therapy, Physiatrist	Augusta
St. Andrews Hospital	Physical therapy	Boothbay Harbor
Thayer Hospital - Mansfield Clinic	Comprehensive medical rehabilitation	Waterville
VA Hospital Togus	Comprehensive medical rehabilitation for veterans	Chelsea

Area 4.- Lewiston

Central Maine General Hospital	Physical therapy, amputee clinic, Physiatrist	Lewiston
Rumford Community Hospital	Physical therapy	Rumford
St. Mary's General Hospital	Physical therapy	Lewiston

Area 5.- Portland

Bath Memorial Hospital	Physical therapy	Bath
Maine Medical Center-Hyde Rehabilitation Center	Comprehensive medical rehabilitation services	Portland
Mercy Hospital	Physical therapy, physiatrist	Portland
Osteopathic Hospital of Maine	Physical therapy, amputee clinic	Portland
Parkview Memorial Hospital	Physical therapy	Brunswick
Regional Memorial Hospital	Physical therapy	Brunswick
Webber Hospital	Physical therapy	Biddeford

Mental Health Services presently available.

Area 1. - Presque Isle

Aroostook Mental Health Clinic	Emotionally disturbed	(Community General Hospital)	Fort Fairfield
Houlton Mental Health Clinic	Emotionally disturbed	(Madigan Memorial Hospital)	Houlton

Area 2. - Bangor

Bangor State Hospital	Mentally ill, emotionally disturbed	Bangor
Eastern Maine Guidance Center	Emotional disorders	Bangor
Mt. Desert Island Child Guidance	Emotional disorders	Bar Harbor
Utterback Private Hospital	Mental disorders	Bangor

Area 3. - Augusta

Augusta State Hospital	Mentally ill, emotionally disturbed		Augusta
Kennebec Mental Health Center	Emotionally disturbed	(Thayer Hospital)	Waterville

Area 4. - Lewiston

Child and Family Medical Health Services	Emotionally disturbed	Lewiston

Area 5. - Portland

Bath-Brunswick Mental Health	Emotionally disturbed		Bath & Brunswick
Mental Health Clinic	Emotionally disturbed	(Maine Medical Center)	Portland
Sweetser Home	Emotionally disturbed child		Saco

Other Rehabilitation Services presently available

Area 1. - Presque Isle

Opportunity Training Center		Presque Isle

Area 2. - Bangor

Bangor Regional Speech & Hearing Center	Speech and Hearing therapy	Bangor
Eastern Maine Friends of Retarded Children	Work Activity Center, School for retarded	Brewer
United CP of Northeastern Maine	School for physically handicapped child	Bangor
Little Red School House & Training Center	Work activity center, school for retarded	Dover-Foxcroft
University of Maine Speech & Hearing Center	Speech & Hearing therapy, teaching clinic	Orono

Area 3. - Augusta

Cerebral Palsy School	School for orthopedically deformed	Augusta

Area 4. - Lewiston

Lewiston-Auburn Occupational Training Center	Evaluation, work adjustment, workshop	Lewiston

Area 5. - Portland

Governor Baxter School for Deaf	Residential school for the deaf	Falmouth Foreside
Maine Institution for the Blind	Sheltered workshop for blind	Portland
Northeast Speech and Hearing	Speech & hearing therapy, pre-school training for deaf	Portland
Pine Tree Society for Crippled Children	Speech & Hearing therapy	Bath
Portland Goodwill Industries	Work adjustment training, sheltered workshop	Portland
Pride Training School	School for retarded of all ages	South Portland
Work Adjustment Center	Evaluation, work adjustment training, workshop	Portland

SUMMARY OF NEEDS AND PRIORITIES

1. Develop a residential Comprehensive Rehabilitation Center for Statewide use. (Priority 1)

2. Develop a Diagnostic Center for criminal offenders. One center to serve entire state. (Priority 1)

3. Establish (or expand) vocational adjustment/sheltered employment facilities.

Location	Area 2	Area 4 Expand	Area 5 Expand	Area 1	Area 3
Priority	1	1	1	2	3

4. Develop Satellite workshops in all areas.

Location	Area 5	Area 4	Area 2	Area 3	Area 1
Priority	2	3	3	4	4

5. Expanded vocational rehabilitation services in general hospitals.

Location	Area 5	Area 3	Area 2	Area 4	Area 1
Priority	1	2	1	3	4

6. Develop half-way houses for female public offenders.

Location	Area 5	Area 2
Priority	1	2

7. Develop half-way houses for male public offenders.

Location	Area 5	Area 4
Priority	1	2

8. Develop half-way houses for male alcoholics.

Location	Area 5
Priority	1

Priority 1

a. In Medical Rehabilitation

PLAN FOR THE ESTABLISHMENT OF A COMPREHENSIVE REHABILITATION CENTER IN THE GREATER PORTLAND AREA TO BE LOCATED AT, OR ADJACENT TO, A MAJOR MEDICAL FACILITY HAVING A WIDE RANGE OF MEDICAL REHABILITATION SERVICES.

This is a long range goal, but is considered to be the state's greatest facilities need. The Center should be fully equipped and staffed to provide an integrated and coordinated service directed toward the physical, emotional, mental, social, and vocational restoration and adjustment of each individual client. The multi disciplinary approach should extend to public and private agencies located either within the Center complex or in proximity to it.

The Center should function as the hub of a statewide regionalized network of integrated rehabilitation services. These regional services should extend their sphere of influence to include the community hospitals, nursing home facilities, and local branches of other public and private community health services.

OTHER KEY AREAS IN THE STATE (SPECIFIED IN THE COMPREHENSIVE PLAN FOR MEDICAL REHABILITATION SERVICES) SHOULD BE ENCOURAGED TO DEVELOP THEIR MEDICAL REHABILITATION PROGRAMS.

Development of medical rehabilitation facilities is under the direction of the Health Facilities Planning Council. This group, along with the task force subcommittee that prepared the Commission's plan for a statewide regionalized network of medical rehabilitation facilities and services, believes that first priority should be given to the expansion of medical rehabilitation services in the Bangor-Brewer area. (See discussion of the proposed regional plan for medical rehabilitation services in Section B of this chapter.)

b. In Vocational Rehabilitation

A HOSPITAL IN THE BANGOR-BREWER AREA SHOULD EXPAND ITS REHABILITATION FUNCTION TO INCLUDE VOCATIONAL EVALUATION AND TRAINING, ESPECIALLY IN ITS "HOSPITAL INDUSTRIES."

In addition to medically oriented service, key hospitals should develop vocational evaluation, training, and placement programs in cooperation with the appropriate state agencies.

A VOCATIONAL ADJUSTMENT/SHELTERED EMPLOYMENT FACILITY SHOULD BE ESTABLISHED IN THE BANGOR-BREWER AREA.

As soon as possible, facilities of this type should be developed in each of the key areas in the state, with the objective of offering vocational services that will enable clients to obtain remunerative employment, either in the labor market or in a sheltered environment. They should include vocational evaluation, work adjustment training, transitional employment, and long term sheltered employment. While specialized services for certain disability groups may be desirable at selected locations, as a general rule single disability facilities should not be encouraged. The services of specialists, such as mobility and braille instructors, should be available at each facility as required.

Too much emphasis cannot be given to the need for supervised domiciliary accomodations at or near selected facilities. Personal adjustment training is as much a part of total rehabilitation as the job skills that clients learn at the facility during the day.

DEVELOP A SYSTEM OF SATELLITE WORKSHOPS IN EACH REGION TO PROVIDE REMUNERATIVE EMPLOYMENT TO THE HANDICAPPED IN OUTLYING AREAS.

Initially these workshops would provide only employment, receiving supervision of the program and a major part of their work from the regional center. As these satellite workshops become more sophisticated, and as the need is shown to exist, they may be upgraded to include evaluation and any other services which may be indicated.

EXPAND SERVICES OFFERED AT THE LEWISTON-AUBURN OCCUPATIONAL TRAINING CENTER TO PROVIDE DOMICILIARY CARE.

EXPAND SERVICES OFFERED BY THE MERGING GOODWILL INDUSTRIES AND WORK ADJUSTMENT CENTER TO PROVIDE ADDITIONAL TRAINING AND DOMICILIARY CARE.

EXPAND REHABILITATION SERVICES AT A MAJOR MEDICAL CENTER IN THE GREATER PORTLAND AREA TO INCLUDE VOCATIONAL EVALUATION AND TRAINING IN THEIR "HOSPITAL INDUSTRIES."

In this way the Center would meet the need for a vocational adjustment/sheltered employment facility in this key region.

C. <u>In Correctional Rehabilitation</u>

ESTABLISH A MULTI-DISCIPLINARY DIAGNOSTIC AND TREATMENT CENTER FOR ADULT MALE PUBLIC OFFENDERS.

ESTABLISH A SIMILAR DIAGNOSTIC AND TREATMENT CENTER FOR JUVENILE PUBLIC OFFENDERS.

The purpose of these centers should be to permit specialists to arrive at a complete assessment of the individual's underlying problems, verify his handicapping conditions, supply short term therapeutic treatment, and recommend a plan to be followed that will facilitate his re-entry into the community. (See recommendation and supporting rationale in Section C-3 of this chapter - Correctional Rehabilitation.)

ESTABLISH A PRE-RELEASE CENTER FOR ADULT MALE OFFENDERS IN SOUTHERN MAINE.

The center should enlist the aid of public and private agencies, businessmen, lawyers, employers and other community volunteers to conduct classes and in other ways to implement the transition of offenders from institutional to community living. (See Section C-3)

ESTABLISH A PRE-RELEASE CENTER FOR FEMALE OFFENDERS

d. In Alcoholism Rehabilitation

ESTABLISH A HALFWAY HOUSE FOR MALE ALCOHOLICS IN PORTLAND

It is estimated that there are approximately 25,000 alcoholics in Maine. By Mental Health Center Areas, the distribution would be approximately as follows:

Area	1	2,800 alcoholics
	2	5,600
	3	4,300
	4	3,800
	5	8,000
		25,000

The Portland halfway house (there is also one in Bangor) is intended to provide supportive therapy and environment for those who require this kind of reinforcement. Programs are concerned with treating the whole person including his physical, social, and spiritual needs. For the handicapped homeless they provide transitional living arrangements until the individual is able to establish a living place of his own. Their principle function is to provide an adjustive melieu so that the individual is not required to step back immediately into the environment that contributed to the problem. Other halfway houses for alcoholics should be established in the near future.

Priority 2

a. In Vocational Rehabilitation

ESTABLISH A VOCATIONAL ADJUSTMENT/SHELTERED EMPLOYMENT FACILITY IN THE PRESQUE ISLE-CARIBOU AREA.

The Opportunity Training Center in Presque Isle, through a 1968 state referendum, has been voted additional state monies to expand its facilities This further development of the Center should ideally be in the direction of: (1) providing needed space for academic and vocational training activities so that larger numbers of students can be served, (2) providing supervised residential living quarters so that students from outlying areas may be accomodated, and (3) establishing a sheltered workshop for young adults needing both transitional and terminal employment.

A HOSPITAL IN THE KENNEBEC VALLEY REGION SHOULD EXPAND ITS REHABILITATION FUNCTION TO INCLUDE VOCATIONAL EVALUATION AND TRAINING, ESPECIALLY IN ITS "HOSPITAL INDUSTRIES."

As noted earlier, this area contains the Augusta-Gardiner-Waterville-Winslow-Fairfield complex and extends its influence a considerable distance into the surrounding region. Principally because Augusta, the state capitol, is headquarters for a great many state and regional services, the Kennebec Valley region is a major node within the statewide comprehensive rehabilitation plan. Medical rehabilitation programs are being developed, and there is a major mental health area center in Waterville.

DEVELOP A SATELLITE WORKSHOP IN THE BIDDEFORD-SACO AREA.

b. <u>In Correctional Rehabilitation</u>

ESTABLISH A HALFWAY HOUSE FOR FEMALE PUBLIC OFFENDERS IN THE BANGOR-BREWER AREA.

ESTABLISH A HALFWAY HOUSE FOR MALE PUBLIC OFFENDERS IN THE LEWISTON-AUBURN VICINITY.

This is seen as an extension of the pre-release center for male offenders, described earlier as one of those given first priority. It would function essentially the same as halfway houses for alcoholics, and would serve primarily those men who have been placed in employment in the quite heavily industrialized and expanding Lewiston-Auburn area, where a number of Manpower Development and Training programs have been established.

The halfway house concept is particularly applicable to the public offender, since it seeks to dispel the sense of alienation these people feel so intensely, and to break down the invisible barrier between this person and society, using the best available tools in a person-to person encounter. The transition from institutional living to community living may entail a formidable array of problems. If one has spent his last 5 to 10 years in a correctional institution, the return to the free community can be an unnerving and traumatic experience.

Priority 3

a. In Vocational Rehabilitation

A HOSPITAL IN THE LEWISTON-AUBURN AREA SHOULD EXPAND ITS REHABILITATION FUNCTION TO INCLUDE VOCATIONAL EVALUATION AND TRAINING, ESPECIALLY IN ITS "HOSPITAL INDUSTRIES."

ESTABLISH A VOCATIONAL ADJUSTMENT/SHELTERED EMPLOYMENT FACILITY IN THE KENNEBEC VALLEY REGION.

As noted earlier, this area because of its geographic and demographic characteristics is seen as a principal node within the statewide comprehensive rehabilitation complex and should be developed accordingly. Although a number of restorative services, public and private, are available in the Kennebec Valley region, structured vocational adjustment and sheltered employment programs for the handicapped do not currently exist.

DEVELOP A SYSTEM OF SATELLITE WORKSHOPS ASSOCIATED WITH THE LEWISTON-AUBURN OCCUPATIONAL TRAINING CENTER.

As noted, first priority has been given to the development of comprehensive training in the Lewiston-Auburn area, with an expanded residential Occupational Training Center assuming the role of a major facility. The satellite workshops should function as adjuncts of this program in order to extend its sphere of influence as needed.

ESTABLISH SATELLITE WORKSHOPS IN THE COASTAL AREA.

It is essential that more complete vocational adjustment and sheltered employment facilities be developed for the coastal region.

Priority 4

a. In Medical Rehabilitation

EXPAND MEDICAL REHABILITATION SERVICES AT A HOSPITAL IN THE PRESQUE-ISLE-CARIBOU AREA TO INCLUDE VOCATIONAL EVALUATION AND TRAINING, ESPECIALLY IN ITS "HOSPITAL INDUSTRIES."

b. In Vocational Rehabilitation

DEVELOP SATELLITE WORKSHOPS TO SERVE PERSONS IN OUTLYING AREAS OF SOMERSET, KENNEBEC AND LINCOLN COUNTIES. REMUNERATION SHOULD BE PROVIDED AS PART OF THE REHABILITATION PROGRAM, AND EMPHASIS SHOULD BE ON BOTH TRANSITIONAL AND TERMINAL TRAINING AND EMPLOYMENT.

DEVELOP SIMILAR SATELLITE WORKSHOPS TO SERVE DISABLED PERSON LIVING IN AROOSTOOK COUNTY. THESE SHOULD BE OPERATED AS EXTENSIONS OF THE REGIONAL FACILITY IN THE PRESQUE ISLE-CARIBOU AREA.

Some Observations Concerning Rehabilitation Facilities and Workshops Development in Maine (18, p.51)

1. Many handicapped persons live beyond commuting distance of current facilities and those envisioned for the major population centers (regional nodes). It is essential, therefore, that these regional centers be equipped to provide domiciliary care on a five-day week basis.

2. All speech and hearing clinics are operating at capacity and most have a long waiting list. Much of the state has no service. Generally, the shortage of trained therapists is a major contributing factor. Training programs should be expanded which would provide more qualified persons, and attempts should be made to attract more skilled persons to the state. (See specific recommendations in Section F-4 of this chapter - Personnel Recruitment, Training, and Utilization.)

3. Develop a public school speech and hearing therapy program to include (1) a school therapist for every 2,000 students and (2) hearing conservation classes in public schools located in central regional areas (See Section E of this chapter - Speech and Hearing).

4. One clinic to provide essential prosthetic and orthotic services should be developed in each regional area as an extension of the services available from the proposed Comprehensive Rehabilitation Center.

5. To the extent possible, and especially when planning for future needs, public agencies providing social services should be located in proximity to one another in order to improve coordination, referral, and client utilization.

6. Recognizing the need for more extensive and effective treatment programs in the area of alcoholic rehabilitation, it is recommended that: (1) those general hospitals which now have a policy of excluding such persons be encouraged to provide services whenever circumstances permit, and (2) that detoxification and intensive treatment centers utilizing recognized socio-medical techniques and supportive services be established in appropriate geographical locations in the state.

7. State sponsored mobile eye care and dental clinics should be initiated to serve such persons as the rural poor in the more isolated and sparsely populated areas of the state, and those, including city dwellers, for whom transportation in existing clinics is a problem.

8. Planning for rehabilitation services and facilities with the neighboring states of New Hampshire and Vermont has been of value and is progressing. Because of excellent transportation to Massachusetts, especially Boston, and the present use of Massachusetts facilities by all three states, it would be logical to include Massachusetts in the present interstate planning. All the possibilities inherent in this cooperative approach should be exploited, including shared use of facilities and services.

5. ARMED FORCES REJECTEE PROGRAM

In 1965, according to Maine Selective Service officials, 64% of those Maine men who had pre-induction physical examinations were rejected for military service. Forty-eight percent of them (or approximately 1,200) were rejected for one or more medical reasons. Since November 1965, 4,597 young men were interviewed by supervisors of the Armed Forces Rejectee Program (sponsored by the U.S. Public Health Service) which expired December 31, 1968 in Maine. An in-depth evaluation of this program was conducted by the State Department of Health and Welfare between January and March, 1969.

While nearly 1,300 of these young men were determined to be under medical care at the time of examination for the causes of rejection, members of the medical community indicated in many specific cases that individual counseling, relative to a variety of available resources, could have been beneficial to rejectees. In nearly 2,200 cases, rejectees were counseled and offered basic health services referral where it appeared desirable. Over 1,100 referrals to health resources were completed by program supervisors since November 1965. There is reason to believe that without the counseling and referral assistance, the 1,100 young Maine men would not have sought medical care for their disqualifying defects.

Nearly 25% of Maine rejectees were high school dropouts. Fifty percent were employed; only 10% of the total of medical rejectees indicated an interest in employment and/or vocational training.

Experience from three years of operating a health-oriented referral service demonstrated clearly the lack of knowledge on the part of most rejectees of the many community health, welfare, education and/or vocational rehabilitation resources which are available to help them function more effectively in accordance with their potential.

The greatest gap in programming appeared to be the neglect of those young men rejected from the Armed Forces by Selective Service System local boards because of physical defects so severe that medical advisors to the boards recommended rejection at the local level. The rejectees never appeared at the Armed Forces Enlistment and Examination Stations and consequently did not come in contact with the rejectee program supervisors. Here lies a vast reservoir of young men who could use services of counseling and referral to a variety of community resources.

The high percentage of Armed Forces medical rejectees in Maine indicates a definite need for this project to be integrated into the Maine Department of Health and Welfare's long-range programming. There would appear to be justification for continuing the project only as a health referral program; however, the need for providing comprehensive referral services (based on experience thus far) might well prove considerably more urgent and provide for a better use of public funds. It would also assure maximum effective utilization of all community resources by Maine youth rejected from the Armed Forces for medical reasons.

THE ARMED FORCES REJECTEE PROGRAM SHOULD BE REINSTATED AS A PERMA-

NENT PROJECT TO PROVIDE COMPREHENSIVE HEALTH REFERRALS AND COUNSEL-

ING SERVICES TO THOSE IN NEED, WITH SPECIAL EMPHASIS ON REFERRAL OF DISABLED REJECTEES TO THE APPROPRIATE SERVICES.

REJECTEES, WITH MEDICALLY IDENTIFIABLE CONDITIONS, WHO HAVE BEEN SCREENED AT THE LOCAL LEVEL SHOULD BE REFERRED DIRECTLY TO THE CENTRAL OFFICE SUPERVISORS OF THE ARMED FORCES REJECTEE PROGRAM.

Continuing development of this program should be based upon evaluation data relative to the following considerations:

1. What are the major kinds of disabilities of Armed Forces Rejectees in Maine?

2. How do these disabilities hinder preparation for entrance into or maintenance in the labor market?

3. To what extent has the program provided for preventative or restorative types of services as related to employment of the individuals involved?

4. What types of services have been rendered through the program to the sample involved?

5. What are the reactions of agencies and resources that have come in close contact with the Services to Armed Forces Rejectees to the program?

6. How does the cost of the program measure up against the benefits which accrue to the individual, the sponsoring agency and society?

7. What recommendations can be made as a result of periodic evaluation for optimum use of existing program staff?

6. PUBLIC ASSISTANCE - WELFARE REFORM

Long-needed reforms in the policy and administration of Maine's general assistance programs are incorporated in an important document now before the 104th Legislature. L.D. 918, Titled "An Act Relating to Welfare Assistance," reflects the major recommendations of a nonpartisan Citizens' Task Force on Intergovernmental Welfare Programs appointed by Gov. Kenneth M. Curtis in December 1967. The 35-member task force, assisted by the New York consulting firm of Community Research Associates, Inc., conducted a thorough study of State welfare programs and reported to the Governor, the legislators and the people of Maine in September 1968. (63)

The comprehensive program of welfare reform proposed by the task force is designed to realize the approximately $6,000,000 the State is currently losing in available Federal matching funds. The Governor has strongly endorsed this program, and provision for the cost of administration of the Act has been made in the Executive Budget. (8)

The Task Force's principal recommendation, which the Welfare Assistance Act is designed to implement, urges that the administration and funding of all general assistance programs be transferred from the municipalities to the state. As Governor Curtis, citing the Task Force study, noted in his special message to the Legislature:

> ...Under our present welfare system, the state administers the specialized programs of assistance to the Aged, Blind, Disabled and Families with Dependent Children, and the federal government shares the cost of these programs. The general assistance programs now administered by the municipalities are financed entirely from local property taxes and the state's general fund. The new arrangement would relieve the municipalities of the cost of general assistance programs.
>
> The present system, in addition to being costly for the municipalities, is also inequitable because of the absence of uniform standards for administration. Personal judgments of municipal officers, who must be concerned with the size of a town's relief appropriation, control the amount of payments to a poor family, rather than need.
>
> Despite often excellent local work, the present system tends to be inefficient, principally because of the archaic settlement laws. Hours and days are wasted in determining which town, if any, should pay for general assistance. Under a statewide program of general assistance, determing the municipality of settlement becomes irrelevant and the time saved can be put to other uses....The towns and cities have been working with an impossibly archaic system that should be replaced. The task force proposal is intended to correct this system. (8, pp. 4-5)

The 17th century settlement laws would be abolished by the proposed Welfare Assistance Act, but provision is made for the continuation of local services. The Commissioner of the Department of Health and Welfare, acting on the recommendation of municipal officers, would appoint a municipal

service officer to authorize emergency general assistance to families or individuals and to bring these cases to the attention of the Department of Health and Welfare staff. In this way the financial and administrative benefits of state responsibility would complement the maintainance of local services.

The Act also provides for the transfer of full-time municipal employees to the Department of Health and Welfare. (The Task Force reported that: "Out of the 496 local welfare offices, there are 20 municipalities which employ full-time welfare directors, and in the 20 offices are 14 social workers and 21 clerks...It is anticipated that a large majority of the 21 clerks would accept employment in a state district office... and that a total of 22 professional workers would probably accept state jobs.")

Liaison Between Planning for Rehabilitation and Social Welfare

From the time the Citizens' Task Force was first appointed and began its deliberations, the Commission on Rehabilitation Needs has had a particular interest in its ideological approach and in the task force findings and recommendations as they evolved. Six of the task force members also served concurrently as members of the Commission. Moreover, the ideological approach--" to make such recommendations as will stimulate maximum movement toward goals of prevention and rehabilitation" is recognizably the same for both planning groups. (63, p.4)

The following policy statement, adopted by the task force at its initial meeting, serves as the preamble to the revised welfare status:

It is the policy of this state:

1. That its social welfare program shall provide assistance, care and service to the persons of the state in need thereof and thereby promote the well-being of all the people of the state;

2. That it is the purpose of the social welfare laws to establish and support programs which contribute to the prevention of dependency and social maladjustment, as well as rehabilitative, preventive and protective services;

3. That assistance, care and service shall be administered promptly, with due regard for the preservation of family life, and without restriction of individual rights or discrimination on account of race, religion, political affiliation or place of residence within the State;

4. That assistance, care and service shall be so administered as to maintain and encourage dignity, self-respect and self-reliance. It is the legislative intent that financial assistance granted shall be adequate to maintain a reasonable standard of health and decency based on current cost of living indices;

5. That it is further declared to be the policy of this state to direct its efforts to the strengthening of family life for the care and protection of children; to assist and encourage the

use by any family of all available personal and community resources to this end; and to provide substitute care of children only when the family, with the use of resources available to it, is unable to provide the necessary care and protection to assure the rights of any child to sound health and normal physical, mental, spiritual and moral development;

6. That all legitimate advantage should be taken of federal funds available toward Maine's public welfare costs.

In conformance with the policy stated in these six points, current laws regarding welfare were reviewed and those found not to be in keeping have been amended or deleted. Accordingly, such antique provisions as the one which prohibits the auctioning off of paupers either for support or service were felt to no longer serve any useful purpose and are eliminated from the revised statutes.

In addition to the dominant emphasis on prevention and rehabilitation which has characterized the planning and recommendations of both groups, a number of other similarities may be cited:

--Provide equitable treatment to all persons in need, regardless of their place of residence, or other potentially discriminating factors.

--Eliminate costly and inefficient duplication between agencies, while encouraging more effective interagency cooperation.

--Ensure that full value is received for every tax dollar expended for rehabilitation and social services. One way of doing this is to appropriate sufficient state funds to obtain a larger share of all the federal monies to which Maine is entitled.

--Develop treatment plans for individuals and families based upon: (a) careful determination of the cause and extent of need, (b) knowledge of the full range of public and private resources available in the community, and (c) utilization of these resources in a coordinated manner through a cooperative team approach.

The Citizens' Task Force presents in its report of recommendations a table of ten governmental programs in Maine providing income maintenance assistance and preventive and rehabilitative services. These include Social Security programs, Economic Opportunity, Work Experience, Vocational Rehabilitation, Manpower Development and Training, and others. The table indicates that for a recent annual fiscal period there were 240,613 beneficiaries from these programs involving some $169,347,584.

GOVERNMENTAL PROGRAMS IN THE STATE OF MAINE PROVIDING INCOME MAINTENANCE, ASSISTANCE AND PREVENTIVE AND REHABILITATIVE SERVICES

Program	Number of Beneficiaries	Amount of Benefits Paid
Old-Age, Survivors & Disability Insurance (Social Security)	135,441	$113,374,728 *
Unemployment Compensation	28,352	7,726,370 **
State Welfare Assistance	34,120	32,499,334 +
Local general assistance	6,900	1,437,999 **
Economic Opportunity Programs	16,000	11,703,303 +
Title V Work Experience and Training Program	900	1,169,596 ***
Vocational Rehabilitation	1,246	535,755 +
Donated Commodity Program	14,203	410,499 +
Manpower Development and Training Act	2,392	1,250,000 **
Department of Indian Affairs	1,200	240,000 +
TOTALS	240,613	169,347,584

* For calendar year 1966

** For calendar year 1967

*** Allocated for fiscal year ending March 31, 1968

\+ Fiscal year ending June 30, 1967

In examining this table it should be noted: that these programs involve nearly 25% of the state's population; that it can be reasonably assumed that the 169 million is spent in Maine and, therefore, has a tremendous impact on the state's economy; and that if the full benefits of the programs are to be realized by Maine citizens, then all public welfare employees, including local welfare officers, must have knowledge of these resources and refer eligible persons to the appropriate programs.

Other Task Force Recommendations

In addition to its major recommendation, the Task Force on Intergovernmental Welfare Programs proposed a number of other measures which have the support of the Executive Department and have been incorporated in the Governor's Budget Document.

1. Administrative limits should be removed from Aid to Families with Dependent Children payments, enabling these payments to cover the full budgeted needs of recipients. Present limitations deny essential aid to many families in need, and must often be supplemented by local tax dollars. The report states: "There is no basis for exploring rehabilitative measures leading to self-support with a family trying to exist on a near-starvation level." (63, p.25)

2. Remove the requirement that municipalities share 18% of the cost of AFDC for settled cases. The Governor noted in his special message: "Abolition of the settlement laws, crucial to the whole scheme of welfare reform, requires this change, and it is another instance of state assumption of local costs."

3. Grant increased assistance to unemployed fathers and their families. Under existing law the federal government pays 69.92 cents of every dollar spent in this program. At the present time the number of families being assisted is severely limited, despite the fact that they comprise one-sixth of the general assistance caseload. If this aid were increased, the state would meet an urgent need, take advantage of available federal funds not now used, and provide an effective counter at any future period of economic recession.

4. The Department of Health and Welfare should explore ways of expanding the Food Stamp and Donated Commodities Programs. The food stamp program now operates only in Androscoggin County, and the donated commodities program now serves fewer than 15,000 people, largely because many municipalities are unable or unwilling to bear the administrative costs.

5. Expand the Medicaid plan (Title 19 of the Social Security Act) to include all the medically indigent. At the present time Maine's participation in Medicaid is limited to about 40,000 persons receiving federal categorical assistance. In addition to these, according to Department of Health and Welfare estimates, there are at least 150,000 other people who are medically indigent--unable to afford essential medical services.

6. Prescription drugs and dental care should be provided to welfare recipients eligible for Title 19 assistance. Costs of these are not met by the state's current Medicaid program, with the result that welfare recipients eligible for Title 19 assistance are forced to make an impossible choice between the purchase of necessary food or drugs.

Improved Organizational Structure for the Delivery of Social and Rehabilitation Services

It will be recognized that there are many similarities between the administrative changes proposed by the Task Force on Inter-governmental

Welfare Programs and those being urged by the Commission on Rehabilitation Needs. Both seek the placement of rehabilitation and social services within a truly functional administrative setting that will foster close working relationships among all the providers of these services, so that the total rehabilitation of families and individuals is achieved.

Both have structured their formal recommendations and the legislation proposed for implementing them in such a way that the state will be enabled to take maximum advantage of the legal and financial provisions available through recent changes in federal legislation, including amendments to the Vocational Rehabilitation and Social Security Acts. Also, they have been mindful of the recently liberalized and restructured administrative functions of federal agencies at both the national and regional levels, which permits a more integrated approach to the delivery of rehabilitation and social services than has heretofore been possible.

An example of this federal encouragement of a cooperative approach to the delivery of services is that State Plans for Assistance must now "provide that such services will be obtained from the State vocational rehabilitation agency when that agency is willing and able to provide them, and that such services will be purchased from another source only when they are not obtainable from the State vocational rehabilitation agency." (16, p.6)

Similarly, regulations relating to the Work Incentive Program (WIN), required by the federal government as a condition of its contribution to the AFDC program, provide that:

> All persons referred to the Work Incentive Program will be provided a prereferral medical examination to determine the individual's condition for participating in work and training activities, unless adequate information for this purpose is already available. States are urged to provide restorative medical services directly related to the participant's employability, utilizing all available resources such as the vocational rehabilitation and Title XIX programs...(16,p.6)

The means of implementing this provision here in Maine are spelled out in the revised State Vocational Rehabilitation Act proposed by the Commission and now pending action by the 104th Legislature. The task force and Governor Curtis have urged that the WIN program in Maine be fully implemented through state sharing of the administrative expenses for work training and placement programs operated by the Employment Security Commission. The federal government, as part of its overall national program, has allocated 400 work incentive training positions to Maine. In regard to the specific federal provision quoted above, a revised State Vocational Rehabilitation Act would extend evaluation and work adjustment services to additional disadvantaged persons.

In order to strengthen the administrative ties between rehabilitation agencies, the Commission has recommended, and legislation has been drafted which would transfer the Division of Vocational Rehabilitation, including its Disability Determination Unit, from the Department of Education to the Department of Health and Welfare. This "Act Relating to Reorganization and Revision of Public Rehabilitation Services" (L.D. 925) specifies the creation within the Department of Health and Welfare of a functional unit of rehabilitation services to be equal in administrative level and status

with the other major administrative units within the department.

Through such organizational changes as these, it is hoped that the delivery of rehabilitation and social services will be extended with greater efficiency and effectiveness to the many thousands of Maine persons now in need of them. With these needs in mind the Maine Conference of Social Welfare, representing some 100 social services agencies, resolved in September 1968 to commend, support and actively promote implementation of the recommendations of the Citizen's Task Force on Intergovernmental Welfare Programs and the recommendations of the Maine Commission on Rehabilitation Needs.

7. THE RURAL DISABLED

As other sections of this report have repeatedly emphasized, the incidence of vocationally handicapping conditions is far greater among the economically and socially disadvantaged than in the rest of the population, and that in fact a multiplicity of vocational impairments may be considered as this group's most predominant characteristic.

It is significant, then, that a high percentage of these individuals are to be found in the rural areas of the state. At the present time, Maine has some 50,000 persons living on farms--and many of these farm families are attempting to survive on incomes that permit only the most marginal level of existence. The 1960 Census showed that 40.5% of all Maine families residing in rural settings have incomes of less than $3,000 a year, compared with 17.7% with the same low incomes in the urban areas. Rural non-farm families with incomes under $3,000 comprised 27% of the total. (69, p.2) The same report from which these statistics are quoted indicates also that in Maine the unemployed are most often rural young people under the age of 25 who are also school dropouts.

For all of the rural disabled, and especially those of low socio-economic status, the scarcity of available rehabilitation and social services, and the long distances which in many parts of the state effectively isolate them from existing services, constitute formidable barriers to their rehabilitation. (Similarly, the long distances that counselors, social workers, and other personnel are required to travel in order to meet with clients substantially increase the cost and lessen the efficiency of the rehabilitation process.)

A great many Commission recommendations have been addressed to the problems of the rural disabled and involve the regional planning of rehabilitation services and facilities; additional staff including paraprofessional assistants and community aides; training and recruitment programs to alleviate the acute shortage of qualified rehabilitation personnel; sharing of regional services and facilities through formal interstate and international agreements; and the introduction of special techniques designed to improve the delivery of services to disabled and other disadvantaged persons in rural areas. Additionally, the Commission recommends that:

BETTER IDENTIFICATION AND REFERRAL PROCEDURES FOR THE RURAL DISABLED SHOULD BE DEVELOPED.

TRANSPORTATION PROGRAMS TO HELP THE RURAL DISABLED GET TO AND FROM PLACES OF EMPLOYMENT AND TO COMMUNITY SERVICES SHOULD BE RESEARCHED AND IMPLEMENTED.

CONTINUING ATTENTION SHOULD BE GIVEN TO THE EXTENDED UTILIZATION OF MODERN TECHNOLOGICAL SYSTEMS, I.E., CLOSED CIRCUIT TELEVISION, AS AN AID TO DIAGNOSIS, TREATMENT, AND COUNSELING.

Expansion of mental health services, both through the schools and the regional mental health programs have been emphasized in Sections B-4 and C-4 of this chapter along with the need to provide domiciliary accommodations at major rehabilitation facilities and sheltered workshops.

Employment opportunities for the rural disabled should be greatly improved and attention should be given to the possibility of helping low income families relocate in a different part of the state, when a job opening is available there that the family breadwinner would otherwise be unable to accept. This relocation and readjustment of the family would require the services of several public and private agencies, and in some instances financial assistance might be required, perhaps in the form of a relocation allotment.

Training and placement programs are needed for those whose skills have become obsolete or in other ways are inadequate to the demands of the current and future labor market. Sheltered workshops and manpower development and training programs such as the education, training and rehabilitation services provided by the Department of Health and Welfare can contribute to this effort, through a full-scale team approach by many different agencies will undoubtedly be required.

Governor Curtis, in his special message to the 104th Legislature on "Human Resources" gave special emphasis to the following program development needs which would extend more complete services to the rural disabled.

1. Expanded Work Incentive Programs to unemployed fathers, mothers, and young people 16 or older who are not in school, utilizing the full number of training positions allocated to Maine by the federal government for this purpose.

2. Allocation of state funds to the Department of Health and Welfare to maintain and develop homemaker programs.

3. Increased monthly payments for foster home care, with the possibility of higher payments for children with special problems.

4. Additional vocational rehabilitation counselor positions; also, funds to provide grants to communities that are developing vocational rehabilitation programs.

5. Permanent legal status for the Governor's Committee on Employment of the Handicapped.

6. An extensive capital improvements program for the Indian reservations--at Indian Island, Peter Dana Point and Pleasant Point reservations, construction of indoor and outdoor recreation facilities and extension of water and sewage facilities to accomodate new housing projects. At the Princeton Strip, extension of water and sewage facilities. At Pleasant Point, construction of four new classrooms; at Peter Dana Poing, one. These projects were described by the Governor as "basic, compelling needs which must be met.

8. SOCIAL SECURITY AND VOCATIONAL REHABILITATION

In its allied planning for social and rehabilitation services, the Citizen's Task Force on Intergovernmental Welfare Programs reported that during the 1966 calendar year, 135,441 persons in Maine received Social Security benefits including Old Age, Survivors, and Disability Insurance, in the amount of $113,374,728. This was considerably greater than the combined sum of all other government programs in Maine which provide income maintenance, assistance, and preventive and rehabilitation services. (63, p.10)

The original Social Security Act of 1935 and the many liberalized amendments to it which Congress has enacted since, has played a major role in the current social services revolution. Some of the provisions of this legislation have never been fully exploited by the State of Maine and there are still many thousands of Maine people who could benefit if they were.

The Commission has endorsed recommendations made by the Citizens' Task Force on Intergovernmental Welfare Programs concerning expansion of the state's Social Security provisions. (See discussion in Chapter IV, Section C-6) Additionally, the Commission recommends that:

ALL PUBLIC AGENCIES RESPONSIBLE FOR THE DELIVERY OF SOCIAL AND REHABILITATION SERVICES FUNDED JOINTLY BY THE STATE AND THE FEDERAL GOVERNMENT UNDER PROVISIONS OF THE SOCIAL SECURITY ACT SHOULD GIVE GREATER EMPHASIS TO COORDINATING THEIR ACTIVITIES IN ORDER TO REACH FAMILIES AND INDIVIDUALS IN ALL AREAS OF THEIR NEED AND TO FURTHER THEIR TOTAL REHABILITATION.

Legislation designed to implement this recommendation has been proposed by the Commission and is now pending action by the 104th Legislature. Legislative Document 925, "An Act Relating to Reorganization and Revision of Public Rehabilitation Services," emphasizes optimum utilization of federal assistance under the Vocational Rehabilitation Act and the Social Security Act in order to further the total rehabilitation objective. (1, p.9)

Disability Determination Unit

Responsibility for making determination is disability required under the Social Security Act and its amendments is a function of the Disability Determination Unit of the Division of Vocational Rehabilitation in the Department of Education. As specified in L.D. 925, the Commission recommends that:

THE DISABILITY DETERMINATION UNIT SHOULD BE TRANSFERRED FROM THE DEPARTMENT OF EDUCATION TO THE PROPOSED UNIT OF PUBLIC REHABILITATION SERVICES WITHIN THE DEPARTMENT OF HEALTH AND WELFARE.

The Commissioner of Health and Welfare would then become the authorized person under the Maine Revised Statutes to enter into agreement on behalf of the state, subject to the approval of the Governor and Council, with the designated federal officials to carry out the provisions of the Social Security Act relating to disability determinations.

9. DISABLED YOUTH

During the Commission's study no area was as comprehensively treated, or with as much concern, as the largely unmet need here in the state of improving the scope and quality of habilitation, rehabilitation, and social services for Maine's handicapped youth.

All of the task forces, consultants, special study committees, and members of the Policy Commission addressed themselves in varying degrees to this problem and as a result, recommendations with implications for disabled youth are to be found in nearly all sections of the final report. The present section, therefore, will be concerned only with those which pertain specifically to disabled youth; it will also present an overview of some of the major findings upon which they are based.

Some Major Recommendations for Services to Disabled Youth

The following recommendations have been adopted by the Commission to serve as guidelines for the coordination, development, improvement, and expansion of public and private services for handicapped children and youth:

EARLY REMEDIATION FOR HANDICAPPED CHILDREN, INCLUDING THOSE WITH PHYSICAL, MENTAL AND EMOTIONAL PROBLEMS, AS WELL AS THE CULTURALLY AND SOCIALLY DISADVANTEGED, SHOULD BE GIVEN GREATER ATTENTION BY ALL RESPONSIBLE AGENCIES, INCLUDING THE SCHOOLS.

THE DIVISION OF VOCATIONAL REHABILITATION SHOULD BROADEN THE SCOPE OF ITS SERVICES TO INCLUDE THOSE OF A PREVENTIVE NATURE, AND ALSO ITS CAPACITY TO MEET THE NEEDS OF HANDICAPPED CHILDREN, IN CONJUNCTION WITH OTHER CHILD-SERVING AGENCIES SUCH AS CHILD HEALTH SERVICES AND THE PINE TREE SOCIETY FOR CRIPPLED CHILDREN AND ADULTS.

VOCATIONAL REHABILITATION COUNSELORS SHOULD BE ASSIGNED TO MAJOR PUBLIC SCHOOL SYSTEMS AT THE SECONDARY SCHOOL LEVEL FOR THE PURPOSE OF DEVELOPING PREVOCATIONAL REHABILITATION PLANS FOR KNOWN HANDICAPPED YOUTH.

THE BUREAU OF GUIDANCE AND SPECIAL EDUCATION IN THE DEPARTMENT OF EDUCATION, THROUGH SPECIALISTS, SHOULD HAVE PRIMARY RESPONSIBILITY

FOR IDENTIFYING HANDICAPPED CHILDREN AT THE ELEMENTARY SCHOOL LEVEL AND FOR DEVELOPING LIAISON WITH REHABILITATION AGENCY SERVICES.

Estimates of Disabled Youth

As noted previously in Section A of this chapter, the Commission's two principal sources of information about the incidence and prevalence of handicapping conditions among the youth of Maine who are 17 years of age and younger were the data prepared by Harbridge House (13) and the study by a special consultant to the Commission, John Fahey. (14)

It is significant that the estimates presented in these studies are seen as conservative by their respective authors, and also that they differ in some important respects. These differences are noted in the Harbridge House report as follows (13, Element II - J-2):

1. The Fahey study's definition of 'handicapped youth' shows no strict correspondence of the status 'disabled' as a qualification for eligibility (for vocational rehabilitation services.) The report acknowledges this, noting that 'within the various categories of disabilities, some clients may be shown who might not require vocational rehabilitation services at a later time.'

2. The tendency of the Fahey report to overstate prevalence is counterbalanced by a severe problem of underreporting, since the tables in the Fahey report indicate only the number of Maine youth receiving services from one or more agencies. They do not indicate the number of Maine youth who may be in need of services.

3. Finally, the Fahey report data are available only for ages 8 to 18, an age grouping incompatible with our analysis. Definitions of condition categories are also at variance with our analysis.

Except for his estimates of emotional and behavioral problems among the state's school age population and among those 8 to 18 years of age who are confined in the state correctional institutions or on probation or parole, Fahey's nonduplicative name list of known handicapped clients is drawn exclusively from the case files of five public agencies and the public and private speech and hearing clinics. Agencies whose files he consulted in the Department of Health and Welfare were the Division of Child Health Services and the Division of Eye Care and Special Services; those in the Department of Education were the Bureau of Guidance and Special Education and the Division of Vocational Rehabilitation. Other records used were those of the private speech and hearing clinics.

In comparison, the Harbridge House estimates in this age grouping are for persons younger than 17 and are drawn from secondary sources, notably the National Health Survey conducted for the U.S. Public Health Service. Both Harbridge House and Fahey classified individuals according to their primary disability. In presenting his Disability Incidence Tables, Fahey called attention to the fact that in several instances the same subject was carried on the roles of more than one agency. In the Tables, however, no

client was recorded under more than one primary disability heading, regardless of the number of disabilities diagnosed.

The high incidence of multiple disabilities among handicapped youth was cited in both surveys. Harbridge House commented on a survey (45) which reported that 53% of a sampling of persons receiving Aid to the Permanently or Totally Disabled had a "secondary disability," while data on "tertiary disabilities" were not collected.

Harbridge House did not include in its estimates the institutionalized population, probationers, parolees, or persons disabled in other than a medical sense. It did, however, adopt the definition of disability as stated in the Federal Register: (15)

> 'Physical or mental disability' means a physical or mental condition which materially limits, contributes to limiting, or, if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by deviant social behavior, or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cultural, social, environmental, or other factors.

Partly as a result of these differences in methodology, definitions, and the age range of the population studied, Harbridge House estimated that in 1967 Maine had 13,541 young persons below the age of 17 who were physically or mentally handicapped, while Fahey's estimate for the same year of physically or mentally handicapped youth between the ages of 8 and 18 (5 to 18 in the estimates of those with emotional and/or behavioral disturbances) was 21,000.

In his nonduplicative name list of known cases, Fahey identified 6,070 young people (3,453 boys and 2,617 girls) as having a medically identifiable disability. Of these, mental retardation represented the largest disability group (25%), with orthopedic (23.9%) and cardiovascular disorders (17.3%) following. (Harbridge House estimated that about 50% of Maine's disabled under age 17 are disabled by reason of mental retardation, attributing the difference to the possibility that its own report "may represent the portion of the disabled not identified by Fahey; for example, those not in school and not being served by a state agency."

Additionally, Fahey, estimated that in the same year (1967) there were 14,498 school age children and youth handicapped by emotional disorders, or about 6.5% of that year's total school population of 223,430. He estimated further that 188 of the 373 young people 18 and under in the state correctional institutions were also handicapped by emotional disorders, and that 231 of the 920 in that age group then on probation or parole were similarly handicapped.

Both Harbridge House and Fahey found that with the exception of emotional disorders the three most common disabling conditions among Maine

youth were:

	Harbridge House	Fahey
Mental Retardation	7,203	1,519
Orthopedic Deformity	2,140	1,454
Cardiovascular Conditions	1,151	1,050

Fahey's disability summary of known cases in 12 categories appears on the following page.

DISABILITY SUMMARY - MAINE YOUTH (Ages 8-18)
Prepared by John J. Fahey - 1967

Sex	Age	Blindness	Visual Impairments	Impaired Hearing	Speech Impairments	Mental Retardation	Neurological	Muscular	Orthopedic	Amputees	Cardiovascular	Mental Illness	Physical Other
BOYS	8	1	4	15	19	48	15	14	91	0	67	2	23
	9	2	3	21	17	72	10	9	75	0	49	1	22
	10	1	6	18	18	90	6	10	59	1	60	0	16
	11	0	5	9	35	101	10	17	72	0	46	4	20
	12	7	6	13	19	114	10	10	65	3	55	5	18
	13	1	10	19	16	112	11	14	62	0	38	1	15
	14	3	3	9	11	110	9	23	51	1	51	1	16
	15	4	7	17	13	78	6	9	65	1	38	4	14
	16	4	11	14	17	59	12	23	51	1	49	4	15
	17	6	6	10	16	33	9	23	30	1	46	1	23
	18	3	11	31	21	88	16	39	91	4	67	10	24
	N/A	50	41	4	30	5	0	4	58	2	26	0	12
										TOTAL		3453	
GIRLS	8	0	3	6	15	37	3	20	82	1	35	1	16
	9	1	2	13	10	41	8	13	66	2	31	1	24
	10	0	3	17	17	51	5	16	65	2	44	0	16
	11	3	2	17	13	73	2	11	60	2	36	0	20
	12	3	3	13	13	94	8	14	66	0	36	1	19
	13	2	3	8	11	64	2	15	49	0	36	1	22
	14	1	3	10	12	59	4	17	40	2	40	0	15
	15	2	7	12	20	53	9	15	46	0	44	2	5
	16	2	1	8	11	42	4	21	54	2	41	2	10
	17	3	2	7	9	33	4	9	44	0	45	1	9
	18	3	6	29	15	55	10	26	61	4	48	6	30
	N/A	29	14	6	13	7	1	4	51	1	22	0	5
										TOTAL		2617	
Total		131	162	326	391	1519	174	376	1454	30	1050	48	409

GRAND TOTAL 6070

N/A = No age given

Emotionally Disturbed Youth

In his report, Fahey noted that "one can find research to substantiate claims of from 4 to 12 percent of the school population as being emotionally disturbed. (68) For the purpose of common understanding, he utilized the definition of emotional handicap as given by Bower: (5)

> ...children who demonstrate one or more of the following characteristics to a marked extent and over a period of time:
>
> 1. An inability to learn which cannot be explained by intellectual, sensory, or health factors.
>
> 2. An inability to build and maintain satisfactory interpersonal relationships with peers and teachers.
>
> 3. Inappropriate types of behavior or feelings under normal conditions.
>
> 4. A general, pervasive mood of unhappiness or depression.
>
> 5. A tendency to develop physical symptoms, pains or fears associated with personal or school problems.

Because screening procedures and other aspects of a program to identify emotionally disturbed children in school are not yet clearly defined and operating in Maine, Fahey developed a sampling procedure in his attempt to arrive at a realistic estimate. (14, p.20)

By projecting his sample estimates to the total number of children enrolled in Maine schools in 1967, Fahey arrived at the following:

Total School Population (Public)		Estimated Percentage Emot.Dist.	Estimated Number of School Population E.D.
Elementary	133,130	4%	5,325
Junior High	59,550	10%	5,955
Senior High	35,750	9%	3,218
	228,430		14,498

In contrast with the magnitude of the problem here cited, it is more than a little alarming to realize that at the present time Maine has but six certified elementary school guidance counselors and only two full time school psychologists. A program recently initiated by the Bureau of Guidance and Special Education is attempting to correct this deficiency by recruitment of a state supervisor for Education of Emotionally Distrubed Children.

A CLINICAL SCHOOL PSYCHOLOGIST SHOULD BE EMPLOYED BY THE BUREAU OF SPECIAL EDUCATION AS A CONSULTANT TO THE PUBLIC SCHOOLS TO ASSIST IN

IDENTIFYING EMOTIONALLY DISTURBED CHILDREN, REFERRING THEM TO THE PROPER COMMUNITY AGENCIES, AND HELPING ADMINISTRATIVE DISTRICTS TO SET UP SPECIAL CLASSES FOR THE EMOTIONALLY DISTURBED.

The Commission's recommendation which appears in Section B-4 of this chapter and proposes that regional mental health clinics share responsibility with the schools for the early detection and treatment of school children with emotional disorders also represents an attempt to alleviate this most serious situation.

Maine's failure to develop adequate mental health programs in the schools and to provide services to school children with emotional difficulties is already having profoundly serious consequences, as the large number of school dropouts, and young adults who are unemployed, underemployed, experiencing difficulties with the law, and creating other social problems, will readily indicate.

Because of the long-prevailing shortages of funds and staff, programs at the state correctional institutions are still largely custodial in nature and give far too little attention to the development of living and working skills. Another example of the way in which the state's shortcomings in this area affect young people is the fact that for the fiscal year ending June 30, 1967, 95 of the 185 commitments to the Men's Correctional Center in South Windham were 18 years of age or under, as were 11 of the 40 inmates at the Women's Correctional Center in Skowhegan; 136 of the inmates at the Maine State Prison, (about a third of the total prison population), were men 24 years of age and under. (14, pp. 21,23,55) (Recommendations in the area of correctional rehabilitation programs for youth will be found in Section C-2 of this chapter).

Fahey makes clear in his report that it matters little if the federal government is willing to subsidize vocational rehabilitation programs at the rate of four dollars for every state dollar expended if the state is unwilling to appropriate the dollar. Also, he points out:

> It is paradoxical, to say the least, that this state is able to keep accurate records of its citizens who are born and who die, but has been unable to establish a systematic recording of the handicapped...The state will have to identify its handicapped by means other than superimposing national norms over a nameless population if citizens and their representatives in the state legislature are to be made aware of existing needs. (14, pp.52,53)

Other problems cited by Fahey are:

a. Shortage of trained professional and para-professional personnel. "Training programs at the state university and especially at Farmington State College are of recent date and cannot be expected to solve our staffing problems in the near future. Our geographical location, the absence of graduate schools to meet present and future training needs, traditionally lower salaries--all point to the necessity of initiating and expanding

these training programs immediately to meet our needs." (14, p.53)

b. Insufficient funds to support preventive and habilitative programs for youth.

c. Lack of effective informational programs to counteract a generally prevailing apathy on the part of the taxpaying public.

Some Existing Rehabilitation Services for Youth, and Recommendations for Their Further Development

a. Division of Vocational Rehabilitation:

ESTABLISH CLOSER LIAISON WITH THE PUBLIC SCHOOLS THROUGH (A) ASSISTING IN EARLY DETECTION OF STUDENTS WHO HAVE IMPAIRMENTS, THEREBY MAKING IT POSSIBLE FOR SOME TO RECEIVE PREVENTIVE SERVICES AND AVOID THE NECESSITY FOR MORE COSTLY AND PROLONGED SERVICES LATER AND (B) COUNSELING AND OTHER REHABILITATION SERVICES FOR KNOWN HANDICAPPED STUDENTS.

(This latter is being well demonstrated in the Waterville area, where a Vocational Rehabilitation counselor is working with the Waterville, Oakland, Fairfield, and Winslow schools.)

b. State Department of Education

IMPROVE THE SCOPE AND QUALITY OF EDUCATIONAL AND VOCATIONAL TRAINING PROGRAMS FOR ALL HANDICAPPED YOUTH, INCLUDING THE PHYSICALLY, MENTALLY, AND EMOTIONALLY IMPAIRED, AND THE SOCIALLY AND CULTURALLY DISADVANTAGED.

Provision should be made for the employment, either on a full time or contractual basis, of greater numbers of trained personnel to work with school children. Urgently needed are psychologists; special teachers of handicapped children such as the retarded, speech handicapped, hard of hearing, emotionally disturbed and socially maladjusted, as well as children who are homebound; school counselors for both elementary and secondary grade levels; school nurses; school social workers; and other specialists required to meet the preventive and restorative needs of children in schools and training programs.

More adequate school programs for children with disabilities could forestall or preclude later needs. In too many cases we are postponing restoration with the result that more extensive and more expensive rehabilitation efforts are needed at a later date when the prognosis is not as good and remediation is more difficult.

IMPROVE THE QUALITY OF HEALTH INSTRUCTION IN THE PUBLIC SCHOOLS BY INSTITUTING A COMPREHENSIVE COURSE IN HEALTH EDUCATION AND CREATING THE POSITION OF HEALTH EDUCATOR IN THE DEPARTMENT OF EDUCATION'S DIVISION OF INSTRUCTION.

Efforts to prevent disability are at least as important as programs to alleviate the consequences of impairment. The objectives of this program should be to improve the health and safety attitudes of school children as well as their behavioral patterns. Among the duties of the Health Educator should be to work in the field of teacher preparation at the elementary, secondary and college levels, and in the area of in-service training, to improve instruction in sex education, drug and alcohol abuse, and the traditional areas of personal, physical, and mental hygiene. The Health Educator should also have a leadership role in recruiting the cooperation and support of volunteer agencies and local communities.

Regional Technical-Vocational Centers

The regional vocational and technical centers, seven of which are already operating here in Maine, with eight more expected to be in operation during the next two years, offer an exceptional opportunity for the evaluation, training, and placement of vocationally handicapped youth and young adults.

The stated purposes of these centers, authorized by state and federal legislation in 1965, has been to: (1) maintain, extend, and improve existing programs of vocational education, (2) develop new programs, and (3) provide more vocational education opportunities for persons of all ages in all communities. The regional center, therefore, is a comprehensive senior high school which offers vocational courses to local high school students and those from surrounding communities. It also provides vocational programs for adult workers presently employed who require new skills, or for those who need retraining for new job openings. The Commission recommends that:

PROGRAM DEVELOPMENT AT THE REGIONAL TECHNICAL-VOCATIONAL CENTERS BE EXPANDED TO INCLUDE COMPREHENSIVE VOCATIONAL REHABILITATION SERVICES TO DISABLED AND DISADVANTAGED YOUTH.

These should include work-study programs, on-the-job training, academic and vocational instruction and training for the physically handicapped and mentally retarded, and a team approach to providing these and related services should be employed. Use should be made of social case workers, medical and paramedical personnel, vocational rehabilitation and employment counselors, and others needed to provide a continuity of service ranging from referral, diagnosis, and evaluation, through personal and vocational counseling and job training, culminating in placement either in the competitive job market or in a sheltered environment.

Close working relationships should be established among responsible agencies such as the Bureaus of Vocational Education and Guidance and Special

Education in the Department of Education, the state rehabilitation agencies, Employment Security Commission, Health and Welfare programs, Bureau of Mental Health, and others which can contribute to the total effort.

In planning the physical facilities at the centers, attention should be given to the needs of the wheelchair confined and others with impaired mobility. Whenever possible the centers should be affiliated with sheltered workshops where the training and evaluation programs can be continued. In some areas where long distances and transportation prove to be barriers to the full utilization of the centers, domiciliary accommodations for students should be provided.

CONTINUE THE DEVELOPMENT AND FUNDING OF IN-SCHOOL AND OUT-OF-

SCHOOL NEIGHBORHOOD YOUTH CORPS PROGRAMS.

Under provisions of the Economic Opportunity Act, the Department of Education in cooperation with local school districts, is presently administering in-school Neighborhood Youth Corps programs for students at 103 high schools in the state. To implement this program the Department employs a full time project director and three full time area supervisors. During the current school year, 592 students have been able to earn $1.30 an hour for 10 hours of work per week.

Beginning this coming June, 100 high schools will continue their Neighborhood Youth Corps programs. It is anticipated that at least 800 job openings will be available to needy students during the summer vacation, permitting them to earn $1.40 an hour for 32 hours of work per week. (The out-of-school Neighborhood Youth Corps Program is discussed under Economic Opportunity and Community Action Programs later in this section.)

Operation PREP (Pupil Rehabilitative Education Project), Portland City School System

In the fall of 1968 a special project was launched by the Portland City School System which already has demonstrated success in the emotional and behavioral adjustment of disturbed young teenagers. This federally funded program has the following objectives:

(1) To provide a remedial education program for young people at the junior high school level who are experiencing emotional and/or behavioral problems and who may also have some degree of mental retardation,

(2) To effect sufficient change in the attitudes, behavior, and scholastic achievement of these pupils to permit them to be reintegrated into the regular junior high school program or to enter high school,

(3) To utilize a battery of therapeutic adjustment services including physical and psychological work-ups, intensive counseling with pupils and parents, social case work, and prevocational training and work adjustment services.

The low pupil-teacher ratio (four specially trained teachers for the current enrollment of 29 youngsters) enables each pupil to receive much more individualized attention than would be possible in the regular classroom. The teachers, as well as the project director, can, and do, provide intensive counseling to pupils and their parents, under the supervision of a psychologist from the Maine Medical Mental Health Center. The project also employs a full time social worker and other part-time professional and paraprofessional personnel, including community volunteers.

Pupils may be referred by any junior high school in the Portland school system, or by the Boys Training Center in South Portland or the Stevens School for Girls in Hallowell. The current ratio is four boys to one girl, all of them between the ages of 14 and 16 (average age is 15.6).

The present program calls for classroom instruction during the morning, and enrichment programs including field trips, recreational activities, and prevocational training and adjustment during the afternoon. The community volunteers and paraprofessional personnel play an especially important role in these afternoon activities.

An important feature of Operation PREP is its emphasis on continuing in-service training for teachers and other program participants, under the guidance of trained rehabilitation specialists. The project team addresses itself collectively to each child's individual problems, in a concerted effort to help solve these problems sufficiently to enable the youngster to remain in school and hopefully to enter the regular high school. Enrollees may, upon successful achievement, return to their regular junior high class during the school year, but more often they remain in the PREP program for the full year and, with satisfactory performance, receive academic credit for grade completion. A close affiliation exists between the program and the regional mental health center, so that children and their parents who need the services available at the center may receive them.

Vocational training and adjustment, both in its economic and overall educational aspects, is given strong emphasis, with the result that 9 of the enrollees are now employed after school in part time jobs. Additional efforts are being made to link the program to those sponsored by such agencies as the Employment Security Commission, Neighborhood Youth Corps, Community Action projects, and local civic groups.

Operation PREP is one of the most promising attempts yet undertaken in Maine to meet the needs of emotionally and behaviorally disturbed young people. The Commission therefore recommends that:

OPERATION PREP SHOULD BE CONTINUED FOR ANOTHER YEAR, AND THAT RE-

APPLICATION BE MADE TO THE FEDERAL GOVERNMENT FOR AN ADDITIONAL GRANT

TO MAKE THIS POSSIBLE.

C. Economic Opportunity and Community Action Programs

Out-of-School Neighborhood Youth Corps

At the present time, 7 Community Action Programs in the state are

conducting out-of-school Neighborhood Youth Corps programs for school dropouts and other young people between the ages of 16 and 21 (inclusive) who have been unable to find other employment. Each enrollee works 32 hours a week at the hourly rate of $1.30. Location of these programs and numbers of enrollees are as follows:

Community Action Program	Job Slots	
Augusta-Gardiner	17	
Hancock County	22	
Portland Regional Opportunity	82	
Waldo County	37	
Androscoggin County	34	
Knox County	16	
Franklin County	14	
	222	Total

Upward Bound

Upward Bound programs designed to help promising high school students cast off the shackles of cultural and social deprivation and realize their innate capacities for self-fulfillment are being conducted successfully at the University of Maine, Bowdoin College, and Gorham State College. Intensive summer sessions at these campuses give high school students with good, but generally unrecognized academic and vocational potential an opportunity to participate in a college-level academic and social setting in order to experience for themselves what college can offer them, and to receive help in formulating realistic objectives. Stimulation is provided in the form of academic, social, cultural, and recreational activities, with academic guidance and personal counseling in both individual and group situations built into the program as an integrated, ongoing function. Medical and dental services are also provided, and students receive a stipend during the time they are in residence.

Follow-up activities involving the student, his parents, teachers, principal, guidance counselor and others extend the evaluation process into the ensuing school year. The project directors at Bowdoin and the University of Maine do this on a somewhat informal basis. Gorham has given considerably more emphasis to this aspect of the program, and employs a full time counselor for this purpose. The Commission recommends that:

COLLEGES AND COMMUNITY ACTION AGENCIES SHOULD MAKE GREATER EFFORTS TO INCREASE THE NUMBER OF ELIGIBLE YOUNG ADULTS ENROLLED IN UPWARD BOUND PROGRAMS, AND SHOULD COORDINATE THEIR PROGRAMMING WITH PUBLIC VOCATIONAL REHABILITATION SERVICES.

On all three campuses the enrollment has been growing, as indicated by the following figures:

	1968	1969
Gorham State College	60	68
University of Maine	55	60
Bowdoin College	44	65

School year follow-up:	1968-69	1969-70
Gorham State College	48	60

Work Study

Through cooperative arrangements between public and private colleges and Economic Opportunity programs, promising young people handicapped by socioeconomic disadvantage are able to set their sights on college and pursue an academic career by working their own way. Typical on-campus jobs are dormitory and plant maintenance, food service, clerical work, library indexing, lab assistant and others. Off-campus employment, conducted under agreements with public and/or private nonprofit organizations, is in such areas as tutoring, youth work, recreation, community service trainees, etc.

College student aid directors, with assistance of Community Action Agencies, take responsibility for identifying eligible candidates, and also for handling much of the paper work, such as the processing of checks. During the academic year the college in which the student is enrolled assists him in finding part time employment related to his vocational objective (15 hours per week). This function is taken over by the sponsoring Community Action Program for the summer months, during which the student is employed full time. These provisions have made it possible for many capable young persons to enroll in college and prepare for professional careers who would never have been able to do so without this assistance.

Rural Youth Corps

The Rural Youth Corps organized in Maine in 1968 under the auspices of the State Office of Economic Opportunity and local Community Action agencies in Aroostook, Washington, Hancock, Piscataquis, and Somerset Counties, is providing an opportunity for rural youth in these counties to participate in the development of the social and economic life of their community and state.

A grant from the U.S. Department of Labor is being used to augment the organizational effort by providing training to rural youth from low income families who have demonstrated the potential to communicate and to work well with young people. Many are high school dropouts, and all have been disadvantaged in some way.

After completing an intensive one-month program in "Human Resources" at the University of Maine, trainees then serve as members of mobile teams, each headed by a professionally trained "coach," which assist in organizing local chapters and, for a period up to five months, gain valuable field experience in community organization and manpower services.

An important function of the mobile teams has been to work in the areas of recruitment and job development for youth, and to assist local young people in developing community projects which their new chapters can sponsor. Each chapter, though affiliated with the statewide program, is autonomous and selects its own projects. These have been directed in large part toward securing, and in some cases, building, Youth Centers to serve as a base of operations. At the present time the 16 local chapters are operating 8 Youth Centers, each of which is equipped with a library, study room, and other educational, social, and recreational facilities.

Activities conducted by the chapters are directed not only to the needs of teenage youth but to the elderly, children of school and preschool age, and other segments of the rural population. Reaching the dropout, tutoring students of all ages, conducting programs for needy children and the elderly, fund raising and recreational projects, helping to distribute commodities available through surplus food programs, are only a few of those undertaken thus far. The chapters also assist in projects of the local Community Action agency, such as self-help housing, referral services, and transporting low income persons and the elderly to clinics and other services.

Membership in the Corps chapters is open to all youth between the ages of 13 and 22, in or out of school. Since its inauguration a year ago, the program has expanded far beyond the bounds of the five counties where it was introduced, and local chapters are now being organized throughout the state. Its present membership of 1,000 young people is expected to double by June 1969.

In addition to providing leadership training for local youth and assisting them in developing service projects, the mobile teams have been concentrating on manpower development among the rural youth population, to help individuals acquire necessary skills that will lead to suitable employment. Trainees spend three days a week gaining field experience in manpower services by working in a variety of public and private non-profit social service agencies such as Community Action programs, Employment Security Offices, social welfare programs, and related activities. Two days a week is spent in organizing youth groups.

A mobile team may stay from three weeks to three months in an assigned area, working in surrounding towns which have expressed interest in forming a local chapter. In addition, each chapter may have one of its members trained and hired by the Employment Security Commission to work one afternoon a week providing job and training information to youth in the area. Local chapters may also arrange, through the Work Study program, to have college students do high school equivalency teaching for school dropouts.

After a period of five months in the field, trainees will be offered suitable jobs for which their training has prepared them, or helped to continue their formal education.

In order to generate more funds for needed staff and to expand its program to more youth, the Corps launched the "Thousand Dollar Club" in January 1969 as a means of gaining the support of citizens, business, and industry. The long range goal is $1 million, and donations of varying

amounts, from $1 dollar upwards, are being received regularly. The Corps director has pointed out that the original federal grants for the program were only for the five-county area, and that the time and resources of the five mobile teams now operating there are limited. It is hoped that through additional funding the program will be enabled to expand to all rural areas of the state.

One of the first state agencies to cooperate with the Corps was the Parks and Recreation Department, and a joint project to develop boating and picnic facilities at four lake sites was begun last fall. The Department of Health and Welfare, Eastern Maine Counseling Center, University of Maine Extension, and several other public and private agencies are also assisting in the development of job opportunities for rural youth and in joint-sponsored training and placement activities. The Employment Security Commission has been actively involved in all phases of the Corps' development, and in all areas the local Community Action agencies have been similarly involved. Projects being planned in cooperation with the Bureau of Mental Health include an in-service training and supervised work experience program for selected Corps members, who would then serve as indigenous mental health workers in their local communities. These Corps members would be trained to assist individuals in locating the services appropriate for their personal problem needs, assisting ex-state hospital patients in their return to the community, providing in-take services for mental health centers, and assisting in the prevention of hospitalization of the elderly.

A somewhat similar project is being undertaken cooperatively with the Services for Aging Unit of the Department of Health and Welfare. One objective will be to achieve closer coordination between the activities of the Senior Centers and Youth Centers in the state, so that each may supplement and reinforce the other. This will involve the extension and orderly development of services to the elderly which many of the chapters are now providing--transportation, regular visits and assistance to the elderly and shut-ins, checking their needs on a regular basis, assisting with an initiating recreation and social programs, and meeting individual needs as they arise.

- THE STATE OFFICE OF PUBLIC REHABILITATION SERVICES AND THE RURAL YOUTH CORPS SHOULD ESTABLISH CLOSER WORKING RELATIONSHIPS IN ORDER TO ENSURE THAT THE SERVICES AVAILABLE FROM BOTH AGENCIES ARE FULLY UTILIZED IN THE REHABILITATION OF THE DISADVANTAGED RURAL POPULATION.

The approach adopted by the Corps, which may perhaps be described as an effective kind of "grass roots 'Outreach'", has promising implications for the rehabilitation of Maine's rural handicapped youth, by providing them an opportunity, while helping themselves, to be of valuable service to others and to effect the overall improvement of their communities.

10. WORKMEN'S COMPENSATION

The Maine Workmen's Compensation Act, administered by the Maine Industrial Accident Commission, provides medical care and financial benefits for insured employees who sustain occupational injuries. Among its provisions are: (1) medical, surgical, and hospital services, (2) prosthetic and orthotic appliances, and (3) maintenance, in addition to the regular benefit payments, for board, room, transportation, etc., when these are required during the rehabilitation and retraining period.

Since August 1965, Maine has had a full-time vocational rehabilitation counselor as a staff member of the Industrial Accident Commission. He is responsible for administrative duties within the office and also makes contacts with injured workers in the field. Medical information is collected from the insurance carrier and personal data from the injured worker himself.

An "Insurance Carrier's Report on Rehabilitation" developed by the Industrial Accident Commission is now helping to identify persons who should be referred for rehabilitation services. Through this and other screening devices the counselor selects cases to be studied in more depth. The presence of this counselor-specialist within the Industrial Accident Commission has resulted in greatly improved communication and cooperation among the many persons and agencies including insurance carriers, physicians, industry representatives, and rehabilitation personnel all of whom are essential to the process of restoring disabled workers to productivity.

The Insurance Advisory Committee of the Maine Commission on Rehabilitation Needs has recommended that:

> REFERRAL, TREATMENT, AND RE-EMPLOYMENT PROCEDURES FOR OCCUPATIONALLY DISABLED WORKERS SHOULD CONTINUE TO BE IMPROVED THROUGH: (A) INSURANCE CARRIERS' MAINTAINING ACCURATE RECORDS OF CASES REVIEWED AS POSSIBLE REHABILITATION PROSPECTS, AND (B) RECEIVING FROM THE ATTENDING PHYSICIAN AN EARLY REPORT COVERING REHABILITATION OPINIONS AND PLANS.

Physicians are urged to acquaint themselves fully with the public and private resources which can assist in the restoration of disabled workers, and to take responsibility for assuring that prompt referrals are made.

In addition to making greater efforts to prevent accidents and illness and also to reduce the severity of these when they occur, employers and their representatives should become more knowledgeable about available rehabilitation services. Since workmen's compensation and group insurance claims must be signed by the authorized company agent, this person should be given the responsibility of discussing potential rehabilitation cases with insurance claims managers, the physician, and rehabilitation counselors.

Estimate of Employees Covered by Workmen's Compensation, 1966

Under present Maine law, employers with four or more employees must insure them for unemployment benefits. Workers employed by an individual or firm having four or more employees are also covered by the workmen's compensation law. The following estimates were taken from records of the Maine Employment Security Commission (1966). Included also are estimates of state and federal employees not covered by the state Employment Security Act but covered under the state and federal Workmen's Compensation Acts. (19, pp. 4-5)

	Work Force	Covered by Employment Sec. Law	Covered - Workmen's Comp.	Percent Employed Covered by Workmen's Comp.
Distribution:				
Agriculture	16,400	--	8,600	50
Non-Farm Self Emp.	40,900	--	--	--
Manufacturing	114,400	113,261	113,261	99
Construction	15,200	12,900	12,900	85
Transportation	16,900	12,159	12,159	72
Wholesale-Retail	57,700	50,096	50,096	87
Finance, Ins.,Real Est.	10,300	9,060	9,060	88
Service, Misc.Mfg.	35,000	15,021	15,021	43
Government	57,300	--	57,300	100
Total	364,100	212,497	278,397	76
Unemployed	16,100			
Total Work Force	380,200		278,397	73
Not Covered Work. Comp.	101,803			27

The uninsured group is made up largely of those in agriculture and lumbering, domestic employees, the self-employed, and persons working for employers with fewer than four employees.

The farm estimate of 50 percent is based on voluntary application for coverage. By act of the Canadian government, itinerant Canadian employees working in Maine must be covered, whereupon this coverage is usually extended also to Maine farm workers on farms that employ Canadian workers.

Of the 16,100 unemployed (as of the date of the report) due to layoffs or other circumstances, an estimated 50% were women.

The self-employed are for the most part repairmen, skilled carpenters, cabinet makers, gardeners, and so on. The uninsured (workmen's compensation) are in some instances covered by group insurance, but usually this coverage is limited and would not provide adequately either for physician's services or rehabilitation.

Liaison Between the Division of Vocational Rehabilitation and the Industrial Accident Commission

The Division of Vocational Rehabilitation has given its Augusta area supervisor the responsibility of periodically reviewing with the Industrial Accident Commission's rehabilitation counselor all cases which have been referred from the Commission.

This liaison is helping to identify the kinds of vocational rehabilitation services occupationally disabled individuals are entitled to, in order that the timely intervention of these services may be implemented.

Current Legislation

Two important bills have been introduced in the 104th Legislature which would extend unemployment and workmen's compensation benefits to all employees:

--L.D. 27, "An Act Relating to Applicability of Workmen's Compensation Law to Employers of One or More Employees", would remove the exemption for "private employers who employ three or less employees" and require that all regular employees be covered.

--L.D. 4, "An Act Relating to Definition of Employer Under Employment Security Law" would require that employers of one or more individuals on or after January 1, 1970, secure unemployment coverage for the employee or employees, thus removing the exemption for "employers of four or more individuals."

In addition to these measures, a bill was introduced which provides for the periodic review of a rehabilitation client's progress as follows:

--L.D. 656, "An Act Relating to Petitions for Review of Incapacity Under Workmen's Compensation Act," specifies that during the time compensation is being paid or vocational rehabilitation is being provided, the incapacity of the injured employee and the need or progress of vocational rehabilitation may be from time to time reviewed by a single commissioner upon the petition of either party on the grounds that the incapacity has subsequently increased, diminished or ended, or that the need to continue vocational rehabilitation has ended. It also provides that after compensation or vocational rehabilitation has been discontinued, the employee may file with the Industrial Accident Commission for further compensation or for vocational rehabilitation.

11. VOLUNTARY ORGANIZATIONS

Relationships with private and voluntary organizations have been established and strengthened in many ways throughout the planning project. One of the most effective links the Commission has had with these organizations has been through the membership affiliations of the many persons who served on the Policy Commission, the six regional task forces, and the study committees. The persons who have been actively engaged in the project hold membership in several of these, and quite often serve on a number of governing boards.

The Commission in its official capacity has worked closely with regional and statewide organizations and through these relations has been able to plan for a rehabilitation partnership between helping agencies both public and private. A partial listing of private and voluntary agencies with which this liaison has been maintained appears at the end of this section.

One of the most effective methods of working and planning cooperatively with voluntary organizations has been through their annual meetings. The Commission therefore recommends that:

VOLUNTARY ORGANIZATIONS WITH A CONTINUING INTEREST IN HANDICAPPED PERSONS SHOULD BE ENCOURAGED AND GIVEN ASSISTANCE IN UTILIZING PORTIONS OF THEIR ANNUAL MEETINGS FOR EDUCATIONAL PROGRAMS IN THE REHABILITATION PROCESS.

The Need for Information and Referral Services

The need for an efficient system of information and referral is the one most often cited by private and voluntary organizations. The Pine Tree Society for Crippled Children and Adults launched a pilot program in the fall of 1968 to determine the feasibility of a statewide information and referral service for the handicapped. Based upon the experience of this pilot program, the Commission has recommended the establishment of a statewide network of information and referral centers linked to the state office of public rehabilitation services. (See Section A of this chapter.)

It is understood that the effectiveness of these centers and the services provided to prospective clients will depend in large part upon the extent and quality of two-way communication and cooperation between the public agencies and those which function in a private and voluntary capacity.

A Partial Listing of Private and Voluntary Organizations with Which the Commission Has Maintained Working Relationships During the Rehabilitation Planning Project

Adult Education Association, Orono

Associated Industries of Maine, Portland

Association for Pastoral Care, Inc., Augusta

Blind Childrens Resource Center, Portland

Community Action Program Councils, Augusta, Waterville, Ellsworth, Strong

Great Bay Training Center, Newington, N.H.

Health Council of Maine, Augusta

Health Facilities Planning Council, Augusta

Kiwanis (Statewide)

Lewiston-Auburn Occupational Training Center, Lewiston

Lions International, Bangor

Maine Association of Industrial Nurses, Waterville

Maine Association for Retarded Children, Augusta

Maine Chapter, National Association of Social Workers, Lewiston

Maine Chapter, National Rehabilitation Association, Augusta

Maine Committee on Problems of the Retarded, Augusta

Maine Conference of Social Welfare, Bath

Maine Council for the Blind, Newport

Maine Heart Association, Augusta

Maine Hospital Association, Augusta

Maine Medical Association, Brunswick

Maine Nursing Association, Augusta

Maine Osteopathic Association, Bangor

Maine Psychological Association, Orono

Maine State Safety Conference, Augusta

Maine State Jaycees, (Statewide)

Maine Tuberculosis and Health Association, Augusta

Mothers of the Handicapped, Augusta

New England Public Health Association

New England Rehabilitation Association

Opportunity Training Center, Presque Isle

Paraplegia Association and Wheelchair Confined, Hallowell

Pine Tree Society for Crippled Children and Adults, Bath

Poland Spring Job Corps Center, Poland Spring

Regional Medical Programs, Augusta

Rotary (Statewide)

United Cerebral Palsy, Inc. (Greater Portland Region; Northeastern Maine, Bangor; and Mid-State Region, Augusta)

United Community Services, Bangor and Portland

Work Adjustment Center and Good Will Industries, Portland

D. INTERAGENCY COORDINATION OF SERVICE PROGRAMS

Manpower development, both client centered and professional, was identified early in the Commission's study as a priority requiring effective and ongoing interagency coordination. Working as a manpower consultant, Kevin C. Baack evaluated a number of public and private programs that help handicapped persons train for and locate suitable employment. He also conferred with the personnel of these agencies, elicited their recommendations for improving services to the state's adult vocationally handicapped population, and on the basis of this information made recommendations for manpower development and training. (4)

Among the state agencies cooperating in the survey were the Department of Health and Welfare, Department of Education, Maine Employment Security Commission, Department of Mental Health and Corrections, as well as the Committee's on Problems of the Mentally Retarded and Employment of the Handicapped. Private programs included the Work Adjustment Center and Goodwill Industries of Portland, Lewiston-Auburn Occupational Training Center, and the Opportunity Training School, Presque Isle.

Baack's major conclusions and proposals reflect the following needs:

a. Increase the client service capacity of the Vocational Rehabilitation Division to permit the successful rehabilitation of at least twice as many persons as are now being handled by that agency. Achieving this objective would require increased levels of funding and staffing and greater efforts to secure a larger portion of matching federal funds earmarked for Maine's vocational rehabilitation services. Continuing failure to rehabilitate vocationally handicapped welfare recipients who could be restored to productivity is a perpetual drain on the state's budget. If increased sums were spent on rehabilitation programs, these citizens would be able to get off relief rolls and onto payrolls. The long range effects would be a proportionately lower welfare caseload, increased tax income for the state, and an increased gross state product.

b. Develop an in-state Comprehensive Rehabilitation Center.

c. Expand client service capacity to concentrate more heavily upon the needs of the mentally retarded, mentally ill, and persons under the supervision of the Bureau of Corrections and the Probation and Parole Board.

d. State agencies must cooperate more closely with private agencies that aid the handicapped and the disadvantaged, and vice versa. Limitations on the amount of funds available for rehabilitation in Maine dictate that agencies both public and private cooperate to the fullest in ensuring that these funds are well spent and that many more persons receive the benefits which these services can provide.

Cooperative Area Manpower Planning System

A prime objective of the Cooperative Area Manpower System is to provide a mechanism for the breaking down of needless interagency barriers. If the CAMPS philosophy is adhered to, state agencies will now plan their programs

to avoid duplication of services and at the same time make provision for these services to fit a continuum. It is hoped that state agencies will adhere to this plan, even if it may involve some changes in agency philosophy, because the net result can only be a savings in state expenditures and improved services for all in need.

The structure and past performance of CAMPS, and the potentialities inherent in its outlook and mode of operation, seem to the Commission to offer the most promising approach for agencies concerned with the manpower development aspects of rehabilitation. The Commission recommends, therefor that:

CAMPS SHOULD BE RECOGNIZED AS THE MOST EFFECTIVE MECHANISM FOR MEETING CLIENT CENTERED MANPOWER NEEDS THROUGH COOPERATIVE AGENCY PLANNING AND THAT THIS EFFORT BE GIVEN CONTINUING SUPPORT BY APPROPRIATE REHABILITATION AGENCIES.

Further, it is recommended:

THAT CAMPS SHOULD PROVIDE FOR FULL REPRESENTATION FROM PRIVATE AND VOLUNTARY ORGANIZATIONS WHICH PROVIDE SERVICES TO THE HANDICAPPED AND DISADVANTAGED.

Structure and Objectives of the Cooperative Area Manpower Planning System

Agencies that participate in the Cooperative Area Manpower Planning System, their interrelationships, and the programs they sponsor or have recently initiated are described in a comprehensive 1969 plan for CAMPS. (6) Represented on the present Maine State Manpower Coordinating Committee are the Maine Employment Security Commission; U.S. Department of Labor's Bureau of Apprenticeship and Training; Bureau of Vocational Education, Division of Vocational Rehabilitation, In-School Neighborhood Youth Corps, and Adult Basic Education, Department of Education; Bureau of Health and Divisions of Family Welfare, Child Welfare, General Assistance, Eye Care and Special Services, and Work Experience and Training Program, Department of Health and Welfare; Office of Economic Opportunity and Community Action Agencies; Economic Development Administration, U.S. Department of Commerce; Farmers Home Administration and Technical Action Panels, U.S. Department of Agriculture; Department of Indian Affairs; and the Department of Economic Development.

In a statement of goals and priorities, the 1969 Manpower Plan calls particular attention to the following: (6, p.54)

> Within the resources available, it is the desire of the various agencies participating in CAMPS to provide the unemployed, underemployed, educationally deficient, physically or emotionally handicapped, welfare recipients, youth and older workers with an opportunity through mental and physical restoration, educational

training, vocational training, on-the-job training, counseling, guidance and job placement to become self-sustaining and more productive members of our society.

Noting that inadequate education is recognized as a prime cause of unemployment and underemployment, the report states:

Our primary goal and priority will be to seek out the disadvantaged unemployed, especially in the rural areas, through outreach efforts of all agencies and to provide an evaluation service to determine the needs of the individual. Those found to be illiterate will be funneled into MDTA basic education or basic adult education facilities of the Department of Education. . .

Another goal will be to provide services and training for the emotionally and/or physically handicapped who are presently unable to effectively compete in today's labor market.

It is CAMPS' intention to place more emphasis on:

--The use of secondary educational facilities as a means of providing offhours vocational training.

--The establishment of day care centers to enable welfare recipients and mothers who must work to enter training and/or employment.

--To solicit cooperation of industry groups in lowering hiring standards and, if possible, restructuring certain occupations in an effort to provide unskilled workers with entry-type occupations that will provide an occupational ladder approach to higher skills.

To accomplish these goals participating agencies will be called upon to provide either direct of supportive services, such as:

--Through Employment Service: aptitude testing, vocational counseling and ultimate job replacement.

--Through MDTA*, WEP, WIN, and CEP: prevocational, vocational and on-the-job training, with maintenance allowances to sustain enrolees while in training.

--Through Vocational Rehabilitation: evaluation and work adjustment services, including diagnostic studies; outreach, referral and advocacy; medical psychological, social and vocational services, including testing, fitting and training in the use of prosthetic or orthotic devices, prevocational conditioning, physical and occupational therapy, speech and hearing therapy, psychological and social services, evaluation, personal and work adjustment, vocational training in combination with other rehabilitation services, evaluation or

*MDTA - Manpower Development and Training Act; WEP - Work Experience Program; WIN - Work Incentive Program; CEP - Concentrated Employment Program; TAP - Technical Assistance Program; FHA - Farm and Home Administration.

control of special disabilities, and extended employment for the severely handicapped who cannot be readily absorbed in the competitive labor market. Included also in vocational rehabilitation services are maintenance as necessary during rehabilitation; occupational licenses, tools, equipment, and initial stocks and supplies; transportation in connection with rehabilitation service; any other goods and services necessary to render a handicapped individual employable; and services to the families of handicapped individuals when such services will contribute substantially to the rehabilitation of such individuals.

--Through Health and Welfare: maintenance services while in training and establishment of child day care centers to enable female heads of families to enter training and/or employment.

--Through NYC, in and out of school: paid work experience and counseling for youths from low income families.

--Through referrals to Jobs Corps: basic education, job skill training, social adjustment and maintenance for disadvantaged youth.

--Through Basic Adult Education: objective will be to eliminate illiteracy through the eighth grade and to raise the level of education through the completion of an equivalent high school education.

--Through TAP of the Department of Agriculture: assistance to rural people and rural communities to identify the services they need for economic, social and cultural growth and how and where to locate these services.

--Through FHA of Department of Agriculture: financial assistance after training, rural housing loans and economic opportunity loans to increase family income and improve standards of living.

Identification of Manpower Problems

The state committee which prepared the 1969 CAMPS Plan noted that while many of the needs for more positive manpower programs in Maine have national parallels, many more are peculiar to the state itself. (6, p.52) For example, there is no information available on the number of persons who are working beneath their skill capacities or how many are engaged in intermittent jobs.

One problem that is manifest in many rural areas is one of industrial under-development rather than unemployment. This situation tends to produce a community of inadequately prepared, personally unmotivated and economically unproductive persons. In the coming year it will require that full attention and all resources be directed toward providing industrial development as well as providing services, training and employment of the unemployed, under-employed, under-educated, and physically and emotionally handicapped youth and older workers. (6, p.52)

The State CAMPS Committee estimates that there are approximately 36,100 persons in the state who could benefit from some manpower program.

Of these 15,300 are unemployed, 13,800 underemployed, 5,800 welfare recipients, and 1,200 minority group (Maine Indians). The unemployed, underemployed and welfare recipients are about equally distributed among the 16 counties in the state in accordance with each county's population. The Indians are located on two state reservations in Washington County and one reservation in Penobscot County.

Some of the other target groups identified by the Committee as representing manpower problems are as follows:

54,000 families with incomes under $3,000
300,000 persons who have not completed high school
80,000 persons who have less than eight years of education
60,000 persons physically or emotionally handicapped
1,100 school dropouts each year
1,100 selective service rejectees annually

In view of the facilities and resources that will be available in fiscal 1969, the Committee estimated that a reasonable number to receive manpower services would be 12,000 (7,080 males, 4,920 females). Of this group, 7,200 are identified as disadvantaged; 4,080 are over 45 years of age; 3,730 are under 21 years of age; 4,800 have less than high school education and 2,240 have eight years education or less; 6,600 are unemployed; and 5,400 are underemployed.

The following discussion of inter-related government-sponsored programs, their current functions, operating linkages, and plans for further program coordination and outreach, is adapted from the State CAMPS Committee study and report. (6, p.56)

1. State Employment Service

The Maine Employment Security Commission, in conjunction with the U.S. Employment Service, maintains 15 local employment offices within the state. The objectives of the Employment Service are to:

a. Provide a broad spectrum of employment and manpower services, such as counseling, testing, placement, referral for employability development and rehabilitation, and job market information.

b. Aid job seekers in finding suitable jobs commensurate with their skills and experience.

c. Aid employers in recruitment of qualified workers to fill their replacement and expansion needs, and to provide them with related services.

d. Assist in the development of human resources through training, identification of need for and referral to other employability development services, and in promoting fuller utilization of these resources.

e. Aid in the development and expansion of employment opportunities, through cooperative action with all appropriate agencies and groups at local and state levels.

f. Keep up-to-date plans and maintain operational readiness to meet manpower needs in time of state disaster or defense emergencies.

Immediate program goals of the State Employment Service are in four main areas: human resources development, job development and placement, manpower and employment information, and administrative and technical support.

(A) Human Resources Development

These efforts are directed at reaching out to and improving the employability of handicapped and disadvantaged youth and adults. Emphasis is on a comprehensive program of manpower services to include:

a. Outreach.

b. Determination of employability services based on individual needs.

c. Referral to other agencies for needed supportive services.

d. Intensive job development with employers.

e. Referral to manpower training and work programs, such as Neighborhood Youth Corps and Job Corps, as well as the placement of those graduating from such programs.

f. Job market information programs to provide basic information needs for human resource development efforts; and

g. Essential administrative and supervisory support.

Services provided by the agency are being directed to the disadvantaged of all ages in order to make them job-ready. Those reached and referred to jobs receive the supportive services they need to remain employed. Of special concern are disadvantaged youth from urban slum neighborhoods and rural pockets of poverty, particularly school dropouts and potential dropouts, with public and private community groups aiding in this effort.

Emphasized are:

--Specialized services to applicants over 45 who are experiencing difficulty in getting or holding a job primarily because of age. Services that are being further developed include intensive counseling, job development, and placement services in all local Employment Service offices.

--Services to help minority group members overcome the effects of discrimination and deprivation. These focus on counteracting artificial restrictions and helping minority group members compete favorably in the job market through intensive recruitment, employability development, skill training, promotional efforts, and job development.

--Improvement in both the quality and quantity of local office specialized services on behalf of the medically and psychologically identifiable handicapped. Greater effort is being expended on necessary training and assistance to Employment Service personnel in working with these known handicapped persons.

--Priority services to all veterans, as required by law. A program, instituted in fiscal 1968, of contacting each returning Vietnam veteran to determine if any manpower services are required, is continuing, with particular emphasis on those who are disabled.

(B) Job Development and Placement

--Through cooperative programming with employers, an effort is made to strengthen the development of human resources and bring the disadvantaged into the mainstream of the economy by giving increased attention to locating job opportunities where none apparently exist.

--The improvement of placement services, particularly for those who are disadvantaged, is of primary importance.

--Testing and counseling services are being expanded and counselors specially trained in this area are making an extensive effort in job development.

(C) Manpower and Employment Information

--The Employment Service has established linkages with Vocational Rehabilitation, Job Corps, Neighborhood Youth Corps, Bureau of Apprenticeship and Training, Office of Economic Opportunity, and Health and Welfare activities at state and local levels. Local employment offices refer clients to these agencies, and they, in turn, refer clients to the Employment Service.

--The job market information program to support human resources development activities and tailored to meet the needs of disadvantaged job seekers is being strengthened. The program is designed to provide adequate employment and unemployment information to educators, counselors, newcomers to the job market and persons changing jobs, the private sector, and government and community agencies. Improvement of current labor reports, including unemployment estimates and the development of special studies, is stressed.

(D) Administrative and Technical Support

As noted above, the Employment Security Commission has developed cooperative working relationships with several government agencies. Examples are the written agreements between (a) the Department of Health and Welfare, and (b) the Division of Vocational Rehabilitation of the Department of Education.

a. Department of Health and Welfare

--The Employment Security Commission, having resources and experience related to the objectives of the Department of Health and Welfare,

provides direct and indirect services to clients receiving assistance from the Department through one or more of its programs. Such services include, but are not necessarily limited to, outreach and referral, registration for employment or formal training, vocational testing and evaluation, employment counseling, job development and job placement.

--The basic mechanism for cooperative activities by the two agencies is the "Case Referral Record," which is used to identify individuals referred and the services requested and provided. Case conferences and joint planning are utilized where appropriate to supplement the services reflected upon the Case Referral Record.

--Services include referrals from either agency to the other, testing and evaluation by the Employment Security Commission and conferences when appropriate for implementing the case plan, screening and registration for Manpower Development and Training programs, registration for employment, vocational counseling, and job development and placement.

b. Division of Vocational Rehabilitation

--This cooperative agreement provides for maximum utilization of the services of each agency, to insure maximum benefits and services to handicapped persons. Both agencies coordinate their activities in all areas necessary to insure such maximum benefits and services.

--Coordination of roles is implemented through the use of Interagency reporting forms and by telephone and personal contacts between personnel of both agencies regarding placement and other activities being carried out for mutual clients.

--Both agencies coordinate their contacts with employers in carrying out their placement responsibilities and maintain a free exchange of information concerning hiring policies and practices, employment trends and opportunities.

--Reciprocal referral procedures include: (a) referral by employment offices to the Division of Vocational Rehabilitation of persons with a physical or mental disability to determine eligibility for and to identify and provide needed vocational rehabilitation services, and (b) referral by the Division to the Employment Service for employment counseling and placement services of persons who are ready to engage in competitive employment and who need assistance in finding a job.

--Testing services are provided through local employment offices to administer, score, and interpret the tests. However, upon request, copies of the Employment Service tests will be released to the Division of Vocational Rehabilitation in accordance with established procedures.

2. Manpower Development and Training Act

a. A mentally retarded/physically handicapped program in Bangor was completed during fiscal 1968. Using facilities at Dow Air Force Base, the MDTA program provided counseling, education, training, rehabilitation and social services arranged jointly between the Employment Security Commission,

Vocational Rehabilitation Division and Bangor City School Department. Thirty trainees were placed in jobs, 7 more have gone on to additional training in related development programs, and 13 remain unemployed.

b. A multi-state MDTA project for training loggers and woodsmen was initiated in fiscal 1968 to be conducted in the U.S. National Forest at Gorham, New Hampshire. This project was designed to provide training for some 125 persons on an open-ended basis for 10 weeks. Maine was allocated 60 of these training slots.

c. The State CAMPS Committee in its report (6, p.59) notes that:

> The most effective vehicle for manpower training is through the multi-occupational training centers. These training centers are located in Portland, Lewiston, Bangor and Washington County.
>
> ...A centralized facility offers the most effective control, supervision, instruction and the best concept of applying the methods of occupational and remedial education, vocational counseling, and pre-vocational orientation on behalf of the individual trainee.
>
> The training center allows for the fullest use of public and private educational institutions, as well as a means of establishing additional skill training as may be required.
>
> The location of the centers also makes it possible to acquire suitable living quarters for out-of-the-area trainees at reasonable costs, as well as the services provided by the local offices in the areas that are needed for the support of all trainees.
>
> The availability of supportive services in the area from other agencies and institutions is a definite asset to the trainee while he is training in the center, especially those trainees from outlying areas who, normally, do not receive these services.

d. Evaluation of MDTA Resources in Relation to Needs.

> The reduced emphasis on training under the Manpower Development and Training Act falls short of meeting manpower goals indicated in the overall CAMPS proposal.

An alternative approach to the manpower problem in Maine may be the emphasis given the Concentrated Employment Program. Greater emphasis has been placed on the MDTA-OJT coupled program in order to utilize OJT monies available and thus accomplish the best overall MDTA training in the absence of adequate funds for straight institutional projects. These OJT proposals are being made in the Portland, Lewiston and Bangor areas.

> It is felt that greater use of available MDTA facilities may be utilized on a contractual basis by the Work Incentive Program and the Concentrated Employment Program in achieving identified manpower goals in the geographical areas of their operation.
>
> ...If little or no supplemental funding is available beyond the basic allocation, an alternative approach that will be explored is cross

funding. For example, this conceivably may be accomplished in the areas of automotive skill training and cooking. There is an acute shortage of the latter skill in the state.

The CAMPS Committee believes that a realistic view of training projects which should be instituted under Section 241 of MDTA, over and above the regular allocation, would involve a total of 321 institutional trainees at an estimated federal cost of $402,160. Training would be in such areas as basic education, nursing, gasoline engine repair, auto mechanics, general clerk, and homemaking. An additional 819 training positions should be established in Penobscot, Androscoggin and Cumberland Counties in the above skills and occupations and also in a selected number of stenographic, auto parts sales, draftsman, dental technician, and cooking positions.

3. Public Health and Welfare

The CAMPS Committee has estimated that of the approximately 47,000 persons being served by the Department of Health and Welfare's Bureau of Social Welfare, about 12%, or 5,800 could probably benefit from comprehensive manpower planning. The Committee notes also that:

> ...while significant program developments in the area of rehabilitation have been made in recent years, it is also important to recognize that the Bureau of Social Welfare is not generally authorized or funded to operate its own training or instructional programs. Therefore, although rehabilitative and social services are an essential part of welfare administration in Maine, the Bureau must look to other agencies and programs for assistance in the manpower field. Such an established and effective liaison is vitally important in view of some of the 1967 Social Security amendments directly relating to the manpower plan and its implementation. (6, p.81)

The cooperative agreement in force between the Department of Health and Welfare and the Employment Security Commission has already been cited. Until the 1967 amendments to the Social Security Act, however, federal policy governing public assistance programs was such that incentive for employment was diminished because the assistance grant was reduced in proportion to earned income. This deduction for earned income is still being imposed in Maine, with the exception of the Work Incentive Program (WIN), but the Citizens Task Force on Intergovernmental Welfare Programs has recommended that public assistance recipients be allowed to retain the maximum amount of their earnings in accordance with the new federal regulations.

The Citizens Task Force stated in its report (63, p.25) that:

> The deducting of all earnings dollar for dollar allows no incentive for parents and children to make use of educational and employment opportunities or to plan for legitimate expenses which are not allowed for in the budgeted grant. Such exemption of earnings is mandatory by federal regulation as of July 1969.

With the implementation of the Work Incentive Program, greater attention will need to be given to job training, education, and job development services as essential factors relating to increased employment for public assistance recipients in all categories, but particularly in Aid to Families with

Dependent Children.

Day care and other types of child care arrangements which are the responsibility of the Department's Division of Child Welfare must be further developed in keeping with the present emphasis on employment services and programs. With the anticipated demand for such services will be the concomitant need to train persons to provide such care and to assist in establishing the centers or alternative child care arrangements.

As already noted in Section C-6 of this report, a number of basic reforms are being proposed in regard to Maine's general assistance program. It is recognized that the general assistance caseload, comprised essentially of persons needing a temporary and emergency type of assistance, consists largely of persons who could benefit from education, training, and employment. Many are single needy individuals, unemployed fathers in unbroken homes, partially or temporarily disabled persons, etc. Efforts are made by state and local welfare officials to help such persons obtain employment, but staff and resource limitations make it difficult to achieve this objective without assistance from regular manpower agencies.

Duties of the Division of Eye Care and Special Services in the Department of Health and Welfare include:

a. Educational and vocational rehabilitation services to the visually handicapped,

b. Health referral services to Armed Forces medical rejectees,

c. Homemaker service,

d. A demonstration Work Experience and Training Program.

The latter program began functioning in June 1965 under Title V of the Economic Opportunity Act. It has been phased out as the Work Incentive Program is phased in, providing a logical transition from one program to the other. Both have required close cooperation between the Employment Security Commission, Community Action Programs, Division of Vocational Rehabilitation, Concentrated Employment Program, Work Incentive Program, municipal officials, and other social service agencies.

The Work Experience and Work Incentive Programs are good examples of the need for cooperative planning and close liaison on the part of many different agencies, not excluding those in the private sector.

4. Education

The basic role of education has been implicit throughout this present discussion. The State CAMPS Committee underscored its importance by stating:

> ...It is the feeling of the Committee that if educational deficiencies can be corrected, many of the other problems can be easily solved. It is with this in mind that the Committee is placing the highest priority on basic education, not only for vocational or academic reasons but for work orientation, behavioral and attitude change. (6, p.53)

The Committee has proposed that an increased number of training positions be made available through MDTA basic education and the basic adult education facilities of the Department of Education. Persons found to be functionally literate may be enrolled directly in vocational skill training or placed in on-the-job training. Refresher training should be utilized for unemployed persons who in the past have had a skill, especially in the clerical and health occupations. This training should be provided through MDTA programs or adult vocational education.

a. In-School Neighborhood Youth Program

The In-School Neighborhood Youth Corps, funded under the Economic Opportunity Act and administered by the Department of Education, is discussed in Sections C-3 and C-7 of this chapter. During fiscal 1968 and continuing into 1969, it has provided work experience, social adjustment, and counseling for some 800 youths from low income families. The program has operating linkages with:

--Vocational Rehabilitation, for referral of enrolees with physical or emotional handicaps to receive treatment or corrective services,

--Employment Service, for job placement and/or further training under MDTA for some 200 graduates. Enrollees who leave school are referred through the Employment Service to Job Corps, out-of-school Neighborhood Youth Corps, or other programs.

--Upward Bound, for summer employment leading to a college career or re-entry into in-school NYC during the school year.

--Community Action Programs, which refer many enrollees to out-of-school NYC directly, when the Employment Service is not the screening agency. Some out-of-school NYC enrollees have been successfully encouraged to return to school, where they are then enrolled in the in-school program.

--Health and Welfare, whose case workers refer many enrollees to the in-school program. About 30% of NYC enrollees are from families receiving some type of welfare assistance. Family Services, Eye Care and Special Services and other Health and Welfare agencies are called upon to provide supportive services when the need arises.

During fiscal 1969 it is estimated that some 1,200 youths will be enrolled in the in-school Neighborhood Youth program.

b. Bureau of Vocational Education and Local Public School Systems

In addition to MDTA, for which the Department of Education has primary responsibility for training, the Maine public school system provides three general types of manpower training:

1. Vocational education for students attending high school,

2. Vocational and technical education for full-time students who have completed high school, or the equivalent, and who are enrolled in the vocational technical schools or schools of practical nursing,

3. Vocational and technical education for both employed and unemployed people offered as part time or short term specialized courses.

The 102nd Maine Legislature made provision for a system of regional technical and vocational centers which eventually will offer a variety of vocational education opportunities to most high school students in the state. Seventeen locations for such centers have been approved by the State Board of Education and seven are in operation at the present time. Eight additional facilities will be in operation within the next two years.

Occupational preparation in a variety of fields is being offered by many high schools throughout the state. It is estimated that during fiscal 1969, approximately 16,500 students will be enrolled in high school vocational programs, with about 3,500 graduates being available for employment in June 1969.

Courses offered in the vocational technical institutes are designed to prepare students for skilled trades or for technical occupations. Most of these courses are for two academic years. Practical nursing courses are of 12 months duration, including a substantial amount of clinical instruction in affiliated hospitals.

Both the institutes and the local school systems, particularly through the regional centers, provide part-time and short-term courses for out-of-school youth, both employed and unemployed. Most are courses of supplemental skill training or technical information for employed people to help them improve their work competence and, in many cases, to advance to positions of greater responsibility. A number of them are conducted in cooperation with labor and/or management groups.

Since these courses make use of already existing facilities, the funding is comparatively moderate. For this reason, and because they fill a widely recognized need, it is hoped that the vocational technical institutes and the regional centers expand their offerings to include any course for which there appears to be a demand.

c. Federal Vocational Education Amendments of 1968

The Vocational Education Amendments of 1968 (P.L. 90-576) open up a great many opportunities for the development of in-school rehabilitation activities for the vocational education of handicapped young people and those with special needs. (65) They authorize more than double the current level of federal appropriations for vocational education, with funds earmarked for disadvantaged persons, for those who have completed or left high school, and for persons with physical or mental impairments. The new legislation:

--Creates a National Advisory Council on Vocational Education to be appointed by the President,

--Provides for a state advisory council to be appointed by the Governor except in states where the members of the State Board are elected. This state advisory council will advise the State Board on the development and implementation of the state's plan for vocational education and will also make an annual evaluation report to the Commissioner of Education and the National Council.

--Specifies that 90% of the federal appropriation to the states is to be used to implement the basic state plan program, and 10% is to be used for research and training.

--Requires that states devote a certain percentage of their allocations to: (1) vocational education programs for academically and socioeconomically disadvantaged persons, (2) postsecondary education, and (3) special vocational education for the physically or mentally handicapped,

--Authorizes a separate annual appropriation for vocational education programs for the academically and socioeconomically disadvantaged, over and above the funds earmarked out of each state's allotment. These additional funds are to be used for non-matching programs which will serve areas having high dropout or youth unemployment rates and involve the participation of students enrolled in nonpublic school.

--Authorizes funds for residential vocational education schools and dormitories for youths between the ages of 14 and 21, with special consideration given to areas having substantial numbers of youths who have dropped out of school or are unemployed,

--Authorizes funds for consumer and homemaking education,

--Authorizes funds for establishing cooperative work-study programs through local educational agencies with participation of public and private employers. Funds may also be used to reimburse employers for added costs needed in providing on-the-job training through work experience and to pay transportation and other unusual costs,

--Authorizes allotments to the states for up to 80% of the cost of compensating students in work-study programs which provide employment to vocational education students who are in need of such earnings,

--Authorizes appropriations for curriculum development in vocational and technical education; awards to students for advanced study in graduate programs; exchange of personnel between schools and private enterprises; institutes and other preservice and inservice training programs for vocational education teachers and persons entering or re-entering the field.

5. Voluntary Organizations

a. On-the-Job Training Sponsored by the Maine Federated Labor Council

This project funded in fiscal 1968 is providing on-the-job training for some 1,000 persons, primarily those displaced by the closing of Standar Packaging Mills at Lincoln and Brewer. Employer involvement is predominant and the most important linkage is with the Employment Security Commission. The program provides testing and vocational counseling to assist individual in determining the most suitable training situation commensurate with their mobility and/or job openings available in the area in which they reside.

b. Employer Involvement

The State CAMPS Committee notes that:

...It is quite evident that employers are becoming more involved in manpower problems and their solutions. Many employers are now serving on area CAMPS committees and on area Manpower Advisory Committees.

Through on-the-job training situations, which will more than double in fiscal 1969, the employers will be directly involved in the training of individuals. This will involve both large and small employers. This close relationship between employers, trainee and manpower agencies will hopefully open the door and point the way for employer sponsored training programs to meet his need for skilled or semi-skilled workers.

Coordination in the planning, development and implementation of manpower training and retraining programs in an assigned region will be handled by "Manpower Training Coordinators," a job classification approved by the State Department of Personnel. They will be assisted by other Employment Service personnel.

Governor Curtis has sponsored a statewide YOU (Youth Opportunities Unlimited) program for summer jobs for youth. In implementing this program, the heads of the state's largest industries were invited by the Governor to attend a state level meeting. As heads of the major industries, they were requested to serve as chairmen of the local committees to induce industry to provide approximately 10,000 jobs for youth during the summer.

6. Other Related Agencies

a. Concentrated Employment Program (CEP) and Model Cities

The planning and development phase of a Concentrated Employment Program has been funded, and the project is now under way in the counties of Cumberland, Androscoggin, Kennebec, Sagadahoc, and Somerset. This overall CEP area has a rural population of 135,925 and approximately 42% of the state's total rural population. The private nonprofit organization funded to conduct the initial phases of the project is known as PINECAP CEP, Inc., and works in close conjunction with the Five Community Action Agencies in the respective counties.

Included in the CEP area is the Portland West Model Cities Neighborhood. Plans call for one of the CEP Orientation and Training Centers to be located within this Model Neighborhood. The Portland local CAMPS has initially been involved in the preplanning phase because of its proximity to the CEP administrative office and will continue to serve as a resource group.

It is anticipated that 700 to 1,000 target area people will be served with the following CEP components: work orientation, employment, personal and family counseling, medical and dental services including psychological evaluations and some treatment, legal assistance, financial counseling and consumer education, cooperative buying clubs, remedial and basic literacy training, skill and vocational training, job referral and placement, follow-up and research.

The Employment Security Commission has pledged continuing support and technical assistance to the PINECAP CEP planning staff. Employment Service personnel who are particularly sensitive to the needs of the area and those of the program participants expected to be served are cooperating with CEP in surveying industries and non-profit organizations to determine the extent of their participation.

The City of Portland Model Cities Planning was approved and funded in November 1967 and includes an area of the peninsula known as Portland West inhabited by approximately 15,000 people.

The Model Cities staff has conducted a door to door survey of the Model Neighborhood which is providing data on manpower needs. Coordination and liaison between the Model Cities staff and CAMPS is effected in two ways: the Model Cities director and his deputy for manpower are members of the local CAMPS, and several CAMPS members serve on the Model Cities Employment and Manpower Task Force.

b. Work Incentive Program

As noted earlier in this section, the Work Incentive Program is now required by the federal government as a condition of its contribution to the Aid to Families with Dependent Children program. The federal government, as part of its overall national program, has allocated 400 work incentive training positions to Maine. Selected for training will be unemployed fathers, mothers who volunteer for the program, and children 16 or older who are not in school.

The Employment Security Commission is responsible for operating the Work Incentive Program (WIN) in cooperation with the Department of Health and Welfare. Its prime objective is to improve the employability of AFDC clients through counseling and testing, education, training, job development and a follow-up procedure.

E. COORDINATION WITH OTHER STATE PLANNING

One of the first organized activities of the Commission was the evaluation of related State planning with special emphasis on rehabilitation recommendations. Prior reference in this report to such evaluation may be found in Chapter II-Sections G and H, Chapter III-Sections A and B, and throughout Chapter IV. The reader is directed specifically to Commission recommendations which reflect prior recommendations of other statewide planning in the following areas:

	Related Planning Area	Reference Location
1.	Planning relative to the poverty stricken	Chapter IV, Sections B-6, C-3, C-6, C-7
2.	Mental Health Planning	Chapter IV, Sections B-4, C-9
3.	Mental Retardation Planning	Chapter IV, Sections B-5, C-4, C-9
4.	Vocational and Special Education	Chapter IV, Sections B-1 B-2, B-5, C-9, D-4
5.	Hill-Burton Planning for Rehabilitation Facilities	Chapter IV, Section C-4
6.	Rehabilitation Workshops and Facilities Planning	Chapter IV, Section C-4
7.	Comprehensive Health Planning	Chapter IV, Section B-3
8.	Correctional Rehabilitation	Chapter IV, Section C-2
*9.	Maine Interagency Health Planning Committee	Chapter II, Section G-2

*The project director served as secretary to the Maine Interagency Health Planning Committee during 1967-1968. This committee has representation from each of the health-related planning functions listed above. The committee meets monthly and serves to avoid planning duplication while laying a basis for comprehensive health planning.

F. ADMINISTRATIVE ASPECTS

1. Public Information and Education

A full description of the public relations approach followed by the Commission during the planning period is included in Chapter III, Sections B-4, C-5 and D-3. Using a variety of techniques and methods, the Commission worked to increase public awareness of rehabilitation needs and to promote greater receptivity in the legislature to rehabilitation service demands.

Many of these activities were in response to recommendations made by the Commission's special subcommittee on information and public awareness. They included:

a. Preparation and wide distribution of two fact sheets, one containing a summary of the Commission's major findings and recommendations, and the other emphasizing the Commission's legislative proposals which were introduced in the current 104th Legislature.

b. Presentations by Commission members and staff at meetings of service groups and voluntary organizations such as the Maine Jaycees, Kiwanis and Lions clubs, health organizations, etc., leading to endorsements by these groups of the Commission's recommendations and their active participation in urging that the legislative proposals be adopted. For example, L.D. 925, the bill proposed and drafted by the Commission for the purpose of reorganizing public rehabilitation services within a single functional unit in the Department of Health and Welfare, prompted the spontaneous endorsement of more than 257 public and voluntary organizations representing a combined membership of over 5,800 Maine citizens. In addition, several hundred private individuals wrote letters on their own behalf supporting this legislation.

c. Preparation of special features for the news media including newspaper articles, radio and television interviews, and arrangements for news coverage of such events as the Governor's Conferences on Rehabilitation Needs, legislative public hearings.

d. Preparation and dissemination of written materials, including sample speeches which were used by Commission and task force members, community leaders and other speakers when discussing the Commission's activities and recommendations at meetings of civic, service, and fraternal organizations.

Several of the news media representatives and public relations personnel who comprised the Commission subcommittee on information and public awareness also served on a special subcommittee on Public Information to the Committee on Correctional Rehabilitation. Both were chaired by Phillip Johnson, news director of a large radio-television station in Portland. Many of the recommendations stemmed from suggestions of the regional task forces, special study committees, and consultants, including Harbridge House. Mr. Johnson's two committees drew up the following set of objectives to serve as guidelines for ongoing programs of public information and education to be conducted by the public rehabilitation agencies:

1. Demonstrate in terms of dollars and numbers the need for, and the benefits which accrue from, good rehabilitation procedures.

2. Explain the concept of rehabilitation: What is it? Who is eligible? What does it accomplish?

3. Describe the relative value of current rehabilitation projects to the state and local community for taxpayers and legislators.

4. Convey the verifiable progress of rehabilitation programs to the citizens and particularly to the employers of the state.

5. Improve the relationship and increase the interest of news media personnel team-approach concept of rehabilitation programs.

6. Generate incentive programs by employers and community groups for rehabilitated persons.

7. Encourage more citizens to extra-time involvement in rehabilitation programs.

8. Establish staff positions for qualified information specialists.

Each of the six regional task forces, in its report of recommendations to the Commission, emphasized the inportance of developing greater public awareness of the purposes and benefits of rehabilitation, the services provided by rehabilitation agencies, and who is entitled to these services. All recommended that the public rehabilitation agencies institute vigorous and ongoing public information programs designed to foster public and legislative support, correct misconceptions about rehabilitation services, and encourage their most effective use.

Similarly, Harbridge House (3, V-15) recommended that the Vocational Rehabilitation agency "should work toward an informational program that is directed toward the various 'publics' which have some relation to the rehabilitation program--the legislature, the general public, the disabled population, special interest groups, potential employers, and other service agencies--and that is designed to achieve a variety of objectives--to apprise the disabled population of the services available to them, to foster financial support, to promote cooperation, and to develop a favorable climate for the employment of rehabilitated clients." The report states specifically that the agency should develop a "planned, coordinated program of public information and public relations...on a full-time, permanent basis." The consultant firm noted additionally in its report that the Division of Eye Care and Special Services "apparantly suffers somewhat from the widespread relunctance of employers to hire blind people, and it does not make a planned, sustained effort to overcome this obstacle."

Accordingly, the task forces, subcommittees and other components of the Commission's planning project recommended unanimously that:

A PUBLIC INFORMATION AND EDUCATION SERVICE SHOULD BE CREATED WITHIN THE PROPOSED UNIT OF PUBLIC REHABILITATION SERVICES IN THE DEPARTMENT OF HEALTH AND WELFARE. THIS SERVICE SHOULD BE HEADED BY A FULL-TIME INFORMATION OFFICER WITH RESPONSIBILITY

FOR THE DEVELOPMENT AND SUPERVISION OF YEAR-ROUND PROGRAMS AS STATED IN THE FOREGOING OBJECTIVES.

A FULL-TIME INFORMATION REPRESENTATIVE SHOULD BE EMPLOYED BY THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS.

THE POSITION OF INFORMATIONAL WRITER SHOULD BE CREATED IN THE DIVISION OF VOCATIONAL REHABILITATION.

The Commission's subcommittee on information and public awareness noted that the information officers "should act in an advisory capacity on all matters of public information and in liaison and consultation with personnel of the respective Departments. Since the information officers will be representing the rehabilitation agencies to the general public, he or she should be thoroughly grounded in all matters of mass media structure, operation, and contact."

Activities of each public information service should include:

a. Scheduling of news conferences.

b. Dissemination of news releases to all media.

c. Arranging for radio and television interviews and special features.

d. Preparing feature stories and also arranging for such features to be written by editorial writers and reporters of the major daily newspapers and the wire services.

e. Scheduling service club, community group, church group and business club speaking engagements by community leaders and rehabilitation personnel.

f. Stimulating interest of community "thought-leaders" by scheduling tours of rehabilitation facilities, arranging for briefings by rehabilitation personnel, circulating informational material to various "publics" such as physicians, employers, educators, etc., and preparing and distributing quarterly reports of documented activities of the respective rehabilitation programs.

g. Seeking establishment of Rehabilitation Committees in the structure of such organizations as Chambers of Commerce, Jaycees, business and industrial organizations, professional groups, etc.

h. Arranging a series of University and college forums on the objectives and present needs of rehabilitation.

i. Publishing a monthly newsletter reporting the progress of rehabilitation programs, projected activities, human interest features, etc., for public and private agency personnel, the news media, and other agencies and

individuals having an active interest in rehabilitation. Additionally, a one-page newsletter, edited preferably by a physiatrist, should be distributed monthly to all practicing physicians in the state.

j. Developing a radio public service campaign and also a television spot campaign describing the objectives and achievements of rehabilitation.

The subcommittee, consultants, task forces and others have stressed that one of the major emphases of a sound public information program should be the recruitment of qualified persons such as counselors, therapists, and others into the various rehabilitation fields. Lack of sufficient numbers of trained personnel is a serious impediment to rehabilitation efforts at the present time. Dissemination of information to students and the general public would help to correct this deficiency.

Since medical practitioners are key persons in the rehabilitation process, greater efforts should be made to inform them about on-going programs and to enlist their full participation on the rehabilitation team.

2. Administrative and Operations Studies of State Vocational Rehabilitation Agencies

One of the three studies prepared for the Commission by Harbridge House was an assessment of the two principal vocational rehabilitation agencies in Maine, the Division of Vocational Rehabilitation in the Department of Education and the Division of Eye Care and Special Services in the Department of Health and Welfare.(3) In accordance with the terms of the Commission's contract with Harbridge House, the report is limited to the presentation of findings and conclusions. However, in a few instances it incorporates some general recommendations to indicate a line of action which the consulting firm deemed most appropriate. Since the purpose of the report was to assess effectiveness, its emphasis throughout is on strengths and weaknesses, particularly as they relate to growth.

The analysis focuses attention, first, on the results the agencies have achieved, and second, on the resources they have at their disposal and the use they have made of them. It deals mainly with services to clients--how many are served and how well they are served. Included are the relative distribution of types of disability among the agency caseloads and among the handicapped population of the state; number of cases closed successfully and unsuccessfully; the effect of factors such as age, sex, geographical location, and type of disability; and the length of time between events in the cycle of referral, evaluation, service and placement.

The report also analyzes the agencies' financial and organizational resources in terms of adequacy of funding and the use made of available funds; cost of rehabilitated and nonrehabilitated cases; range of expenditure per case in relation to results; organization and deployment of personnel; distribution of authority and responsibility; procedures for program review and control; relations with the legislature and the public; coordination with other public and private agencies; and procedures for program planning and development. At intervals throughout the contract period, formal briefings were held with Commission members and a close working relationship with the Commission was maintained. The following comments are abstracted from the Harbridge House report. (3)

Division of Vocational Rehabilitation (DVR)

Compared with the state's total budget for health, education, and welfare services, its investment in Vocational Rehabilitation has been modest indeed.

> Maine is one of the least generous states in supporting the vocational rehabilitation (VR) program, and not surprisingly it is one of the least productive. In fiscal year (FY) 1966 Maine ranked 41st among the states in per capita expenditure for vocational rehabilitation, and it ranked 45th and 46th in the number of counselors per capita and the number of clients served and rehabilitated. (3, Part III - 1)

For about ten years the DVR budget was held at the level of current services, with budget increases that did little more than keep pace with increased medical and living costs. In fiscal 1967 the first economic

breakthrough occurred--the state share increased almost 50% and the federal share increased 70% over the preceding year. Between fiscal 1966 and 1968, the DVR budget was slightly more than doubled. Although the Division has been hampered by a number of problems such as staffing difficulties, small budget, shortages of rehabilitation services, and the time, cost, and effort required to serve clients in the remote areas of the state, it has been able to show considerable progress and the state has received good value for its investment.

The Division is aware of its shortcomings and is working to improve certain deficiencies by efforts to:

--Increase the disability mix of the client population

--Increase outreach efforts towards a younger disabled population

--Invest funds in facilities improvement

--Upgrade the counselor's position

--Provide a more comprehensive inservice training program

--Improve the quality and timeliness of data flow

--Upgrade and expand program research

--Improve interagency coordination.

DVR's most significant asset, Harbridge House noted, is the statewide interest in rehabilitation. The Governor, members of the legislature, department and division heads, counselors, private agencies, and informed citizens share its interest in expansion and improvement of services. Chiefly as a result of this increased interest and funding, the Division has been able to enlarge its staff, and consequently its client services, to a marked degree. During fiscal 1968 (after the Harbridge House report was submitted) the Division rehabilitated 446 handicapped persons into employment, as compared with 349 cases closed rehabilitated the previous year. During the first three months of fiscal 1969, it placed 153 disabled persons into suitable jobs after various forms of treatment and training, making it the most successful first quarter period in the Division's history.

Services which the Division provides to clients include counseling, diagnostic examinations, vocational evaluation, treatment to minimize or eliminate impairment, vocational training, and help in placement. In addition to the central office in Augusta, it operates through eight field offices, several special units located in correctional institutions, and one unit currently working with the public school systems of Waterville, Oakland, Fairfield and Winslow. As of fiscal 1970, its funding will be on the basis of four federal dollars for every state dollar expended for its activities. The following observations regarding the Division's performance are taken directly from the Harbridge House report. (3, Sect. II-2)

a. Problems Outside the Agency's Control

A number of the agency's current problems lie outside its direct control. Principal among these, are the legislative delay in funding the current program, the difficulty of serving a widely dispersed rural population, the serious effect of the state's low salary scale on the acquisition and retention of qualified personnel, and the scarcity of specialized rehabilitation facilities in the state.

The agency cannot prevent an administrative deadlock like the one that occurred in 1967, imposing a six-month freeze on the planned expansion of program and staff. Nor can it control the location of handicapped persons in Maine; the low population density of much of the state renders service difficult and expensive. It cannot unilaterally increase the salary scale, which is a major obstacle to agency effectiveness, or establish a broader range of positions--rehabilitation trainees, administrative aides, and program analysts, for example. It cannot create the rehabilitation facilities that are desperately needed in Maine.

In matters like these, the agency can only hope to play a part in influencing action. In concert with other interested public and private agencies and individuals, it can explore opportunities for economies of scale through joint programs and facilities, it can seek new ways of delivering services--for example, satellite rehabilitation centers or mobile units for rural areas--and it can develop the facts and arguments that pose the strongest case for increased support of the rehabilitation program.

b. Controllable Activities

(1) Services to Clients

Agency performance in fiscal 1967, as measured by the pattern of services to clients, was mixed. Despite its difficulties in staffing and other areas, the Division was able to maintain a reasonably high level of referrals, and it has begun to change the composition of its caseload from a disproportionately high number of orthopedic and speech and hearing cases toward a more representative mixture of disabilities.

A number of problems are evident, however. The number of persons closed not rehabilitated far exceeded the number of rehabilitants. Clients experienced excessive delays in getting service: (waiting periods of more than a year may occur before the referral is accepted or rejected.) Clients in remote areas were less likely than urban clients to be closed successfully.

It is not a policy of the Division to give preference to clients who indicate a high probability of success. But because of budget limitations, service shortages, imcomplete control procedures, and a heavy emphasis on closures, there was apparantly a client selection process that favored less costly or easier closures. As a practical matter, it may be necessary to operate on a forced choice basis, but if so, it should be done according to a systematic set of guidelines and priorities.

A larger number of active or near-active clients were carried into fiscal 1968 than into fiscal 1967, suggesting that services will have to be delivered at a faster rate and at a proportionally higher cost in order

to meet production goals and avoid excessive backlogs. Inventory planning over several years, consistent with production goals and policies, would benefit all agencies involved.

It is extremely difficult to obtain specialized rehabilitation services because of the severe shortage of facilities in Maine. The DVR does not appear to make as much use as it might of the facilities that do exist. For the facilities that it does use extensively, it does not--with one exception--appear to provide commensurate financial support.

(2) Funding

The funding of the DVR has always been substantially below the level of the federal allotment for Maine. The agency has not been able, for various reasons, to make the most effective case for its program before the legislature. The current statewide planning activity should, however, provide a solid base for a more vigorous effort in this direction.

(3) Expenditure Patterns

The pattern of expenditures for case services highlights the scarcity of rehabilitation facilities and the relative emphasis on low-cost cases. A substantial portion of the agency's expenditures goes to purveyors of goods and services; the agency lacks a fully developed system of qualification and control of the vendors with whom it deals.

(4) Organization

The DVR's relatively new organizational structure is logical and adequate to its present level of operations. It will, however, require augmentation at the supervisory and administrative levels as the program grows.

The supervisory positions carry a broad range of responsibilities, and they suffer somewhat from a lack of explicit guidelines and procedures. Some decentralization of authority for allocation and control of case services funds would probably be beneficial.

The quality of supervision and internal communication is variable; more systematic, up-to-date guidelines and procedures are needed. The counseling staff has increased substantially, and the agency's recently expanded orientation program should be augmented by a more comprehensive program of inservice training, supported by a more systematic approach to performance evaluation.*

*It should be noted in this context that since the Harbridge House evaluation was prepared, DVR has taken steps to implement this particular recommendation by employing a full-time in-service training coordinator and instituting a comprehensive training program. Following an assessment of needs in which the entire professional staff participated, a training program has been developed which includes seminars, area conferences, workshops and institutes, as well as individual enrollment in university courses. Emphasis in this expanded program of staff development is on casework practices, counseling theory and techniques, specific disabling conditions, and other professional areas of responsibility.

(5) Program Review and Control

The agency has begun to move toward a more comprehensive system for review and control of program operations. At present, the supervision of case services is informal and uneven in quality. (The reader is referred to Appendix A where examples of "Evaluation Criteria for Counselor Performance" as suggested by Harbridge House are included.)

Counselors do not have an efficient method for managing their caseloads. This, in turn, impedes the supervisory process because it is difficult to get a full picture of the aggregate of clients at various stages of service. Each counselor should have a plan for expediting the progression of clients and applicants through service and a method by which the plan can be tracked. (Appendix B describes a "Caseload Monitoring System"as suggested by Harbridge House.)

The DVR lacks an adequate information system for monitoring of overall agency performance, with clear criteria for assessing results and procedures for close and timely control of expenditures and case services.

(6) External Relations

The image of the DVR that prevails among the legislature, the public, and other public and private agencies is variable, but generally less favorable than it should be. Among the field staff of other agencies, it is poor and this is a serious impediment to continuity of service. The attitude toward the DVR among agency heads and supervisors is more positive. The DVR has not exploited its accomplishments. It has not used systematic planning as a tool for enlisting legislative, agency, and local support, and it has not provided the staff with a plan for and system of informational services. More effort needs to be expended to inform potential employers of the skills and capabilities of rehabilitated persons.

Continuity of services among rehabilitation agencies is improving, but it is variable in quality and not systematically coordinated. The DVR's counselors are not uniformly knowledgeable about other services. No formal system is available to set standards for, and to monitor and control, interagency cooperation. The DVR does not bear full responsibility for development of a statewide plan, but it should have performance standards for referrals into and out of the agency.

(7) Planning, Research and Program Development

Planning is done on isolated segments of the program, but it is not systematic, it does not project far enough into the future, and its results are not adequately communicated within the DVR to other agencies or to members of the legislature.* It should become a formal activity for which all staff members have some degree of responsibility. Similarly, program research should be expanded to support the development of program plans and expanded services.

*DVR has taken definite steps to begin implementing this recommendation in two ways: (a) by assigning its former facilities specialist to full-time research and program development activities, and (b) by bringing into the central office a full-time supervisor of vocational rehabilitation programs now being conducted in the state correctional institutions.

The recent establishment of several cooperative projects to expand services to certain target groups is a major step in the development of the DVR program. Progress in this direction has been impeded by staffing difficulties, but these are being overcome.

Some recommendations pertaining to the Division of Vocational Rehabilitation which the Commission believes should be implemented without delay are the following*

PLACE AT LEAST ONE ADDITIONAL COUNSELOR IN EACH OF THE AGENCY'S EIGHT DISTRICT OFFICES.

This would accomplish several desirable results and especially these:

--Provide better population and geographic coverage, enabling each counselor to spend a larger proportion of his time in getting to know his clients' problems and to provide counseling and other rehabilitation services. Even more important, such services could be provided more promptly. (As of October 1, 1968, the agency's rolls contained over 1,200 of clients still in "referral" status.)

--Avoid client neglect when another worker in the district is absent because of illness, vacation, or educational leave.

ASSIGN A SPECIAL COUNSELOR TO PROVIDE CONSTANT LIAISON WITH HOSPITALS IN EACH OF AT LEAST FOUR COMMUNITIES: PORTLAND, LEWISTON, WATERVILLE, AND BANGOR.

This proposal has not only been emphasized by the Commission through its regional task forces and special consultants, but is also a recommendation of the Department of Health and Welfare. Its objectives are to:

--Establish such a relationship with hospital staffs as to promote early referral to VR of all patients whose impairments indicate the likelihood of their eligibility and need for vocational rehabilitation service.

--Provide for VR service to eligible clients earlier, thus enabling them to return to suitable employment with less loss of time and less family disruption. Too often severely impaired patients return home from hospitals discouraged and frightened about the future. Many months may go by before they come to the attention of Vocational Rehabilitation. Their preparation for return to employment is seriously delayed and made more difficult because of that delay.

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*Recommendations presented here are as stated in "Legislative Proposals Relating to the Division of Vocational Rehabilitation," a fact sheet prepared and distributed by the Division, February 3, 1969.

PROVIDE CLOSER LIAISON WITH SCHOOL SYSTEMS BY ASSIGNING VR

COUNSELORS PART TIME IN THE MAJOR SCHOOL SYSTEMS- SECONDARY LEVEL

The Commission's study has emphasized two contributions which it considered Vocational Rehabilitation, because of its experience and varied services, could make to the schools:

--Help in earlier detection of those students who have impairments, thereby making it possible for some to receive preventive services and avoid the necessity for more costly and prolonged services later.

--Counseling and other rehabilitation services, especially during the latter half of high school, to make the eventual rehabilitation of eligible handicapped students more effective. (This result is being well demonstrated by the recent DVR program in cooperation with the Waterville, Oakland, Fairfield, and Winslow schools.)

OBTAIN APPROVAL OF PERMANENT STATUS FOR TEN CURRENT "LIMITED

APPOINTMENT" POSITIONS WHICH HAVE ENABLED THE DIVISION TO

INITIATE COOPERATIVE VOCATIONAL REHABILITATION UNITS IN EACH

OF THE STATE CORRECTIONAL INSTITUTIONS.

This interagency program is aimed at helping parolees and dischargees become adequate and acceptable citizens when they return to the community. (See Chapter IV, Section C-2)

PROVIDE CLOSER CONTACT WITH REHABILITATION SERVICES FOR ELIGIBLE

PATIENTS OF STATE INSTITUTIONS, SUCH AS THE PSYCHIATRIC HOSPITALS.

The objective would be to strengthen the patients' safeguards against breakdown and to improve their post-hospital level of employment through better evaluation and training.

ADD SUCH SUPPLEMENTAL PROFESSIONAL, ADMINISTRATIVE, AND CLERICAL

STAFF AS NEEDED TO BALANCE THE INCREASED FIELD STAFF.

Division of Eye Care and Special Services* (ECSS)

The Vocational Rehabilitation program of the Division of Eye Care and Special Services in the Department of Health and Welfare has entered on a period of substantial expansion. It has, on the whole, performed effectively within the limits of the available resources.

*Except where otherwise noted, the observations appearing in this section are quoted verbatim from Harbridge House Assessment of Agency Performance, Part VI-1, passim.

The Division's principal problems appear to lie ahead of it. There is a substantial unmet need for rehabilitation of the visually handicapped, and there is a serious lack of specialized rehabilitation facilities within the state. The Division has managed its program by informal means thus far, but most of its methods will be inadequate for an expanded program and staff.

a. Problems Outside the Agency's Control

A number of problems and obstacles to agency effectiveness lie outside the direct control of the Division. They include the unforeseeable vagaries of the political process as in legislative deadlocks; the large areas of low population, where service is extremely difficult to provide; the generally low salary levels of the civil service, and the scarcity of specialized rehabilitation facilities in the state.

These problems appear to affect the Division of Eye Care and Special Services somewhat less seriously than the DVR. The VR program and staff are relatively small, and they are housed in a department that provides substantial administrative and program support. Nonetheless, the program is adversely affected by funding delays, inaccessible clients, low salaries, and lack of facilities, and ECSS can make common cause with the DVR, the statewide planning effort, and other interested public and private agencies and individuals to help develop public and legislative support, and to explore new ways of organizing, coordinating and delivering services to the handicapped in Maine.

b. Controllable Activities

The following observations summarize the principal findings and conclusions of Harbridge House on those activities over which the Division has a substantial degree of control.

(1) Services to Clients

The Division makes an effort to serve a balanced range of clients, as measured by age, severity of disability, and other characteristics. It has recently been placing particular emphasis on reaching younger clients and the more severely disabled.

The number of successful rehabilitations is relatively high in relation to the number of cases closed not rehabilitated.

The probability of success does not appear to vary significantly with age, location, or severity, although clients with a single disability tend to do better than those with multiple disabilities, and a high proportion of rural clients tend to be placed in homework and homemaking occupations.

The agency appears to be maintaining an adequate supply of referrals, and counselor caseloads do not reflect a disproportionate number of cases in referral status. Many referrals, however, experience excessive delays in getting service.

(2) Funding

The funding of the Division's VR program is substantially below the level of the federal allocation, but the Division makes effective use of the funds that it receives. With the active support of the Department of Health and Welfare, it has been able to present an effective case to the legislature in support of budget requests.

(3) Expenditure Patterns

The Division's expenditures have increased at an appreciably greater rate than its productivity. Its expenditure patterns for case services reflect the increased emphasis on medical services and service to the more severely disabled. High-cost cases account for a relatively high proportion of rehabilitants.

Although a large proportion of its funds goes to purveyors of goods and services, the Division lacks a fully developed system of qualification and control of the vendors with whom it deals.

(4) Organization

The organizational structure of the VR program is adequate for the present, but additional supervisory and administrative capability will be required if the program and counseling staff expand appreciably.

The Chief of Rehabilitation Services has a broad range of responsibilities, but lacks the administrative systems and procedures required for maximum efficiency. Greater decentralization of authority for allocation and control of case services funds would probably be beneficial.

Internal communication is, for the most part, informal. More systematic standards and guidelines, and a more systematic procedure for administrative issuances, are needed.

The Division makes effective use of educational leave for upgrading the professional staff. It lacks a systematic means of evaluating performance and planning in-service training to meet individual needs.

(5) Program Review and Control

The Division lacks an information system and a procedure for monitoring and control of overall performance. Its informal procedures have been adequate to the need thus far, but they will not suffice for an expanding program. Too much of the review process depends on the personal, current knowledge of the Chief of Rehabilitation Services.

Counselors do not have an efficient system of caseload management. Such a system, which should include a plan for expediting the progression of clients through the service cycle and standards for measuring counselor performance, would help to reduce delays in service and alleviate the strains of program expansion.

(6) External Relations

In general, the Division's relations with the legislature, the public, and other public and private agencies are good. It could, however, make a greater effort to enlist the cooperation and support of potential employees.

Interagency relations are occasionally hampered by the lack of definition in interagency agreements as to responsibilities, procedures, standards, and controls.

(7) Research, Planning, and Program Development

Program planning is not formal or systematic, but there is an effort to guide the program in a predetermined direction. The Division is expanding its VR program in selected areas, but it has no special projects and no plans for any. As in other areas, the informal approach of the past will probably not suffice for an expanding program.

3. Administrative Relocation of the State Vocational Rehabilitation Agency

a. Study of a Centralized Rehabilitation Services Unit

In the spring of 1968 the full Policy Commission divided itself into 14 subcommittees to review specific topic areas which had been identified during the previous year of planning. The procedure adopted by the Commission required that each subcommittee address itself to certain of these areas and that in doing so, the subcommittee should take into consideration the recommendations of the regional task forces, consultants, and special study committees relating to the particular area of concern. From these preliminary recommendations and other relevant findings, the subcommittees then developed recommendations for presentation to the full Commission.

One of these subcommittees devoted its attention to the Organization and Administration of Public Vocational Rehabilitation Services. The Commission members who served on it were Prof. Leonard W. Mayo, chairman, Dr. Charles D. McEvoy, and the two vocational rehabilitation agency directors Elmer L. Mitchell, Division of Vocational Rehabilitation, and C. Owen Pollard, Division of Eye Care and Special Services.

From April 1, 1968, to September 1, 1968, this subcommittee gave intensive study to the most effective placement, administration, and organization of state vocational rehabilitation services. In the course of their deliberations they discussed the alternatives in depth with task force and Commission members; public and private agency heads, the Commissioner of Education, William T. Logan, and Commissioner of Health and Welfare, Dr. Dean Fisher; members of the State Attorney General's office; and Social and Rehabilitation Service officials at both the regional and national levels. Based upon these discussions and the Commission's previous findings, the following recommendation was developed:

THERE SHOULD BE CREATED WITHIN THE DEPARTMENT OF HEALTH AND WELFARE A FUNCTIONAL UNIT OF REHABILITATION SERVICES, WHICH SHOULD BE EQUAL IN ADMINISTRATIVE LEVEL AND STATUS WITH THE OTHER MAJOR ADMINISTRATIVE UNITS WITHIN THE DEPARTMENT.

In order that Vocational Rehabilitation Services be centralized within one Department, the subcommittee recommended further that:

ALL FUNCTIONS OF THE DIVISION OF VOCATIONAL REHABILITATION INCLUDING AUTHORIZED PERSONNEL AND ALL APPROPRIATIONS AND ALLOCATIONS, BE TRANSFERRED FROM THE DEPARTMENT OF EDUCATION TO THE DEPARTMENT OF HEALTH AND WELFARE WITHIN THE REHABILITATION SERVICES UNIT.

Prior to its adoption by the full Policy Commission early in October 1968 as one of 20 major recommendations, the proposal to establish the functional unit as stated above was discussed at length with Gov. Kenneth M. Curtis, who gave it his full endorsement. After its final adoption by the Commission, Governor Curtis gave the matter particular emphasis when addressing his statewide Conference on Rehabilitation Needs held October 29, 1968, in Augusta.

Later he chose to include the recommendation and the legislation which was drafted to implement it as part of his own legislative program to the 104th Legislature. In his special message on "Human Resources", delivered to the legislature on February 4, 1969, Governor Curtis formally proposed the creation of the functional unit, stating that the unit should:

> ...coordinate the services of the Division of Vocational Rehabilitation, to be transferred from the Department of Education, plus the Division of Eye Care and Special Services, the Division of Alcoholism Services, and any other rehabilitation programs that are developed. (8)

b. The Legislative Bill to Reorganize and Revise Public Rehabilitation Services

This bill, Legislative Document 925, is designed to create a broad rehabilitation statute including revision of the Vocational Rehabilitation Act and to provide for the administrative reorganization of public rehabilitation services within one departmental structure. Briefly entitled, "Public Rehabilitation Services," the legislative document includes essentially four (4) parts:

> --Part 1 of the L.D. creates a functional unit of rehabilitation services within the Department of Health and Welfare at a level comparable to the Bureaus of Health, Social Welfare, Medical Care and Administration.
>
> --Part 2 creates a broad rehabilitation services law including revision of the State Vocational Rehabilitation Act. Thus, the vocational rehabilitation act providing for public vocational rehabilitation services would be removed from the Department of Education Revised Statutes (Title 20) and placed under "Health," subtitle "Public Rehabilitation Services" within the Revised Statutes of the Department of Health and Welfare (Title 22).
>
> --Part 3 transfers the Division of Vocational Rehabilitation from the Department of Education to the Department of Health and Welfare.
>
> --Part 4 provides for an appropriation of $27,394 of state money requested from the General Fund to cover the administrative costs of establishing the proposed unit.

In drafting this legislation, the subcommittee took note of the fact that 71% of this $27,394 state appropriation may be matched by available federal Vocational Rehabilitation funds at the new 4:1 ratio, and would thus generate a total of $97,245. It estimated further that in fiscal 1970, with a total working appropriation of approximately $750,000 for

the entire functional unit, some $2,500,000 of federal Vocational Rehabilitation funds would be available for the operation of these rehabilitation services.

It is noteworthy that the recommendation as it has evolved originated early in the fact finding and evaluation phase of the Commission's planning. Each of the six regional task forces devoted considerable attention to restructuring the administration and delivery of vocational rehabilitation services, and of integrating them within a framework which would enhance their effectiveness and also encourage maximum utilization of available state and federal funds. Task Force I, II, III, IV, V and VI all recommended specifically that a single, integrated and functional unit of rehabilitation services be created, and that this unit be established within the Department of Health and Welfare.

Since its formal presentation as a major recommendation of the Commission at the Governor's Conference in October, the proposed legislation in the form of L.D. 925 has received the backing of hundreds of interested individuals and the official endorsement of more than 257 public and private organizations.

4. Personnel Recruitment, Training and Utilization

Manpower shortages in virtually all areas of rehabilitation, together with the perennial shortage of sufficient funds, are undoubtedly the two most serious obstacles to the successful functioning of public and private agencies in the rehabilitation field. In effect, both constitute a single problem: When funds are lacking, adequate numbers of qualified personnel are not to be had and agencies by necessity must continue to do the best they can with the resources at hand.

This philosophy, however, imposes strict limitations on the quantity and quality of services provided. The result is that only a fraction of the need is met, and thousands of persons who could be restored to productivity--or who might never have become disabled in the first place--are consigned to neglect.

Recommendations for greater numbers of trained personnel are either stated or implied throughout this report, reflecting concern expressed by Commission members, task forces, consultants, and study committees. Projected budgets submitted by the state agencies responsible for implementing various aspects of Maine's public rehabilitation programs were drawn up with many of these specific recommendations in mind. Approval of these budget requests by the current legislature would therefore have the effect of translating short term goals into action programs during the current biennium, and would go a long way toward reaching the ultimate long term goal of serving every handicapped person in the state during the next decade.

More adequate staffing patterns for the state agencies and institutions have also been strongly urged by Governor Curtis and by many legislative and community leaders who realize that only in this way can the challenge of Maine's unused human resources be met.

Essential, also, are improved salary scales; more realistic case loads for counselors, social workers, probation-parole officers and other rehabilitation personnel; and by no means least, more effective programs of training and recruiting qualified people into rehabilitation careers. In this latter instance, it is vitally important that a strong network of communication and collaboration be developed between agencies and institutions that produce or have assumed training responsibilities for rehabilitation personnel (e.g. the State University system, private colleges, major medical facilities,) and those who use them (the public and voluntary rehabilitation services, public school districts, etc.)

Problems Peculiar to Maine

Despite the many benefits which America's Vacationland offers its wage-earning residents, it is still beset with a variety of problems which hamper the recruitment and retention of trained personnel, especially those who have acquired a considerable degree of technical or professional competence. While the state undoubtedly has comparatively purer lakes and streams and air, less highway congestion, and a more unhurried mode of living than other urbanized areas along the Atlantic seaboard, these commendable features may well be offset for many persons by some equally obvious deficits.

Notable among these are low salaries (compared with living costs); lack of cultural activities and opportunities for personal and professional advancement through easily accessible programs of higher learning; transportation barriers and the clustering of community services in widely scattered regional centers; modest state expenditures for social services and education at all levels; and a generally conservative viewpoint which seeks to maintain the status quo and looks with a typically Down East mixture of suspicion and humor upon innovative and "radical" change. While Maine residents are proud to point out that the "old ways" have been preserved and, more important, have retained their validity in a period of nationwide cultural upheaval, they are still uneasily conscious of the fact that the state's much-needed industrial development, bringing opportunities for employment, technological advance, and municipal improvement, as well as a much healthier overall state economy, have been slow in coming about.

The result of these and other socio-cultural-economic factors is that the state is in a generally unfavorable position to attract highly skilled and trained professional manpower from out-of-state, especially those in the younger age group. The most promising approach to solving manpower problems here will be to educate, train and recruit persons, especially young persons, from among Maine's own resident population. This, evidently, will require the provision of incentives attractive enough to halt the steady flow of young people who annually leave Maine to establish careers and raise their families in other states.

The prevailing socio-cultural-economic climate has equally portentous implications for the delivery of rehabilitation services. Persons working in the social service fields are hampered by a somewhat unenlightened attitude on the part of the general public regarding what the purposes of these services should be, and the benefits to the community and the general economy which derive from them. Personnel are hampered also by having to travel long distances in the course of their daily work with clients; heavy client-worker ratios; scarcity of available rehabilitation services and facilities to which they can refer clients or which can aid them in providing supportive services; lack of cooperation and coordination among the agencies that do exist, brought about largely by the pressures of heavy case loads and lack of time which preclude what otherwise could be a sound liaison relationship developed through joint planning and sharing of interests, and fruitful personal interactions.

Reversing the Trends

On the positive side, however, Maine has a unique opportunity to establish productive working relationships for the very reasons which we have here called "deficits." Geographical and transportation obstacles can be overcome through modern technological advancements in communication and travel. Maine's administrative structures, too, are relatively uncomplex and personal, compared with such urbanized areas as New York City, for example. Professional people, like everyone else in Maine, can get to know one another without having to cross the social and administrative barriers that mandate roles and draw demarcation lines around subgroups, professional and otherwise, in the vastly more complex urban cultures. And because the regional centers have strong ties with their surrounding neighborhoods, a regional concept of shared services through close teamwork and enlightened self-interest is entirely possible and feasible.

Not least, the Down East temper is predominantly democratic and tolerant and, perhaps above all, pragmatic: Maine people are ready enough to shed their doubts about whether or not a system will work as soon as they are shown that it really does. They also are known for having a canny business sense: If a one dollar investment is certain to return four, it can almost be predicted that the Maine Yankee will take this "chance." Finally, even though he is a firm believer in self-help, he goes to fires not to watch them but to help put them out; he joins the other men in the community to raise a new barn for his neighbor; and his moral conscience, passed down to him from his puritan ancestors, dictates that a neighbor who "deserves" his help shall receive it. In other words, his heritage permits, indeed requires him to be simultaneously humanitarian and utilitarian; there is no dichotomy between them.

This high regard for utility implies also a refined sense of economy: One does not waste or abuse what is known to be useful. When applied to the perceived practices of government, it may well generate apprehension about the extent to which government, especially "big government", honors these deeply-held precepts in both its practical and theoretical operations. Accordingly, it is of utmost importance that public rehabilitation agencies not only take infinite pains to utilize all available resources with maximum efficiency and resourcefulness; they must be equally vigilant in their efforts (or more appropriately, their responsibility) to show the taxpaying public what is being done, in terms of a good financial return on the total investment.

The Commission recognizes--and so, we believe, does the general public--that these investment returns can, and are being, demonstrated. But nonetheless it is essential that inefficiency, overlapping of functions, and fragmentation of services which frustrates and blocks the rehabilitation of clients be eliminated where these are found to exist. A good way of doing this is a concerted effort on the part of both public and private agencies to develop an approach to serving clients that makes full use of all available manpower resources in an orderly, efficient, and "team-spirited" manner. Specifically, it is recommended that:

AN INTERDEPARTMENTAL COMMISSION ON HEALTH MANPOWER SERVICES SHOULD BE CREATED UNDER THE AUSPICES OF THE STATE PLANNING OFFICE TO EVALUATE BOTH THE INTRA-AND INTERAGENCY ROLES OF PRESENT AND PROJECTED HEALTH SERVICE PERSONNEL.

This Interdepartmental Commission should be comprised of the directors (or their designated representatives) of the State Department of Personnel, state departments that provide health services, manpower services, and the major private and voluntary health service organizations of the state. One of the major undertakings of this proposed Commission should be to provide leadership and guidance for an in-depth study of both professional and paraprofessional job requirements and responsibilities of health services personnel. The Interdepartmental Commission could thus become the central body to authorize contracts with institutions of higher learning or professional research organizations to serve as consultants and carry out study details.

Development of Rehabilitation Personnel

A more immediate and particularized need is for an extensive study of the personnel structure and job requirements of vocational rehabilitation staff of the public rehabilitation agencies at the present time. Accordingly, it is recommended that:

THE PUBLIC REHABILITATION AGENCIES HAVING PRIMARY RESPONSIBILITY FOR VOCATIONAL REHABILITATION WORK WITH THE MAINE COMMISSION ON REHABILITATION NEEDS TO CONDUCT A STUDY OF VOCATIONAL REHABILITATION PERSONNEL FUNCTIONS AND STAFFING REQUIREMENTS IN TERMS OF THE CURRENT CLASSIFICATION SYSTEM, SALARY STRUCTURE, AND STAFF UTILIZATION.

A preliminary evaluation of staffing patterns within the Division of Vocational Rehabilitation and the Vocational Rehabilitation Unit of the Division of Eye Care and Special Services was part of the overall assessment of the two agencies prepared for the Commission by Harbridge House. (3) This study, as we have indicated in Section F-3 of this chapter, presents a number of general findings and conclusions intended to serve as guidelines for future planning and a more detailed assessment of agency functions. It includes observations concerning salary structure, hiring procedures, and current practices in the areas of personnel evaluation and staff development.

Some of the general recommendations made by Harbridge House have already been implemented by the respective Divisions; for example, the Division of Vocational Rehabilitation now has a full-time training specialist and a greatly expanded program of staff development has been initiated. However, the recommendation for the development and adoption of new policies and procedures on salaries, job classifications, and staff utilization has not yet been implemented.

The following recommendations for in-service training, continuing education, recruitment, and professional development of rehabilitation personnel evolved throughout the full term of the Commission's statewide planning project. These reflect the thinking and conclusions of in-state and out-of-state consultants, special study committees, the regional task forces, and the Commission subcommittee on Professional Development of Rehabilitation Personnel chaired by Prof. Louis A. Ploch of the University of Maine.

1. Professional Qualifications:

ALL PERSONS HIRED FOR COUNSELING POSITIONS IN THE TWO VOCATIONAL REHABILITATION AGENCIES SHOULD HAVE A MINIMUM OF A BACCALAUREATE DEGREE. IN MOST CASES, IF NOT ALL, THE DEGREE SHOULD HAVE INCLUDED A STRONG EMPHASIS ON THE BEHAVIORAL AND SOCIAL SCIENCES.

If for any reason a person without a bacalaureate degree is hired, such person should be required to obtain a degree within a specified period. The individual should be at least partly subsidized for such education.

2. Orientation and Supervision:

NEWLY HIRED COUNSELORS SHOULD RECEIVE ADEQUATE ORIENTATION AND AT LEAST SIX MONTHS OF ON-THE-JOB SUPERVISION.

3. In-Service Training:

THE PUBLIC REHABILITATION AGENCIES AND STATE INSTITUTIONS SHOULD PROVIDE CONTINUING IN-SERVICE TRAINING PROGRAMS FOR ALL EMPLOYEES. THESE PROGRAMS SHOULD STRESS THE INTERPERSONAL APPROACH NECESSARY FOR THE REHABILITATION PROCESS TO BE SUCCESSFUL.

Suggested areas to be given emphasis in staff training programs for counseling personnel include: psychological testing services, dynamics of behavioral pathology and psychological adjustment, counseling techniques with special emphasis on the life styles and aspiration levels of the culturally and economically disadvantaged, adaptive skills development, self-help programs, and techniques of job placement and follow-up.

4. Continuing Education:

ALL PROFESSIONAL PERSONS HIRED WITH LESS THAN A MASTER'S DEGREE SHOULD BE GRANTED EDUCATIONAL LEAVE AS SOON AS POSSIBLE AND NO LATER THAN SIX YEARS AFTER BEING HIRED.

TUITION COSTS FOR ADVANCED COURSES TAKEN BY PROFESSIONAL EMPLOYEES SHOULD BE REIMBURSED WHEN THESE COURSES ARE RELATED TO JOB PERFORMANCE.

ALL AGENCIES SHOULD BE SUFFICIENTLY STAFFED THAT THE GRANTING OF EDUCATIONAL LEAVE WILL NOT CAUSE AN UNREASONABLE WORK LOAD TO FALL ON ANYONE.

SPECIFIC PLANS SHOULD BE DEVELOPED THAT WILL ENCOURAGE AND PROVIDE INCENTIVE TO NON-PROFESSIONAL PERSONNEL TO UPGRADE THEIR EDUCATIONAL STATUS.

WHENEVER PERSONNEL COMPLETE A MAJOR COURSE OF IN-SERVICE TRAINING OR RECOGNIZED OFF-SITE PROGRAM, THEY SHOULD RECEIVE WAGE INCREASES COMMENSURATE WITH THEIR NEW OR ADVANCED TRAINING ACCORDING TO ACCEPTABLE PERSONNEL DEPARTMENT REGULATIONS.

THE STATE DEPARTMENT OF PERSONNEL SHOULD BE ENCOURAGED TO REVIEW ITS POLICIES REGARDING THE EDUCATIONAL ADVANCEMENT OF REHABILITATION PERSONNEL WITH A VIEW TO IMPLEMENTING A UNIFORM PROCEDURE WHICH WILL GRANT DUE RECOGNITION AND FINANCIAL REWARDS TO EMPLOYEES WHO ACHIEVE RECOGNIZED EDUCATIONAL OBJECTIVES.

5. Development of a Formal Academic and Training Curriculum

THE STATE UNIVERSITY SYSTEM SHOULD PROCEED IMMEDIATELY TO DEVELOP FORMAL DEGREE PROGRAMS FOR THE TRAINING AND ACCREDITATION OF REHABILITATION COUNSELORS, WITH PROVISION FOR TRANSFER OF CREDITS EARNED IN ACCORDANCE WITH TERMS OF THE NEW ENGLAND EDUCATION COMPACT.

In addition to the formal academic programs for rehabilitation counselors leading to the baccalaureate and master's degrees, the University and colleges should also offer a variety of practical programs for the training of both professional and paraprofessional personnel. Preservice degree programs leading to careers in rehabilitation should have a strong liberal arts base, but there should also be emphasis on supervision, consultation, administration, and preparation for work in interdisciplinary settings.

Much greater efforts should be made to obtain available federal grants for the support of these programs of higher education.

PUBLIC AND PRIVATE AGENCIES ENGAGED IN REHABILITATION SHOULD CONTRACT WITH THE CONTINUING EDUCATION DIVISION (CED) OF THE UNIVERSITY OF MAINE AND OTHER INSTITUTIONS OF HIGHER LEARNING TO PROVIDE A WIDE RANGE OF BOTH CREDIT AND NON-CREDIT COURSES IN THE BEHAVIORAL AND SOCIAL SCIENCES AND IN THE FUNCTIONAL ASPECTS OF REHABILITATION PRACTICES.

Interdepartmental cooperation and planning among such agencies as the public rehabilitation services, Employment Security Commission, Department of Mental Health and Corrections, Veterans Administration, and the private and voluntary organizations that employ persons in some phase of rehabilitation activity would ensure the enrollment of a sufficient number of students to justify a broad curriculum of both general and specialized courses.

Additionally, arrangements should be made with the New England Center for Continuing Education to provide credit and non-credit courses for rehabilitation personnel in the tri-state (Maine, New Hampshire, and Vermont) area and in the New England region. Cooperative interstate agreements relating to such areas as research and program planning, exchange of information on training resources which can be utilized on a regional basis, exchange of in-service trainees should also be further explored and implemented. The interstate education compact provides the means for implementing these programs.

6. Staff Utilization and Recruitment:

RECRUITMENT AND TRAINING PROGRAMS SHOULD BE DEVELOPED LEADING TO THE UTILIZATION OF PARA-PROFESSIONAL AND SUPPORTIVE PERSONNEL, SUCH AS AIDES AND ASSISTANTS, FOR PROVISION OF SERVICES NOT REQUIRING FULL PROFESSIONAL PREPARATION.

Special recruitment and training measures should be designed to enlist properly screened persons who are vocationally handicapped by physical or mental impairments and/or economic and social disadvantage. Programs should also be developed by means of which rehabilitation agencies can prepare more of their clients for occupations in the various rehabilitation fields.

Efforts should also be made to recruit more volunteers in rehabilitation agencies as a means of strengthening the services provided, promoting employment opportunities in rehabilitation, and improving community relationships with the agencies.

In areas where strong in-group (ethnic, religious, occupational) cultures exist, there should be efforts to train members of the relevant group to aid professional workers.

THE PUBLIC VOCATIONAL REHABILITATION AGENCIES SHOULD OFFER SUMMER TRAINEESHIPS TO COLLEGE STUDENTS AS A MEANS OF ORIENTATION TO PROBLEMS AND CAPACITIES OF DISABLED PERSONS, FOR CAREER ORIENTATION, AND FOR TESTING OF CAREER DECISIONS. THE AGENCIES SHOULD ALSO CONTINUE TO ENCOURAGE COLLEGE AND UNIVERSITY STUDENTS TO COMPLETE SPECIAL PROJECTS UNDER AGENCY GUIDANCE.

THE POSITIONS OF COUNSELOR TRAINEE AND COUNSELOR AIDE SHOULD BE CREATED WITHIN THE DIVISION OF VOCATIONAL REHABILITATION AS THE FIRST RUNGS OF THE CAREER LADDER, LEADING TO THE POSITION OF COUNSELOR.

7. Salaries and Caseloads

SALARIES AND CASELOADS OF REHABILITATION COUNSELORS SHOULD BE ADJUSTED TO MORE NEARLY CONFORM TO PREVAILING NATIONAL AND NEW ENGLAND STANDARDS.

In addition to the strengthening and expansion of college level courses in all areas of rehabilitation, efforts should be made to interest young people in rehabilitation careers by: (1) including instruction about rehabilitation needs and processes in the elementary and secondary schools, (2) enlisting the interest and support of school guidance counselors, (3) developing recruitment materials such as brochures, films, radio and television spots, etc. and (4) developing recruitment programs through the aid of professional and community-based organizations.

5. Utilization of Completed Research

In the course of planning for comprehensive rehabilitation services in Maine, the Commission has accumulated a valuable collection of informational materials relating to practically every aspect of vocational and total rehabilitation. Printed documents include those prepared for and by the Commission; research studies obtained from a number of different private and public sources; regular publications of federal and state rehabilitation agencies and voluntary organizations; and studies, including final reports, prepared by the other states and territories as part of their comprehensive rehabilitation planning. In the collection, also, are visual materials (films, kinescopes, etc.) and audiotapes, some of which were supplied to the Commission by Maine radio and television stations, and others produced commercially. (47) The project staff has maintained a running file of news clippings, feature stories, magazine articles, etc. which trace the history of Commission planning and report on major findings and recommendations.

Research Abstracts

A useful supplement to the ongoing rehabilitation planning and research activities to be sustained and accelerated by the public rehabilitation agencies is the Commission's rehabilitation library of over 2,000 digests of relevant research information published and distributed by the Regional Rehabilitation Research Institute at the University of Wisconsin. The Commission was one of the early subscribers to the RIS Information Service, and the topical abstracts, ranging over a broad field of rehabilitation interests, have been referred to often since the library was purchased in 1968. A consultant to the Commission, Francis H. Sleeper, M.D., made extensive use of them in compiling his report concerning the directions Maine should be taking in the field of rehabilitation research and some specific ways in which these research activities should be conducted. (60) The RIS digests are printed on $8\frac{1}{2}$ x 11 card stock, and retrieval is facilitated by numbering and filing abstracts serially. Included in the RIS model are an automated system (decks of multiple-coded IBM cards) and a manual system of subject index cards coded by subject area.

The complete collection of material which is now housed in the Commission's planning office will be turned over to the Division of Vocational Rehabilitation when the planning project comes to an end. The Division already has a substantial reference library maintained by the staff person responsible for research, program planning, and in-service training activities; the Commission's resource and informational materials will broaden its scope and enhance its usefulness considerably.

Recommendations for Research in Rehabilitation

The following recommendation, described more fully in Chapter IV, Section A, of this report, is considered to be of utmost importance to the development of a substantive and functional program of rehabilitation research in Maine:

THE PROPOSED UNIT OF PUBLIC REHABILITATION SERVICES SHOULD DEVELOP AND KEEP CURRENT A NON-DUPLICATIVE LIST OF KNOWN HANDICAPPED PERSONS IN MAINE ELIGIBLE FOR REHABILITATION SERVICES.

It should become mandatory for state agencies to report all handicapped persons to the proposed central information service, and non-public rehabilitation services should be encouraged and helped to follow the same procedure. A uniform reporting system should be adopted by all agencies, and a central registry of both potential and actual rehabilitation clients should be created and maintained as an ongoing activity within the rehabilitation services unit. Information received at the central registry should be tabulated and stored by means of modern data processing techniques and should be furnished promptly to properly authorized persons upon request.

On the basis of this and other information obtained by the rehabilitation services unit:

AN INTENSIVE STUDY OF REHABILITATION REFERRAL PATTERNS AND PRACTICES SHOULD BE MADE, AND CONTINUING PROGRAM ASSESSMENT OF ALL REHABILITATION SERVICES AND FACILITIES SHOULD BE MAINTAINED.

To implement the functional assessment of rehabilitation processes in Maine and to provide for practical follow-up studies of rehabilitation clients, it is recommended that:

FIVE PERCENT OF STATE MONEY APPROPRIATED FOR VOCATIONAL REHABILITATION SERVICES SHOULD BE EARMARKED FOR RESEARCH EACH YEAR.

The appropriation request which accompanies the Commission's legislative proposal to create a functional unit of rehabilitation services in the Department of Health and Welfare includes an item for the salary of a Deputy Director.

THE PRIME RESPONSIBILITY OF THE REHABILITATION SERVICES UNIT'S DEPUTY DIRECTOR SHOULD BE IN THE AREA OF RESEARCH, PROGRAM PLANNING AND DEVELOPMENT. HE SHOULD DEVELOP AND ADMINISTER A VIABLE PROGRAM OF RESEARCH AND PROGRAM DEVELOPMENT FOR THE COMPOSITE UNIT.

It is important that the Deputy Director work closely with the vocational rehabilitation training supervisor in arranging for workshops and other in-service training programs for the rehabilitation staff. These programs should be utilized as a means of stimulating the development of meaningful research, disseminating information about significant available research, and expediting the utilization of research findings as applicable to rehabilitation procedures.

A MAJOR CONCERN OF THE RESEARCH ACTIVITIES TO BE CONDUCTED BY THE REHABILITATION SERVICES UNIT SHOULD BE TO STIMULATE BASIC AND APPLIED RESEARCH THROUGH THE STATE UNIVERSITY SYSTEM, THE

PRIVATE COLLEGES, AND THE PUBLIC AND PRIVATE HOSPITALS AND LABORATORIES.

Some of the ways in which the rehabilitation services unit should assist and promote this effort are by actively participating in research projects and by aiding the institutions in securing money available in the form of federal grants.

AN ADVISORY COMMITTEE ON RESEARCH TO THE REHABILITATION SERVICES UNIT SHOULD BE ESTABLISHED, WITH REPRESENTATION FROM ALL AGENCIES CONCERNED WITH REHABILITATION.

Among the departments and divisions whose participation and cooperation should be sought are the Executive, Education, Health and Welfare, and Labor and Industry Departments; Bureaus of Mental Health, Corrections, and Mental Retardation; the Industrial Accident and Employment Security Commission. Federal agencies concerned with rehabilitation, such as the Veterans Administration, should also be represented as well as rehabilitation-oriented elements in the private sector; for example, the major insurance underwriters, and the voluntary health and social service organizations.

INSTITUTIONAL AND STATE AGENCY RESEARCH SHOULD BE AUGMENTED BY INCREASING EMPHASIS ON COMMUNITY-ORIENTED RESEARCH.

Use of community aides, particularly in case finding and data collection should be explored, and special consideration should be given to persons vocationally handicapped by such factors as chronic illness, educational deficits, and socioeconomic deprivation.

Suggested Directions for Rehabilitation Research in Maine

A number of areas to which Maine should direct attention in its future research and program planning activities were suggested to the Commission by Dr. Francis Sleeper in his report. (60) An underlying assumption of the report is that basic and applied research must complement each other through ongoing programs aimed at effective research communication and utilization. Some ways of accomplishing this have been proposed in the above recommendations. Research in rehabilitation is above all functional; its chief value is in its relevance to actual situations in which the need for change and improvement has been recognized.

The following topics for practical research in rehabilitation were outlined by Dr. Sleeper in his report:

1. A review of current rehabilitation referral patterns, to be conducted in cooperation with hospitals, training and placement programs, and related services and facilities.

2. Evaluation of the client's overall potential for rehabilitation, comparative results from treatment, and attention to the factor of motivation for recovery.

3. Exploration of "functional restoration," with emphasis on kinds of treatment that can produce this result, and the occupational prognosis of partially restored clients.

4. A comparative study of clients accepted and not accepted for service, with determination of what, if any, rehabilitation services are indicated for non-accepted clients.

5. An investigation into the effect of environmental settings on treatment procedures as a means of preparing institutionalized clients to return to the community (milieu therapy).

6. Effects of extrinsic motivation in the treatment of chronic alcoholism.

7. Environmental and other causes of mental retardation.

8. Factors that predict success in the vocational placement of both the educable and trainable mentally retarded.

9. A study of potential employment opportunities for the blind and other special disability groups to supplement and expand the traditionally accepted areas.

G. SPECIAL PLANNING TOPICS

1. Architectural Barriers

The recognition that many of our physically handicapped citizens are being barred from employment, and even from exercising the rights and duties of citizenship, simply because they are unable to enter and use buildings of all types in the community, prompted the regional task forces, consultants, study groups, and a special Commission subcommittee on "Rehabilitation Barriers" to address themselves to this problem. They were especially concerned with the need to eliminate architectural barriers in buildings designed for public use, as well as the many industries, shops, and other privately owned structures which are accessible only to the physically fit.

The Commission's survey of employers and their hiring practices in regard to the handicapped pointed up the fact that the physical layout of the plant or place of business is a primary reason why certain types of physically handicapped persons such as those with visual impairments and the wheelchair confined are not employed. (57, p.5) For example, in response to the question "Would you hire someone in a wheelchair?" 31 of the 120 employers interviewed stated that "the layout of the facilities (architectural design) would not permit."

The problem is equally serious with regard to buildings constructed with public funds. Noting that the physically handicapped and the disabled aging have as much right as anyone to use these buildings, the task forces and the Commission's subcommittee cited the following comments by the National Commission charged with developing specific recommendations for the elimination of architectural barriers: (10, pp. 1-4)

> Due to medical and rehabilitation advances, the number of aged and disabled people in the population is steadily increasing and fewer of them are housebound.
>
> The modern man-made environment is designed for the young and healthy. Yet almost everyone, sooner or later, is handicapped by a chronic or temporary disability or by the infirmities of old age. By designing for the ideal human body, we bar real people from getting an education, earning a living, becoming a part of active community life.
>
> One out of 10 persons has some disability which prevents him from using buildings and facilities designed only for the physically fit...Over and beyond the handicapped one-tenth of the Nation are the millions temporarily disabled by accidents who could return to school or work sooner if buildings were designed for accessibility.
>
> ...During the next 10 years there will be increasing numbers of traffic accident victims who become permanently disabled.
>
> The number of war veterans who must use wheelchairs is also increasing, both because of the nature of the war in Vietnam--with its land-mines and boobytraps--results in proportionately more crippling wounds and because medical advances enables more men to live.

Every year, 100,000 babies are added to the population who are born with kinds of defects that will require them to use crutches, braces, or wheelchairs all their lives. In the past, fewer such babies lived...

In Maine, the Pine Tree Society for Crippled Children and Adults, which administers the state's Easter Seal program, conducts a continuing survey of public and private buildings in terms of their accessibility to the handicapped. The Society also provides leadership and direction for an ongoing informational program, in partnership with both the President's and the Governor's Committees on Employment of the Handicapped, aimed at arousing public interest in eliminating and preventing architectural barriers through organized state and community action. The Commission recommends that:

THE PINE TREE SOCIETY FOR CRIPPLED CHILDREN AND ADULTS SHOULD CONTINUE TO EXERT LEADERSHIP IN THE REMOVAL OF ARCHITECTURAL BARRIERS, AND THAT ITS EFFORTS TO CREATE AWARENESS OF BARRIERS IN THE COMMUNITY RECEIVE THE FULL SUPPORT OF PUBLIC AND PRIVATE AGENCIES CONCERNED WITH REHABILITATING THE HANDICAPPED IN MAINE.

Commission Activities in Cooperation with Public and Private Programs

Throughout the planning project, the Commission has helped to focus attention on barriers through its own public information program conducted by the project staff and the regional task forces. Architectural and other barriers to rehabilitation have been the subject of numerous releases to the news media, and these have been given wide circulation by radio, television, and the daily and weekly press.

A further example of the Commission's interest in this area was its distribution to task force members and other rehabilitation planners of the Design for ALL Americans report cited earlier in this section.

An early recommendation of the Commission was for a proposed revision of Maine's architectural barriers law to make it apply not only to the construction of new public buildings but also to the major reconstruction, remodeling, or enlargement of existing ones. Enabling legislation was drafted by the Governor's Committee on Employment of the Handicapped, and it has since been enacted into law by the 104th Legislature.

William P. McCahill, executive secretary of the President's Committee on Employment of the Handicapped, was a keynote speaker at the Governor's Conference on Rehabilitation Needs in Augusta on October 29, 1968. The Conference, which was attended by more than 400 Commission planners and interested citizens, was given excellent coverage by the statewide media. In his remarks on "Untapped Resources," Mr. McCahill said:

One of our greatest untapped assets is the young disabled veteran coming back to careless communities across our country. Many of

these young men are wheeling their chrome chairs home to college campuses where they can't get to second or third floor classes once they do get inside. It wasn't planned that way, but architectural barriers just as effectively deprive them of their rightful education as they have their younger disabled brothers and sisters who can't get an education in 90% of our high schools today without being hauled up and down stairs like a sack of potatoes.

...Actually, we should shape our environment for tomorrow not for the average person but for the less than average, physically. If we do this, we will eliminate the present barriers of architecture and make our own old age a more meaningful and less frustrating time of life. (40)

Architectural Barriers Law

Maine's first legislation requiring public buildings to be made accessible to the physically handicapped was enacted by the 103rd Legislature. Although it applied only to new buildings constructed in whole or in part with funds of the state or its political subdivisions, it followed the federal guidelines in specifying:

--Grading to attain a level with at least one primary entrance,

--At least one public walk to a primary entrance, not interrupted by steps or abrupt changes in level,

--Doors at the primary entrance or entrances at grade level to have a clear opening of no less than 32 inches when open, and operable by a single effort,

--Floors to have nonslip surfaces,

--Ramps and stairs constructed in accordance with specifications set forth in the legislation,

--Elevators, rest rooms, drinking fountains, and telephones accessible to and usable by the physically handicapped,

--Doors not intended for normal use to be made identifiable to blind persons, and warning signals for emergencies to provide audible and visual signals simultaneously for the benefit of persons with either hearing or sight disabilities.

Administration of the law is the responsibility of the State Director of Public Improvements, the Commissioner of Education, and the governing officials of counties and municipalities in accordance with their respective authorities.

This original law, which became effective in September 1967, was initiated by the Governor's Committee on Employment of the Handicapped, as was the recent amendment to it--L.D. 310--recommended by the Commission, enacted by the 104th Legislature and signed into law by Governor Curtis in March 1969. The new act adds an additional section to the original law, so that it now applies also to any public building that is remodeled or enlarged at a cost of $250,000 or more. It will become effective in June of this year.

State Parks and Memorials

Maine's state parks and memorials are among her most noted tourist attractions and several thousand in-state and out-of-state visitors enjoy them each year. Yet at present there is none which is completely accessible to the handicapped. It is therefore recommended that:

THE PARK AND RECREATION COMMISSION SHOULD EQUIP AT LEAST ONE STATE PARK WITH SUITABLE FACILITIES FOR PHYSICALLY HANDICAPPED CHILDREN AND ADULTS, AND THAT TO THE EXTENT POSSIBLE NEW STATE PARKS INCORPORATE SUCH FACILITIES.

Attention should be given to permitting access by persons in wheelchairs to the public buildings (exhibits, eating areas, rest rooms), widening and hardtopping some of the trails and walkways, eliminating barriers such as solid curbing around parking areas. Features necessary to permit use by the wheelchair confined, persons on crutches, those with heart conditions, or the elderly, would include ramps to entrances not at ground level, doorways wide enough for a wheelchair, and special guardrails in some instances. All of these adjustments if properly planned for would add little to construction costs and attract increasing numbers of tourists. The State of Georgia is currently equipping a park and recreation area in this way.

As noted in Section C-9 of this chapter, Rural Youth Corps members are now being utilized by the Park and Recreation Commission in the development of boating and picnic facilities at a number of sites in the Northern Aroostook area. This spring they will be involved in landscaping, erecting prefabricated components, and general construction and maintenance. On their own initiative, Rural Youth Corps chapters have shown a keen interest in helping the handicapped. It is believed that their further involvement in making certain of the state's recreation areas accessible to the physically handicapped and the elderly is particularly consistent with their program and objectives.

2. Transportation and Other Barriers to Rehabilitation

The Commission through its task forces and especially its subcommittee on "Barriers to Rehabilitation" reviewed a number of problem areas, including transportation methods and travel routes, which impede effective rehabilitation in the state. The subcommittee adopted a broad approach and in its report to the full Policy Commission, identified the major barriers as follows:

1. A finite disposable income to the residents of Maine.

2. The attitude of the population in establishing priorities concerning the spending of this income.

3. The geography of the state, which involves distance, routes of travel, climate and topography.

4. The demographic characteristics of the population.

Some of these barriers, the subcommittee noted, are amenable to only a small degree of change, although they can be modified:

--Disposable Income. The total amount of money available to citizens of Maine to fulfill their goals and aspirations can be considered a fixed quantity. What is spent to satisfy personal needs and desires, what is donated to churches and other nonprofit charitable institutions, what the citizens are willing and able to pay in taxes--all these can vary, but the total is finite. Within the amount surrendered in taxes, the citizenry must choose what will be spent for highways, police protection, education, pollution control, encouragement of tourists, and all the myraid services of state government, including those of a helping nature.

--Geography and Demography. The sparse population in many parts of Maine presents problems in the efficient delivery of service. The size of the state, its topography, climate, where the people live and their characteristics are all factors adding complexity and difficulty to rehabilitation processes.

--Attitude of Citizens and Lawmakers. The basic problem besetting rehabilitation in Maine, the subcommittee reported, has been the low priority accorded it by the public, and reflected by the lawmakers. With the creation of a more favorable attitude, two things will flow which will have far-reaching effects. The first is effective legislation, including the appropriation of adequate funds to accomplish the desired rehabilitation goals. Examples of needed legislative changes recommended by the Commission are:

--Reorganization of state-level rehabilitation resources into a single integrated and functional unit of rehabilitation services.

--Adequate funding to correct prevailing staff shortages and improve pay levels.

--Adequate funding to provide needed rehabilitation facilities and equipment.

Needs which have been identified by the Commission and require action by the appropriate agencies include:

--Improvements in many areas of communication, through mechanisms for good interagency cooperation, uniform record keeping and reporting, a central registry of cases being served, an effective information-referral system, etc.

--Increased educational efforts aimed at health professionals; at clients, in order to improve their expectations and aspirations; and at the general public. Agencies should continue to improve their programs of recruitment, in-service training, and educational leave; the lack of educational programs for rehabilitation personnel at the colleges and the university in the state should be overcome.

--Improvements in the delivery of services through outreach and imaginative programming. Specifically, it is recommended that:

TRANSPORTATION PROBLEMS OF REHABILITATION CLIENTS AND OTHER

DISABLED PERSONS SHOULD BE GIVEN THOUGHTFUL REVIEW BY THE

GOVERNOR'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED.

Lack of usable public transportation systems is a formidable barrier to physically handicapped persons but little attention has been given to this problem by either the states or the federal government. In Maine, where public transportation systems are used by comparatively few people except those in urban areas, the problem of getting from place to place is most acute for the severely disadvantaged and especially those in the isolated, rural parts of the state. These are the persons who quite often are prevented from receiving the rehabilitation services they need because they are unable to get to them. Client transportation programs similar to those operated locally by community action agencies, Rural Youth Corps chapters, and voluntary organizations should be planned for and put into operation on a statewide scale.

3-4. Job Development and Placement; Programs in Partnership with Private Industry

The Commission's survey of employers' readiness to hire the handicapped in Maine was conducted by the six regional task forces, assisted by the project staff and a professional consultant, during the summer and fall of 1968. It was approved and distributed by the Commission in October. (57) Among its objectives were to determine:

1. Employers' policies, and their willingness to hire persons with handicaps.

2. The extent to which they actually do hire such persons.

3. Under what circumstances persons with certain kinds of handicaps are rejected for employment.

4. The job performance of the handicapped where employed.

5. The extent to which public and private agencies refer their handicapped clients to employers for possible job placement.

6. Employers' awareness of restorative services available to employees who suffer a disabling accident or illness.

7. Types of jobs currently available that could be filled by persons with specific handicaps.

It was hoped, too, that the survey findings would point out some specific ways to improve employment opportunities for the handicapped. More frequent and more productive contacts between employers and the agencies responsible for placement such as the Employment Security Commission and the Vocational Rehabilitation Division was thought to be one of these, and the survey responses bore this out.

Need for the Survey

The Governor's Committee on Employment of the Handicapped had repeatedly stressed that the capacity of Maine employers to hire the handicapped had never been adequately explored.

This was also an early conclusion of task forces, and when they presented their preliminary recommendations to the Commission in February 1968 they noted that placement of rehabilitated clients in jobs commensurate with their ability was not being accomplished satisfactorily. They recommended particularly that the Governor's Committee be adequately funded and staffed to promote its stated objectives: that of informing employers and the public about the abilities of the handicapped when properly placed, and of assisting the handicapped in finding rehabilitation services and employment.

Immediately after the fact-finding and reporting phase of the task forces' activities, they approached the Commission with a proposal to conduct a survey of employer attitudes and practices, and volunteered to interview employers in their own regions.

The offer was accepted, and the Commission directed the project staff to develop a survey sampling method that would yield the required information. A description of the methodology that was adopted appears in Chapter III, Section D-c, of this report.

Referral and Follow-up

One of the immediate results of the survey was that a wide variety of potential job openings for the handicapped were identified.

During the interview, each employer who expressed interest in considering a handicapped person for a job in his firm was given a referral form which he could either fill out then or mail to the Commission later. He was asked to check off on the list of 13 disability categories those types of conditions which he felt he could accept, and to include a brief description of present or future jobs.

The forms were completed by 32 (or 27%) of the 120 employers interviewed in the survey and represented upwards of 200 potential job openings, some of which were currently available. Occupations ranged from maintenance and production to professional, supervisory, and administrative positions. A food supplier gave as possibilities more than 80 jobs in his firm for office workers, shippers, wrappers, delivery, sales, etc. Another employer, a food processor,indicated that he had eight current openings. (In this instance the categories excluded were: heart conditions, past respiratory disease, wheelchair confined, seriously impaired vision, and persons subject to seizures.)

Employer Attitudes a Determining Factor

The availability of jobs, and employers' willingness to hire handicapped persons to fill them, depends mostly, it seems, on the kind of work operations performed in the plant, and the individual employer's opinion of how well a person with a certain kind of handicap can be expected to perform these operation.

Following is a partial list of job openings for which the 32 firms that completed the referral form said they would like to interview handicapped applicants:

Professional and technical positions (paper company)
Layout (newspaper)
Clerk-Typist (newspaper)
Stitchers (shoe company)
Machine operators (shoe company)
General laborers (manufacturers)
Cut-up line and other operations (poultry processing)
Packers (cannery)
Mechanic (electronics)
Assembling (electronics)
Receiving clerk (electronics)
Chemist (plastics)

Twenty-five of these firms indicated on the referral form the kinds of handicapping conditions that would be considered for available job open-

ings. Three indicated all 13 categories, and four did not fill out this part of the form.

The responses of the 25 firms to the item, "Interested in hiring handicapped as follows", are given below in order of frequency:

Speech impairment	25
Limited learning	22
Physical deformity	22
Loss of limb	21
Loss of hearing	21
Past conviction for a criminal offense	18
Heart condition	17
Past mental or emotional disturbance	16
Controlled alcoholic	16
Past respiratory disease	13
Occasional seizures	10
Wheelchair confined	8
Blind or nearly blind	5

During the interview, each of the 120 respondents was given a list of the 13 disability categories and asked to check Yes or No to the question, "Assuming the person has skills you can use in your business and his behavior is satisfactory, would you hire someone with (a known heart condition, complete or almost complete loss of vision, etc.) These are their responses in order of frequency:

Speech impairment	115
Physical deformity	113
Alcoholic	111
Past conviction	108
Loss of limb	108
Limited learning capacity	102
Past mental or emotional disturbance	98
Heart condition	87
Loss of hearing	82
Respiratory disease	69
Occasional seizures	38
Wheelchair confined	35
Loss of vision	19

Groups With the Least Favorable Chances

It will be noted from this listing and the one compiled from the referrals, that the four disability groups with the poorest chances of being hired are persons who have had a disease of the lungs or respiratory system, who have had occasional seizures or loss of consciousness, persons in a wheelchair, and those with complete or almost complete loss of vision.

The first of these can no doubt be accounted for by the comparatively high proportion of firms in the survey sample that engage in food handling and processing, or whose operations produce harmful impurities in the air such as paper or sanding dust, or chemical fumes.

The last three, however, are clearly groups requiring special study; much greater efforts are needed to help these persons train for suitable occupations and to aid them in placement.

The Blind or Partially Sighted

There is particular need for a survey of jobs that can be successfully handled by the partially or totally blind. When this information is obtained, it should be given wide distribution. In addition, research is needed to discover employment opportunities outside the traditionally accepted areas, ones which are not yet recognized as feasible for this segment of the handicapped population.

Nineteen of the employers interviewed in the survey said they would hire persons with "complete or almost complete loss of vision," but only 11 of them do. Reasons given by the others for not hiring were:

All jobs require vision	41
Safety hazards	35
No reason given	8
Insurance	3
Unable to drive	3
Company policy	1
Work too hard	1
Doctor's advice only	1
Doubtful	1

The Wheelchair Confined

Responses of the 120 firms to the question, "Would you hire someone in a wheelchair?" indicate that the physical layout of the plant or place of business is a major reason why such persons cannot be employed. Reasons given for not hiring this group were as follows:

All jobs require mobility	48
Layout of facilities (architectural design) would not permit	31
Safety	6
Transportation difficulty	1
Company policy	1

It is also significant that while 35 firms out of the 120 total said they would hire the wheelchair confined, only 13 of them actually do. The kinds of work now being done by these employees include:

Advertising salesman
Shipping clerk
Hand sewer (shoe)
Wrapper (poultry)
Truck dispatcher
Owner-manager
Directing fork lift (lumber)

Epileptics

The problems encountered by controlled epileptics who apply for jobs--and disclose this condition on the application--should be given closer study with a view to allaying employers' fears and improving the chances of this group for successful employment. Some employers (not in the survey sample) have commented informally that they have controlled epileptics working for them but that they wouldn't hire an epileptic, controlled or otherwise, if they knew about his condition beforehand.*

It would appear from the survey responses that known epileptics are definitely considered high risk. Thirty-eight firms said they would hire an epileptic, and 23 of them do.

Firms that said they would not hire gave these reasons:

Too dangerous (safety)	42
Not feasible	6
No reason given	5
Would depend on how well controlled	3
Insurance	2
Would give public a poor impression	1
Past experience	1
Co-worker reaction	1
Unable to drive car	1
Company policy	1

However, information supplied by some of the 23 firms that do hire persons described in the questionnaire as "known to have had occasional seizures or loss of consciousness" indicate that they are performing these jobs:

Packer
Bench worker (shoe)
Molding machine operator (shoe)
Coreman (lumber)
General production (paper)
Office worker
Assembling electrical components

"I Would" vs. "I Do"

A comparison of the number of firms who told interviewers they would hire persons in the disability groups shown in the following chart with the number who said they do hire at present, reveals some notable discrepancies.

*The personnel manager of Trans-Canada Airlines, speaking at an institute on "Rehabilitation of Seizure Patients" made several suggestions which he feels could open employment to epileptics. Among them are (a) statistical records which support the claims for adaptability to industry, (b) a list of occupations successfully held by siezure patients, (c) information about seizures and how employers can deal with them, and (d) a center to which work can be brought in order to overcome the fears about plant safety and general morale. The speaker noted, however, that "the employer has a real responsibility for the safety and well being of all employees; his first responsibility for disabled or handicapped workers is to his own employees." --Bolton, Elliot, in Employability in Industry, Montreal Council of Social Agencies, 1959, pp.40-42

	Would Hire	%	Do Hire	%	% of Difference
Known heart condition	87	76	71	60	16
Loss of vision	19	16	11	9	7
Loss of limb	108	91	37	31	60
Physical deformity	113	96	46	39	57
Wheelchair	35	30	13	11	19
Limited learning capacity	102	86	54	45	41
Speech impediment	115	97	44	37	60
Occasional seizures	38	32	23	19	13
Past emotional or mental disturbance	98	84	47	40	44
Respiratory disease	69	59	27	23	56
Recovered alcoholic	111	95	51	43	52
Loss of hearing	82	70	35	29	41
Past conviction for criminal offense	108	92	50	41	51

Ability Counts

Despite these discrepancies which will be discussed later, at least equally notable are employers' frequent statements that they are ready at all times to consider applicants on an individual basis. Typical responses were:

"Personal characteristics and personal evaluation are deciding factors."

"We certainly would hire, providing the person is capable of handling the job.

"We are interested in handicapped referrals in all categories as long as the applicant is ready psychologically."

"Definitely Yes, with proper skills."

It would appear from these and from the very evident interest in the survey and its purposes expressed by nearly all respondents that employers are concerned primarily with the individual and his abilities. Almost every person interviewed focused discussion on the individual worker instead of the disability. Some voiced their dissatisfaction with the questionnaire because of its heavy emphasis on disability by category. They felt it stereotyped people and lumped them together into disability groups, and this they thought was unrealistic. Consequently, some refused to fill out the referral form, others checked all categories on the form, and some left this part of it blank.

Employers were concerned that the so-called "handicapped" worker be able to carry his fair share of the load without needing undue supervision or too much special consideration. They also wanted to be sure that the new employee will "fit in" with his co-workers and the job environment.

Firms that hire the handicapped, 101 of the 120, or 84% have learned that the majority of these workers are able to do so quite satisfactorily. In answer to the question, "How would you compare the performance of these workers (in the 13 disability groups) with that of other workers," 85% rated them average or above average, and only 5% below average.

The breakdown of responses was:

50% average
35% above average
10% no experience
5% below average

A number of employers praised these workers for their "dependability" and "above average motivation," as well as their high production and low rates of absenteeism and job turnover.

However, the percentages vary somewhat for persons referred by such public agencies as the Employment Security Commission, the Division of Vocational Rehabilitation, Department of Health and Welfare, and the Bureau of Corrections. The question, "How would you describe the 'job readiness' of these referred applicants" produced these responses:

56% average
7% above average
37% below average

This would seem to indicate that our state-sponsored training and retraining efforts are in need of strengthening; also, that greater attention should be given to the overall personal adjustment of rehabilitation clients.

Closer linkages between agencies that can help these persons through the difficult first few weeks or months on the job would ensure more successful placement by providing a combination of needed services such as individual and family counseling, transitory financial aid, and other supportive programs on a temporary basis.

It would appear, too, that rehabilitation and placement agencies should make a special effort <u>beforehand</u> to determine as nearly as possible if the client they are about to refer is suited temperamentally, emotionally and psychologically to the kind of work he will be expected to do, as well as to the overall job environment. This more sensitive appraisal of both the job situation and the client's emotional maturity is important, not only for <u>his</u> welfare, but also to increase the number of satisfactory job placements--which in turn will lead to more universal acceptance of handicapped workers by potential employers.

<u>Agency Referrals--"Infrequent"</u>

While only 19 of the 120 firms interviewed stated that they do not employ any handicapped workers at present--although most of them said that they <u>would</u> hire such persons if they were qualified and available--92% of the total sample reported that they are seldom, if ever, contacted on behalf of a handicapped employee.

It is apparant also from the responses that the smaller the company, the less frequent the referral. As might be expected, smaller firms hire comparatively fewer handicapped workers than larger ones.

		Have Handicapped Workers	No Handicapped Workers
Small	(4-50 employees)	23	17
Medium	(51-300 ")	38	2
Large	(301+ "	40	0

A possible explanation is that small firms which now are required to pay a minimum wage, and whose greatest capital expenditure is for wages, expect the persons they hire to have a high degree of mobility, sensory acuity and intelligence, as well as a high level of adjustment needed, for example, in dealing with the public. Many small firms require their employees to perform a variety of physical and mental tasks, and to perform them efficiently. In some instances, employees are expected to do as many different things and to assume nearly as many responsibilities as the owner-operator himself.

This is by no means to imply that a great many so-called "handicapped" persons do not possess these attributes to the same, and in many cases to a greater extent than other employees. However, it would appear that because smaller firms are generally interested in hiring only the most "capable" persons they can afford, they have had relatively few experiences in hiring persons known to be rehabilitated, and especially those referred by a public agency.

As we have pointed out, smaller firms report that they get fewer referrals from agencies than the larger ones. Yet, significantly, the smaller the company, the greater the probability that the handicapped worker is rated "above average." This in itself should indicate that the handicapped worker possesses the attitudes and skills that small as well as large companies expect of their workers.

Dr. Howard A. Rusk, director and founder of New York University's Institute of Rehabilitation Medicine, better known as the "Rusk Institute," spoke to this point when he addressed a joint meeting of the Maine Hospital Association, Maine Rehabilitation Association and Commission on Rehabilitation Needs in Rockland, June 1968:

> More than 30 surveys have been made in this country to measure the performance of properly trained and properly placed individuals with a handicap. All have shown that the disabled have a better production rate, lower accident rate, lower absenteeism rate, and nine times less turnover than the normal employees working alongside them. Note that I said 'properly trained and placed.' This last is the secret of why rehabilitation works...
>
> In today's society we don't pay for strength alone. We pay for the skill in your hands and what you have in your head. We have learned that nature gives tremendous powers of compensation. The blind man 'sees' with his senses of touch and hearing. Put him in a job where he can use these acquired skills and he will out-produce the normal worker. Put paraplegics at a bench job requiring upper arm strength and hand skill and they can kill the ordinary worker productionwise. The reason is that they are working with the hypertrophied muscles with which they walk...(58)

While it is probably true that placement agencies exercise a degree of caution in referring certain handicapped individuals to jobs, as indeed they should, it may be that their knowledge of the client's abilities could be more effectively communicated to the prospective employer. It is important that agencies maintain these precautions in order to avoid spoiling whatever favorable attitudes employers may have about the abilities of their handicapped workers.

But it is possible that employers who have had little or no experience with handicapped workers see these clients as feasible for only one or two kinds of jobs with the firm, whereas in actuality they might be quite capable of handling a variety of work assignments.

The following chart indicates the number of companies in the survey who said they had had referrals from specific agencies and individuals:

Referral Source	Small	Medium	Large	Total
Employment Security Commission	10	17	21	48
Bureau of Corrections	1	11	12	24
Division of Vocational Rehab.	2	6	7	15
Health and Welfare Dept.	--	5	5	10
Private Employment Agencies	--	3	5	8
State Hospitals, Veterans Hospitals	--	2	5	7
Physicians	1	3	2	6
Handicapped Workshops or Centers	--	1	4	5
Division of Eye Care & Special Sv.	--	1	1	2
Hospitals, Private	--	--	2	2
Maine Rehabilitation Association	--	--	2	2
Bureau of Mental Health	--	--	2	2
Other	2	3	1	6

Employers' Knowledge of Helping Agencies

A question was also asked to reveal the employer's knowledge of rehabilitating agencies. The question, "If a worker can no longer perform his normal job duties because he develops one of the conditions described on the list, what public or private agencies might help him become productive again?" revealed:

Don't know	34
Division of Vocational Rehab.	22
Physicians, nurses, hospitals	9
Alcoholics Anonymous	9
Employment Security Commission	8
Employee's company	7
Veterans' Administration	5
Insurance company	4
Mental health clinics	2
Health and Welfare	2
Tuberculosis & Health Assoc.	2
Heart Fund	1

Bureau of Corrections	1
Alcoholism Services (Health & Welfare)	1
Industrial Accident Commission	1
Neighborhood Youth Corps	1
Sheriff's Department	1
Pine Tree Society	1
Maine Medical Center	1
Occupational Training Center	1
Clergy	1

It is perhaps significant that the question, "What public or private agencies might help--" was asked earlier in the interview than the one pertaining to which agencies have actually made referrals. Also, the responses to the "might help" question were offered without any prompting. Still, it would seem from the large number of "don't know" responses that agencies both public and private could greatly enhance their services to the handicapped by making themselves better known and by seeking to establish more frequent and more productive contacts with potential employers.

Some Areas to be Explored

Nearly 70% of all firms in the survey reported that one or more of their regular employees had been seriously handicapped by injury or disease during the past two years (83 yes, 37 no). Twenty-seven of the firms said the employee returned to his previous job with the company, and 11 firms said he returned to the company in a different job. In other words, 38 firms out of 83 retained or re-employed their seriously handicapped workers.

This statistic suggests that research is needed to learn how many of the workers reported by the remaining 45 companies as seriously handicapped were referred after appropriate medical treatment to training, retraining and placement agencies.

In connection with this, it is important that physicians, hospitals and other potential referral sources be familiar with the broad scope of available rehabilitation programs and assume some of the responsibility for seeing that their patients avail themselves of needed services.

Information and referral centers established in strategic locations in the state and operated in conjunction with a centralized reporting and record keeping system would facilitate the treatment and vocational rehabilitation of such potential clients as those who are unaccounted for in this survey.

In addition to a systematic and current listing of handicapped persons, the nature of their handicap, and place of residence, there is also need for a companion listing of jobs in local communities which would be feasible for persons with known handicaps.

SUMMARY

Based on the seven major questions to which this survey was addressed, the following conclusions have been drawn from the data revealed by the questionnaire responses:

1. Very few companies in the sample have specific policies that preclude the hiring of rehabilitated workers.

2. Twice as many companies expressed a willingness to hire persons with handicaps than actually have such persons on the payroll at the present time.

3. Nearly all the employers interviewed stated that they are interested in employing persons for their abilities, rather than their disabilities, and that a handicapped individual stands as good a chance as any other if he is capable of handling the work. However, rehabilitated persons who have had lung disease, have seizures, complete or almost complete loss of vision, or are wheelchair confined seem to experience the most difficulty in securing suitable employment.

4. Eighty-five percent of the firms that employ the handicapped rated their job performance as average or above average.

5. While employers reported some referral contacts with public and private agencies trying to place rehabilitated workers, the great majority of employers--92%--stated that they are seldom if ever contacted on behalf of a prospective handicapped employee.

6. Employers expressed a lack of familiarity with specific agencies which can help a handicapped worker become productive again.

7. Of the 120 firms interviewed, 32 employers specified a wide range of positions currently available to rehabilitated workers. More than 200 job openings from manual and semi-skilled to supervisory and professional were identified.

Recommendations

Referral forms received by the Commission were forwarded to the Employment Security Commission and local employment counselors followed up on these contacts. At the present writing it is not known how many actual job placements were secured. The Commission recommends, therefore, that:

THE EMPLOYMENT SECURITY COMMISSION, THROUGH ITS DISTRICT OFFICES AND WITH GUIDANCE FROM THE GOVERNOR'S COMMITTEE ON EMPLOYMENT OF THE HANDICAPPED, SHOULD DETERMINE HOW SUCCESSFUL THESE CONTACTS WERE IN TERMS OF JOBS FILLED AND EXPECTED FUTURE OPENINGS.

It is recommended also that:

LOCAL EMPLOYMENT OFFICES UTILIZE THE COUNSELOR CONTACTS WITH RESPONSIVE EMPLOYERS AS A BASE ON WHICH TO BUILD CONTINUING LIAISON RELATIONSHIPS WHICH WILL LEAD TO EXPANDING EMPLOYMENT OPPORTUNITIES FOR THE HANDICAPPED.

5. Inner City and Rural Poverty

Current and projected programs designed to improve the quality of life and promote the rehabilitation of Maine's rural and urban disadvantaged population are treated in several sections of this report, together with specific recommendations which have been proposed in the course of rehabilitation planning. Key sections of Chapter IV in which these appear are B-6, C-6, C-7, C-9, D-2, D-3, D-6 and E-1, but there are many references to rural and urban poverty in other sections as well.

Programs with a vocational emphasis which have been discussed include Neighborhood Youth Corps projects, MDTA, work-study, Upward Bound, work adjustment services, Work Incentive and Concentrated Employment programs and a number of others. Particular attention was given in Sections C-7 and C-9 to the Rural Youth Corps program, funded by the U.S. Office of Economic Opportunity and the U.S. Department of Labor, which is training cadres of young men and women from low income families to actively mobilize their fellow young people for community-and self-betterment. After a period of initial training and five months of field service as members of mobile teams, Rural Youth Corps trainees are prepared and are helped to find regular employment or to continue their schooling. Originally programmed and funded to operate in Maine's five northern counties, it has been so well received both by rural youth and by the communities in which RYC chapters have been organized that it will soon be expanding far beyond the five-county area.

Allied with the Commission's planning has been that of the Citizens Task Force on Intergovernmental Welfare Programs whose recommendations, drafted as a master bill for welfare reform and now being considered by the 104th Legislature, are discussed in Section C-6.

As previously stated in Section D-8, the Commission has been cooperating actively with Model Cities planning since these urban programs were first authorized in Maine under the Demonstration Cities and Metropolitan Development Act of 1966. Close liaison was established and maintained, especially during the crucial early stages, with Portland's Model Neighborhood project. Known as "Portland West," it was the only one in Maine to be authorized and funded from the first round applications. Some months later a project proposal submitted by the city of Lewiston was accepted and funded from four applicant Maine communities in the second round, and the planning phase of this project is now underway.

Task force members from Region V, which includes Cumberland County and hence the city of Portland, served on the "Portland West" Special Education Task Force, the purpose of which has been to improve and expand educational opportunities for all children in the area, but especially those with physical mental, emotional and behavioral problems. The Commission's executive director has served as a resource person to the Special Education Task Force. From its inception, Model Cities and statewide rehabilitation planning have both had broad, comprehensive objectives and so each has been able to complement the other.

Their approaches to planning and problem solving have also been similar. Both have given special emphasis to broad community participation be-

cause they recognized that people at the local level are best situated to make recommendations directly affecting themselves and their neighbors; also, these are the people whose involvement in local problems will be a determining factor in either the success or failure of measures designed to alleviate these problems. Both planning efforts have sought and promoted unified action by public and private agencies which often times have a tendency to go their separate ways, focussing their concern on a singular problem with scant regard for related and often causative problems.

Other similarities will be recognized in these stated objectives of the "Portland West" project:

--To combat poverty and low income.

--To provide better education and proper child development.

--To improve and expand preventive and rehabilitative social services to all.

--To improve the health of the community.

--To reduce the incidence of crime and delinquency.

Some statistics from the "Portland West" summary of its 1969-1973 comprehensive city demonstration plan and 1969 first year action program published in the booklet The Need/ The Plan/ The Action indicates the kinds of problems the project is addressing:

--41% of the children in Portland West suffer from hard-core poverty.

--Average family income is approximately half of the national and regional averages--in a metropolitan area where living costs are above the national average.

--35% of the Portland West labor force are either unemployed or unable to secure full-time employment.

--Health care from government sources is both limited and fragmented to a degree which is frustrating to both professionals and service recipients.

--The problem of transportation to employment, medical services, etc. is often insurmountable.

--Schools, with one exception, are over 100 years old and all are overcrowded.

--Of the seven elementary schools, only one has such common facilities as gym, cafeteria, library, and special classes.

--There are no classes for emotionally disturbed children, and only one psychologist in the city for 14,500 children.

--There are virtually no day care centers where low income working mothers can take their young children, hence most must try to subsist on meager welfare payments.

--Substandard housing and a generally poor physical environment prevail

As noted above, the operation of "Portland West" includes a Five Year Plan and a First Year Action Program. These have been designed to alleviate the social and environmental conditions referred to here--and many others like them; also, to lay the groundwork for continuous improvement through concerned and perceptive involvement of federal, state, and local efforts, both public and private, and by creating opportunities for community participation and self-help.

Several of the first year projects are directly related to rehabilitation areas which the Commission has been studying:

Education and Child Development

1. Provide educational opportunities for all children, including the physically and mentally handicapped and the emotionally disturbed.

2. Comprehensive school evaluation of learning disabilities for both in-school and pre-school children.

3. Area vocational technical high school.

4. Pupil Rehabilitation Education Programs.

5. Special education project for emotionally disturbed children.

6. Family home care.

7. Recreation Coordinating Council.

Preventive and Rehabilitative Social Services

1. Pilot School Social Service Component.

2. Neighborhood Social Service Outpost.

3. Homemaker-health aide services.

4. Senior citizens nutritional project and continuation of senior citizens centers system.

5. St. Elizabeth's Day Care Center.

6. Consumer education program.

7. Tenant services for elderly public housing.

To Combat Poverty and Low Income

1. Vocational-Employment Orientation Center.

2. On-the-Job Training Project (OJT)

3. Neighborhood Youth Corps (in-school, out-of-school, summer).

4. New Careers Project.

5. Mainstream Project.

6. Work Training in Industry Project.

7. Opportunities Development Corporation Project.

8. Neighborhood Youth Employment - referral project.

9. Work Helps Youth Project.

10. Youth work experience medical career orientation project.

Community Health Improvement

1. Comprehensive health program for all schools in the city of Portland.

2. Education for Health.

3. Health Station.

4. Data collection and maintenance.

5. Comprehensive rodent control.

Delinquency and Public Offenders

1. Detection and elimination of causative factors.

2. Prevention, by treating delinquency in its early stages.

3. Rehabilitation of potential and chronic offenders.

4. Youth Bureau.

5. Model Police Unit.

6. Alcoholism Halfway House.

H. LEGISLATION TO REVISE THE STATE REHABILITATION LAW

The Commission, working closely with the Department of Education and the Department of Health and Welfare, has drafted legislation designed to create a broad rehabilitation statute which includes revisions of the state Vocational Rehabilitation Act and provides for the administrative reorganization of public rehabilitation services within one departmental structure. (The State Vocational Rehabilitation Act had not been revised since 1959.)

The proposed statute, L.D. 925, designates the Department of Health and Welfare as the sole state agency responsible for providing rehabilitation services, including but not limited to, vocational rehabilitation services. Eligibility is broadened to include provisions for rehabilitation of handicapped persons and evaluation and work adjustment services to disadvantaged individuals in conformance with the 1965 and 1968 amendments to the federal Vocational Rehabilitation Act and the 1967 amendments to the Social Security Act.

If enacted, L.D. 925 would remove the present Vocational Rehabilitation Act from the Department of Education Revised Statutes (Title 20) and create a new rehabilitation law under "Health," subtitle "Public Rehabilitation Services" within the Revised Statutes of the Department of Health and Welfare (Title 22).

This new statute, presented in the 104th Legislature, represents the first broad public rehabilitation services law which has ever been introduced in Maine. Its major purposes are to improve the administrative structure and coordination of these services through a single, functional rehabilitation unit, and also to create a legal framework within which the liberalized federal provisions may be fully implemented.

CHAPTER V

THE COMPOSITE WORKING PLAN

The current and projected estimates of demand for public vocational rehabilitation services previously discussed in this report were prepared by Harbridge House. (They are shown separately in Chapter IV, Section A, Tables 1 through 10.) The Harbridge House estimates reflect those persons in Maine who are considered eligible for vocational rehabilitation services in accordance with the following criteria: (a) the presence of a medically definable physical or mental disability, (b) identification of a substantial vocational handicap, and (c) a reasonable expectation that vocational rehabilitation services will render the individual fit to engage in a gainful occupation.

It should be noted, however, that the Harbridge House estimates do not include persons in the state correctional institutions, on probation or parole, or those whose vocational handicap is due primarily to socio-economic disadvantage or educational deficits.

The overall estimates of current and projected needs and the cost of meeting these needs for the total disabled population feasible for vocational rehabilitation are not intended to reflect such reality considerations as available financial and personnel resources. Theoretically, it would cost $34,673,416 to provide vocational rehabilitation services to the estimated 52,219 persons considered eligible for them this year, at the rate of $664 per rehabilitant. When anticipated numbers and costs are projected to 1975, the total federal-state expenditure for rehabilitating 55,664 persons at the rate of $966 per rehabilitant would increase to $53,771,424.

Exhibits

The three sets of tables (Exhibits A,B, and C) in this chapter are intended to illustrate projected needs and costs for public vocational rehabilitation agency case services, programs, and facilities. Exhibit A reflects the Commission's best estimate of the two vocational rehabilitation agencies' optimum yearly working caseload which they should be gearing their programs to meet, together with estimated annual costs. Numbers of persons considered eligible are based upon realistic projections of referrals to the agencies each year, beginning with the approximately 4,000 actual referrals for 1968 and projecting a 10% increase per year to 1975.

The cost of providing rehabilitation to all anticipated referrals from 1969 to 1975 is based upon the 1968 average cost per rehabilitant (case services) for each of the nine broad disability categories listed. To allow for the steadily mounting increase in annual case services expenditures, the 1968 base average is adjusted at the rate of 7% per year.

The disability category entitled "Behavioral Disorders" refers specifically to the institutionalized correctional cases and the current and projected costs of serving them. Further, it is recognized that large numbers of the socially and culturally disadvantaged will also be found to have a physical or mental disability, and thus will be distributed

across the nine general categories presented in Exhibit A.

Exhibit B charts the two vocational rehabilitation agencies' own estimates of annual program costs from fiscal 1969 to fiscal 1975. They are intended to reflect a realistic assessment, as seen by the agencies themselves, of essential budgetary requests for staffing, case services, research, planning, special projects, and other activities related to the delivery of services and to ongoing program development.

Exhibit C, compiled by the facilities specialist of the two agencies, is an overview of the state's public and private rehabilitation facilities, with estimates of the number of clients served, and projected costs for the next two years.

Exhibit A
PROJECTED NEEDS AND COSTS BY DISABILITY CATEGORY
FOR PUBLIC VOCATIONAL REHABILITATION AGENCY CASE SERVICES*
(Cost in Thousands of Dollars)

DISABILITY CATEGORY	Actual Coverage 1968		Estimated FY 1969		FY 1970		FY 1971	
	No.Rehab.	Expend.	#In Need	Cost	#In Need	Cost	#In Need	Cost
Blind[1]	39	$ 68,000	150	$288,000	175	$ 350,000	200	$ 400,000
Other Visual Impairments[1]	52	28,000	375	144,000	400	175,000	450	200,000
Deaf[2]	9	10,000	40	45,000	44	54,000	48	62,000
Other Speech & Hearing Impair.[2]	35	17,000	160	81,000	176	96,000	194	113,000
Amputees[2]	66	38,000	210	128,000	231	151,000	254	178,000
All Other (Physical)[2]	305	207,000	2300	1,668,000	2530	1,963,000	2783	2,310,000
Mentally Ill[2]	27	19,000	450	342,000	495	402,000	545	474,000
Mentally Retarded[2]	78	32,000	500	217,000	550	255,000	605	299,000
Behavioral Disorders[2]	30	7,000	340	81,000	374	95,000	411	112,000
TOTALS	641	426,000	4525	2,994,000	4947	3,541,000	5490	4,148,000

*Estimated by Commission on Rehabilitation Needs

[1]Responsibility of Division of Eye Care

[2]Responsibility of Division of Vocational Rehabilitation

Exhibit A - Continued
PROJECTED NEEDS AND COSTS BY DISABILITY CATEGORY
FOR PUBLIC VOCATIONAL REHABILITATION AGENCY CASE SERVICES*
(Cost in Thousands of Dollars)

DISABILITY CATEGORY	FY 1972		FY 1973		FY 1974		FY 1975	
	#In Need	Cost	#In Need	Cost	#In Need	Cost	#In Need	Cost
Blind[1]	225	$ 450,000	250	$ 500,000	250	$ 525,000	250	$ 550,000
Other Visual Impairments[1]	500	225,000	550	250,000	600	300,000	650	350,000
Deaf[2]	53	74,000	58	86,000	64	102,000	70	126,000
Other Speech & Hearing Impair.[2]	214	134,000	235	157,000	259	185,000	285	218,000
Amputees[2]	279	209,000	307	246,000	338	289,000	372	314,000
All Other (Physical)[2]	3061	2,718,000	3367	3,199,000	3703	3,766,000	4073	4,431,000
Mentally Ill[2]	600	558,000	660	657,000	726	773,000	799	911,000
Mentally Retarded[2]	665	352,000	731	414,000	804	488,000	884	574,000
Behavioral Disorders[2]	452	132,000	498	155,000	548	183,000	603	215,000
TOTALS	6049	4,852,000	6656	5,664,000	7292	6,611,000	7986	7,716,000

Exhibit B
PROJECTED STATE VOCATIONAL REHABILITATION AGENCY PROGRAM COSTS*
Division of Eye Care and Special Services
(Cost in Thousands of Dollars)

CATEGORY	FY 1969		FY 1970		FY 1971	
	Number	Cost	Number	Cost	Number	Cost
Staffing Requirements (Number needed and cost)						
(a) Professional	12	$114,000	17	$164,000	20	$194,000
(b) Other	3	16,000	5	26,000	6	31,000
Subtotal	15	130,000	22	190,000	26	225,000
Case Services (Number served and cost)	525	302,000	575	335,000	650	375,000
Allocation to Research, Special Projects and Planning				25,000		30,000
TOTALS (Costs)		$432,000		$550,000		$630,000

*Estimated by Agency Administration

Exhibit B - Continued
PROJECTED STATE VOCATIONAL REHABILITATION AGENCY PROGRAM COSTS*
Division of Eye Care and Special Services
(Cost in Thousands of Dollars)

CATEGORY	FY 1972		FY 1973		FY 1974		FY 1975	
	No.	Cost	No.	Cost	No.	Cost	No.	Cost
Staffing Requirements (Number needed and cost)								
(a) Professional	22	$214,000	23	$224,000	24	$234,000	24	$236,000
(b) Other	7	41,000	8	46,000	8	47,000	8	48,000
Subtotal	29	255,000	31	270,000	32	281,000	32	284,000
Case Services (Number served and cost)	725	420,000	800	480,000	850	544,000	900	616,000
Allocation to Research, Special Projects and Planning		40,000		45,000		50,000		50,000
TOTALS (Costs)		$715,000		$795,000		$875,000		$950,000

*Estimated by Agency Administration

Exhibit B. (Continued)
PROJECTED STATE VOCATIONAL REHABILITATION AGENCY PROGRAM COSTS*
Division of Vocational Rehabilitation
(Cost in Thousands of Dollars)

CATEGORY	FY 1969		FY 1970		FY 1971	
	Number	Cost	Number	Cost	Number	Cost
Staffing Requirements (Number needed and cost)						
(a) Professional	29	$ 236,000	33	$ 279,000	33	$ 293,000
(b) Other	29	128,000	33	152,000	34	159,000
Subtotal	58	364,000	66	431,000	67	452,000
Case Services (Number served and cost)	4,000	832,000	4,800	1,042,000	5340	1,173,000
Allocation to Research, Special Projects and Planning		93,000		156,000		156,000
TOTALS (Costs)		$1,289,000		$1,629,000		$ 1,781,000

*Estimated by Agency Administration

Exhibit B. (Continued)
PROJECTED STATE VOCATIONAL REHABILITATION AGENCY PROGRAM COSTS*
Division of Vocational Rehabilitation
(Cost in Thousands of Dollars)

CATEGORY	FY 1972		FY 1973		FY 1974		FY 1975	
	Number	Cost	Number	Cost	Number	Cost	Number	Cost
Staffing Requirements (Number needed and cost)								
(a) Professional	38	$ 335,000	38	$ 352,000	47	$ 431,000	47	$ 453,000
(b) Other	38	185,000	38	194,000	46	240,000	46	252,000
Subtotal	76	520,000	76	546,000	93	671,000	93	705,000
Case Services (Number served and cost)	5961	1,415,000	6720	1,524,000	7631	1,738,000	8724	1,871,000
Allocation to Research, Special Projects and Planning		150,000		146,000		156,000		159,000
TOTAL (Costs)		$2,085,000		$2,216,000		$2,565,000		$2,735,000

*Estimated by Agency Administration

Exhibit C
FACILITIES SUMMARY
(Cost in Thousands of Dollars)

CATEGORY	Present		FY 1970			FY 1971		
	# Fac.	# Served	# Fac.	#Served	Cost	# Fac.	# Served	Cost
Public								
1.Services for the Deaf	1	158	(1)	50	$ 40,000	(1)	50	$30,000
2.Rehabilitation Center for Mentally Retarded	1	45	0	-	-	0	-	-
3.Residential Care for Mentally Retarded	1	1545	0	-	-	0	-	-
4.Mental Health Clinics	8	5056	(2)	500	30,000	0	-	-
5.Diagnostic Center for Public Offenders	0	-	0	-	-	1	-	-
6.Work Adjustment tgn. Mentally Ill	0	-	1	50	35,000	1	50	35,000

1. Baxter School, Falmouth, Expand services; provide vocational training and work experiences

2. Bliss Rehabilitation Center, Pineland Hospital and Training Center

3. Pineland Hospital and Training Center, Pownal

4. Aroostook, Houlton, Bangor, Bar Harbor, Lewiston, Augusta, Bath-Brunswick, Portland

5. (No estimate on number to be served or cost. Should be in accordance with request made to legislature).

6. (First one needed in Augusta; Second one at Bangor.)

Exhibit C (Continued)
FACILITIES SUMMARY
(Cost in Thousands of Dollars)

	Present		FY 1970			FY 1971			FY 1972		
	#Fac	#Served	#Fac	#Served	Cost	#Fac	#Served	Cost	#Fac	#Served	Cost
Private											
1.Ed. and pre-voc activities for MR	4	224	(4)	200	60,000	0	-	-	0	-	-
2.Services for child with a severe handicap (CP)	3	98	(2)	60	40,000	(1)	30	20,000	0	-	-
3.Speech and hearing services	3	3001	(3)	300	24,000	0	-	-	0	-	-
4.Evaluation and work adjustment	2	98	1 (2)	35 80	75,000 40,000	0	-	-	1	35	30,000
5.Workshops	2	107	4 (1)	200 35	80,000 15,000	2	80	40,000	3	125	75,000
6.Mental Health (Emotional Problems)	2	1579	0	-	-	0	-	-	0	-	-
7.Comprehensive Medical Rehab and Adj.Services	1	1046	1 (1)	750 50	100,000 30,000	1	500	75,000	2	300	100,000
8.Halfway House Alcoholism	1	15	1	60	25,000	1	60	25,000	0	-	-
9.Halfway House Public Offender	0	-	2	120	50,000	1	60	25,000	1	60	25,000
10.Comp.Rehab Center (Or services)	0	-	0	-	-	1	250	1,000,000	0	-	-

1. Presque Isle, Brewer, Dover-Foxcroft, Portland. (Expand Presque Isle first)
2. Augusta, Bangor, Portland. (Expand Portland first, Bangor second, Augusta third.)
3. Portland, Bangor, Bath and associated offices. (Expand Portland first).
4. Opportunity Training Center, Lewiston-Auburn; Work Adjustment Center, Portland. (Start new one at Bangor)
5. Goodwill, Maine Inst. for Blind. (Expand Goodwill) (Start new ones in all planning areas.)

6. Utterback, Bangor; Sweetser, Saco
7. Hyde Rehab Center. (Expand services with "Hospital Industries.") (First new one Bangor, second Waterville-Augusta Area)
8. Bangor. (First new one Portland, second Lewiston area.)
9. (Existing public ones at Skowhegan and Hallowell) Start new one first in Portland, second Bangor, third Lewiston.)
10. (Build a center or mechanism for coordinated services in one area. First choice Portland.)

CHAPTER VI

CONTINUED PLANNING AND FOLLOW-UP

A. PERIODIC REVIEW OF ENTIRE PLAN

1. Schedule and Structure

STATEWIDE PLANNING FOR REHABILITATION SERVICES SHOULD BE UPDATED ANNUALLY, PREFERABLY IN THE SPRING BEFORE THE CLOSE OF EACH FISCAL YEAR.

A Governor's Advisory Committee to Rehabilitation Services should guide this annual review, and the Committee chairman should document the findings and recommendations in a written report to the Commissioner of Health and Welfare and the Governor.

Responsibility for year-round planning and development according to priority objectives should be assigned to a Rehabilitation Services deputy director. This activity would entail the preparation of written reports on the status and development of the several rehabilitation components, compiled with assistance from the administrators and staff within Rehabilitation Services.

The continuing state plan for rehabilitation should involve all elements of public rehabilitation services, including the vocational rehabilitation function. Therefore, the deputy director will need to work closely with administrators and staff of each of these rehabilitation elements in appraising the implementation of planned objectives, both short and long range.

After being considered and approved by the director of Rehabilitation Services, these reports should be submitted to the Advisory Committee well in advance of their annual review to serve as a basis for their evaluation of current and projected rehabilitation needs.

2. Advisory Organizations Involved, and Procedures

A STATEWIDE CITIZENS ADVISORY COMMITTEE TO THE REHABILITATION SERVICES UNIT SHOULD BE APPOINTED BY THE GOVERNOR WITH REPRESENTATION FROM EACH OF THE SIX REGIONS UTILIZED IN STATEWIDE REHABILITATION PLANNING.

The chairman and other officers of this Advisory Committee should be elected by the membership. Additionally,

CITIZENS ADVISORY COMMITTEES SHOULD BE ESTABLISHED IN EACH OF THE

MAJOR PLANNING REGIONS TO PROVIDE COUNSEL TO THE REGIONAL REHABILITATION FUNCTION.

These regional advisory committees should operate as extensions of the Governor's Advisory Committee to Rehabilitation Services, and close liaison between the statewide and regional committees should be maintained. One of the functions of the regional committees should be to present periodic reports of their findings and recommendations to the statewide committee.

It is essential that close linkages between rehabilitation planning and comprehensive health planning be maintained.

AT LEAST ONE MEMBER OF EACH REGIONAL REHABILITATION ADVISORY COMMITTEE SHOULD ALSO SERVE ON THE REGIONAL COMPREHENSIVE HEALTH PLANNING ADVISORY COMMITTEE IN HIS AREA.

B. CONTINUED PROGRAM PLANNING

1. Responsibility of the State Vocational Rehabilitation Agency

Continuing program execution and assessment of rehabilitation services, including vocational rehabilitation services, should be the responsibility of the director of Rehabilitation Services under the supervision of the Commissioner of Health and Welfare.

Program planning and development within the various components of rehabilitation services, including vocational rehabilitation services, should be a continuing function of all administrative and professional staff, guided by a deputy director for research, planning and development. The implementation of the vocational rehabilitation program and its continuing improvement are the responsibility of the director of vocational rehabilitation and his staff.

2. Interagency Involvement

The Rehabilitation Services Unit concept provides for much closer interagency linkages than has ever before been possible, and draws together the elements of social casework, medical care, public assistance, rehabilitation, and general health services within a single administrative structure.

Through the Cooperative Area Manpower Planning System (CAMPS), an ongoing program of interagency coordination in manpower development should be maintained, as recommended earlier in Chapter IV, Section D.

3. Staffing Requirements

A director of Rehabilitation Services, his deputy director, and the administrators of the several rehabilitation components, including vocational rehabilitation, will have responsibility for continuing and im-

plementing the plan, under the general supervision of the Commissioner of Health and Welfare.

4. Advisory Groups to be Retained

THE SIX REGIONAL TASK FORCES SHOULD BE PHASED INTO CITIZENS REGIONAL REHABILITATION ADVISORY COMMITTEES DURING THE SPRING OF 1969.

THE GOVERNOR SHOULD BE URGED TO GIVE FIRST CONSIDERATION TO POLICY COMMISSION AND REGIONAL TASK FORCE MEMBERS IN MAKING APPOINTMENTS TO A STATEWIDE CITIZENS ADVISORY COMMITTEE TO REHABILITATION SERVICES.

It is to be noted that the statewide rehabilitation planning office and project staff will be terminated as of June 30, 1969. The Policy Commission for Statewide Rehabilitation Planning has been reappointed by Governor Curtis to continue until February 14, 1970.

5. Schedule and Method of Updating Data

a. Annual Review

As noted, the Commission recommends that the statewide plan be updated yearly, and that a written report of this review, to include findings and recommendations, be prepared prior to the close of each fiscal year. Copies of this report, and other pertinent information compiled by a Governor's Advisory Committee to Rehabilitation Services, should be forwarded to the appropriate state and federal officials.

b. Nonduplicative List of Handicapped Persons

Data to be derived from a nonduplicative list of handicapped persons in Maine eligible for rehabilitation services should be utilized as the basis for an ongoing program of rehabilitation planning. Procedures for developing such a list have been recommended in Chapter IV, Section A. The Commission further recommends that the nonduplicative list be compiled by fiscal 1970 and maintained on a continuing basis thereafter.

c. Information and Referral Centers

By fiscal 1971, a system of regional information and referral centers should be established under the auspices of the Department of Health and Welfare, in cooperation with other state and voluntary agencies concerned with rehabilitation.

d. Budgeting Procedures

Budgeting for rehabilitation services should be projected on a yearly instead of a biennial basis. Budgeting should be primarily

on the basis of recognized need, rather than as a projection from prior expenditures.

6. Rehabilitation Research Needs

As noted in Chapter IV, Section F-5, the Commission recommends that an interdepartmental committee on rehabilitation research be established, with emphasis on the compilation, distribution and utilization of basic and applied research.

Additional recommendations for meeting present and projected rehabilitation research needs in Maine will also be found in Chapter IV, Section F-5.

B I B L I O G R A P H Y

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2. Annual Progress Report, Maine Commission on Rehabilitation Needs, Augusta, Maine, December 15, 1967

3. Assessment of Agency Performance, Division of Vocational Rehabilitation, Division of Eye Care and Special Services, Harbridge House, Inc., Boston, Massachusetts, February 1968.

4. Baack, K., Evaluation of Programs in Maine Designed to Assist Handicapped Adults Through Rehabilitation, Vocational Training and Placement, Maine Commission on Rehabilitation Needs, Augusta, Maine, September 8, 1967.

5. Bower, E.M., Early Identification of Emotionally Handicapped Children in School, Charles C. Thomas, Publisher, Springfield, Illinois, 1960.

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APPENDIX A
SUGGESTED EVALUATION CRITERIA FOR COUNSELOR PERFORMANCE

The Counselor Evaluation Report used by DVR is a first step toward providing a system of standards for review of professional staff performance. However, more objective evaluation criteria, related specifically to job content and program goals, are needed. Listed below are some general topics which might be considered in preparing revised criteria for the DVR's counselor evaluation system. (This list is not meant to be exhaustive, nor may all the items be judged pertinent to the DVR's immediate needs.)

(1) Disability mix--If the counselor handles a general caseload, does its disability mix correspond to agency policy and goals for the year? Is he emphasizing disabilities which can be served more easily or which he has more experience in handling?

(2) Severity mix--Does the counselor follow agency standards for severity? How adequate are his client evaluations? Is there any evidence that he is backlogging more difficult cases?

(3) Age mix--Does the age distribution of the counselor's caseload conform to standards? Does his outreach process tend to attract various age groups? Is there any evidence that he discriminates on the basis of age?

(4) Sex mix--Are the proportions of men and women in the counselor's caseload representative of the agency's client population? Is there a differential in his rehabilitation success ratios for the two sexes?

(5) Occupational mix--Does the counselor favor professionals versus nonprofessionals, skilled versus unskilled labor?

(6) Referral source balance--Does the counselor have preferred sources? Is he developing new referral sources?

(7) Progress of caseload--Does the counselor's caseload show a balance of clients in all statuses, so that no backlogging occurs? Are his clients moving into and out of private facilities according to an established schedule ?

(8) Total time in service--Does the counselor's average client move through service quickly?

(9) Budgeting--Does the counselor plan his budget allocations to fit with the billing cycles of service facilities (for example, semiannual college tuition payments)? Is most of his budget committed in the first six months?

(10) Expenditure patterns--Is there a pattern and balance to the funds the counselor spends in diagnosis, treatment (medical, prosthetic devices, etc.), rehabilitation and adjustment (pre-vocational training), and work preparedness (training, maintenance)? (This topic is closely related to appropriateness of plan development.)

(11) Time-budgeting--Is there a reasonable balance in the time the counselor spends in agency administrative details, development of referrals, intake processing, examining services of private and public organizations, counseling, plan development, travel, placement, professional development, and public relations?

(12) Quality of closures--Does the counselor screen referrals adequately? Does he use the explanation "other" excessively for status 08, 28, and 30 closures? Why did his clients refuse services or not cooperate? Does his use of "disability too severe" conform with agency policy and definition? Have alternative plans been made for persons closed not rehabilitated? Are successful closures (status 26) placed in situations appropriate for their aptitudes and interests?

(13) Placement activity--Does the counselor know the employment market? Has he contacted employers? Has he worked in cooperation with counselors in rehabilitation facilities, the facility, MESC, etc.? Has he helped the client with job interviews? Does he check on a client's job performance several months after placement? Does he ask employers one and two years afterwards about the adequacy of DVR's training and assessment of client capabilities?

APPENDIX B
CASELOAD MONITORING SYSTEM

We have noted that caseload management is a skill in need of development in the agency. This appendix outlines the basis of a system for improving the counselor's knowledge of his caseload as a whole and for monitoring overall progress. We present here only the design of a visual display upon which an internal monitoring and reporting system could be based.

The system begins with a control board for each counselor. This is a wall-mounted display with all service statuses across the top and months down the side (see Figure B-1).

Each cell has a rack or pocket in which small cards are kept for each client. The card, which can be handwritten, need only contain this information:

- client's name
- folder number
- date entering each status ("00-July 14, 1967; 02-August 27, 1967")--the purpose of this is to keep track of total time in service and time at any particular status
- special reminders

The cards can be color coded to yield additional classes of information, such as disability, but this is optional.

When a referral is received, a card is made out and put into the 00 column at the appropriate month. No card moves until a status change is made. Thus, in October, for example, there may still be cards in the July or June row, meaning that no status changes have yet been made for these clients. If the supervisor wishes to determine why no status changes have occurred, he can pull any of the cards, note the file number, and make a detailed review. The status date of entry ensures that the cards will be returned to the proper cell.

This display provides a quick picture of overall caseload movement and indicates any tendency for cases to cluster or stagnate in the various statuses. From it, monthly and quarterly reports can be prepared for the counselor, the supervisor, and the central office, to summarize progress and identify problem areas in the movement of cases from referral to closure.

FIGURE B-1
STATUS DISPLAY BOARD

	STATUS					
	00	02	04	06	. . . . .	30
From Prior Year						
July						
August						
September						
. . . . .						
June						

STANDARD INDEX

This Standard Index is being used in the reports of all State planning agencies for the convenience of readers, and as an aid for future planning and reference. An asterisk following an item means that the item is either not applicable or is shown in the addendum.

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