# Maine Department of Human Services

# Response to

# Homelessness in Maine

[Report I]



John R. McKernan, Jr., Governor
H. Rollin Ives, Commissioner, Department of Human Services

Prepared by the Office of Planning, Research & Development
February 9, 1990

TABLE OF CONTENTS

# INTRODUCTION

The Department of Human Services: Response to Homelessness in Maine documents the Department's services related to prevention of homelessness through support services for people at risk, to acute care for the homeless and to remedial services toward more stable living situations.

This is the first of a series of documents that the Department of Human Services will be developing. The purpose is to describe the background and current status of the homeless, and to begin identification of gaps in services and information as a basis for developing specific additional action or directions.

While the Department of Human Services works closely with a number of other agencies and organizations, this report is primarily about the activities of the Department. People who are homeless or at risk of being homeless frequently utilize the services of the Department without being identified as such. Therefore, this document not describe all of the services provided to homeless or at risk people.

As the Department focuses attention on this population group, the needs will become more clearly defined, the number of homeless/at risk served will be better documented, and plans to meet the unique needs of this population will be developed.

Section I Summary presents background of the homeless in Maine and serves as a summary, Section II services provided by DHS gives details of DHS activities.

# I. SUMMARY

## A. A Problem of Definition

Accurate estimates of the number of people living on the streets, in jury-rigged structures, or in emergency shelters, are difficult to find. To some extent this is a definitional problem. In addition to people in shelters or literally without a roof over their heads, people are also living in quarters that are temporary and makeshift, sleeping on the floors of friends' or family's apartments, tolerating substandard accommodations, or surviving on a day-to-day basis in "flophouses." They may turn to public or private shelters only when they lack sufficient funds to pay for a night's lodging. To their numbers, must also be added people who are institutionalized on a time-limited basis, such as in hospitals and jails, who upon release or discharge, will be without permanent residence.[1]

It is for these reasons that several researchers have urged adopting as a definition of homelessness as anyone "without an address which assures them of at least the following thirty days' sleeping quarters which meet minimal health and safety standards".[2] However, most states have generally adopted more restrictive definitions such as:

> ... persons or families who, on one particular day or night, have neither friends, family, nor sufficient funds which will provide for certain elementary resources they need to survive.[3]

Even if one restricts the category "homeless" to people who are in shelters or on the street, difficulties abound in securing good estimates of their numbers and composition, for many do not wish to be discovered. The homeless populations themselves may be subject to fluctuations in season, economic activity, and mass displacement from sites of usual residence. For these reasons, estimates of the homeless population in cities across the country are bound to be rough. In many instances, they are little more than guesswork.[1]

## B. Who are the Homeless?

Shelter workers and city residents have long noticed what social scientists have only recently begun to document: from the late 1960's on, women began to appear as a homeless population in large urban centers, increasingly. The race and age composition of men in public shelters also began to change markedly in the mid-1980's (getting younger, with a much heavier representation of minorities). By the end of the decade, the presence of large numbers of obviously disturbed street dwellers had become a feature of downtown avenues.[1]

Observers generally agree that the forces responsible for mass displacement through the 1970's and 1980's were unemployment or underemployment, scarcity of affordable housing, reinstitutionalization of the mentally disabled, and social service cutbacks and the culling of disability rolls. Those forces of dislocation conspired to create a novel breed of homeless poor -- those labeled the "new poor."

"Discouraged workers," those who have exhausted their benefits, those who are employed part-time, and those who have never entered the labor market, are not included in the unemployment figures, although they all lack work meaningful or gainful employment.[1]

A proportion of the homeless population is found to be significantly disabled and/or casualties of the deinstitutionalization movement. It has become evident that any effort to salvage a policy of community care will require that a continuum of supportive living facilities - emergency, institutional and long term care - be made available to the chronically disabled. Two fundamental barriers are commonly cited: community opposition and insufficient financial support, especially the lack of capital resources at local and state levels which remain tied to state institutions.

Family violence victims and their children are confronted with the prospect of homelessness when they flee the abusive household, and when they leave the structure of a family violence shelter program. Shelters for domestic violence victims offer a short-term protective environment for the avused, but a lack of available economic resources and housing options often results in the victim and children returning to the abusive situation.

Teenagers, especially young, pregnant women with no family support and young men lacking job skills, form an increasing proportion of the homeless. Also, the rising incidence of child abuse and substantial abuse within families is prompting Mainers to elect the streets as a safer, preferable alternative. Some children may have been unsuccessful in a foster care placement as the lack of appropriate resources and the lack of damage evident in these children makes placement in the foster care system incrreasingly tenuous for older children. Once out of the home, options are few and those that do exist are often hazardous. Some teens survive for awhile with makeshift arrangements. They tend to travel in groups, pick up other jobs where available, and set up living quarters in abandoned buildings where possible. Other find living arrangements with older teens or adults in situations that may be unsafe or abusive. Some become adept at petty thievery or prey to better organized rackets such as prostitution or drug trafficking.

Increasingly, many working families are among the ranks of the homeless. They are periodically displaced by evictions, over-crowding, fire, layoffs, or simply the inability to pay their monthly rent because of unemployment.

Maine 1980 census data indicates that 13 percent of the population, or 141,000 persons, are below the poverty level. Of these, almost 52,000 households (118,000 people) may be considered to be at risk of homelessness in Maine.

C. What is the Problem?

In 1986 on any given night, between 250 and 350 people in Maine were in need of shelter. Today that number is conservatively estimated at between 400 and 500 individuals. About two-thirds of the homeless were chronically ill. This group has been characterized by a high incidence of mental illness, substance abuse, or both. The rest have diverse characteristics. They may be single parent households; working families; adolescents who have left home; or victims of domestic violence, patients with AIDS, or persons with substance abuse.

Although homelessness occurs in all parts of Maine, it is seen most frequently in the cities where emergency shelters and social and medical services can be found.

While there are significant gaps in Maine's network of emergency shelters, the majority of homeless people are able to find an overnight bed. In keeping with a tradition of self-sufficiency, Maine people, through state and local government, churches and non-profit groups, and individual actions, have responded to the plight of the homeless with shelter, food and other important services. According to the Maine State Housing Authority study in February 1989, Homeless Assistance Plan, approximately 600 emergency shelter beds currently exist in 50 shelters in Maine.

Virtually all shelters receive some sort of state assistance for the provision of services, and some shelters have obtained a limited amount of state assistance for the purchase or repair of their physical facilities.

However, these efforts are only the first steps in a response to the root causes of homelessness. There are gaps in the availability of shelter beds and services, especially for women, youth, persons with chronic substance abuse problems or who have mental illness. This problem may be an increasing concern in the rural areas of Maine.

Those experiencing the extreme measures of homelessness need sustained treatment for their mental illness or substance abuse, and help in gaining access to the confusing array of assistance programs. They need decent, short-term affordable housing which can offer a base of stability so that longer term solutions can be built.

Four-fifths of these households pay more than one-half of their total income for rent or mortgage and heat. The slightest change in their economic situation can tip them into homelessness. One-fifth of the at-risk group live in substandard and/or overcrowded housing and have poverty-level incomes. They experience homelessness daily in cold, unsafe, overcrowded housing.

D. What does DHS Provide?

The Department of Human Services is deeply concerned with the increasing numbers of homeless people in the State. Although there is some debate among state and local agencies on the definition of the homeless population as well as the number of people who are homeless, the Department believes that this group of people is growing at an accelerated rate. DHS has formed an internal task force to analyze the needs of the homeless and to ensure that the internal structure allows maximizing the flow of services to this population.

The Department categorizes services to the homeless (or potentially homeless) within three phases along the continuum of need: preventive programs, acute or crisis services and remedial/rehabilitative programs. Traditionally, the public often associates the "hands-on" crisis-oriented services such as homeless shelters and soup kitchens as the main area of assistance required by the homeless. However,

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

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

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

   Major assistance to the potentially homeless is provided by municipalities using general assistance funds administered by the DHS Bureau of Income Maintenance (BIM). These funds provide the means for local government agencies to keep the potentially homeless in their homes. In FY '90, more than half of the $8.5 million in budgeted general assistance funds will be spent on housing and utilities. General assistance funding is also the major source of financing for crisis and acute services for the homeless since a large portion of the costs of running municipal shelters are funded through general assistance.

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

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

3. Remedial or rehabilitative services to allow the individual to become as self-sufficient as possible and to reduce dependance on private or government support. Services include:

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

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

E. What are the Gaps in Services and Information?

In spite of all these DHS programs, homelessness remains a problem. Most of these programs are under-funded and are able to provide services to only a portion of the potentially homeless population. The Department is continuiing its efforts to improve funding for programs which focus on the homeless. Coordination of efforts with other departments and groups which provide services to the homeless is being pursued as an opportunity to provide increased effectiveness of service delivery across the continuum of the homeless aid system.

Major problems exist in defining gaps:

- The lack of consistent definition of homelessness, or clear description of the target population;

- The lack of consistent data systems to determine the size of the population or the services provided to that population;

- The lack of clearly defined outcomes for either the clients in the homeless population or the services provided; and

This document begins to address the need for a description of DHS services. The gaps in services and information will be identified more specifically throughout this document.

F. With what Agencies does DHS Work to Address the Homeless Problem?

The Department of Human Services Task Group for the Homeless is made up of those units within DHS which provide direct or indirect services to assist homeless individuals. The Task Group membership includes:

- Bureau of Elder and Adult Services
- Bureau of Child and Family Services
- Office of Alcohol and Drug Abuse Prevention
- Bureau of Income Maintenance
- Bureau of Health
- Office of Planning, Research and Development

The Task Group's purpose is to present a current plan of DHS involvement in services to the homeless, and to advise the Commissioner's Office initiatives.

The Director of Planning and Policy Development is a member of the Homeless Interagency Task Force of the Maine Coalition for the Homeless. The Interagency Task Force is made up of the head (or designee) of all State agencies and many private organizations involved in homeless services.

DHS programs are coordinated with the other departments and organizations within the State which provide direct services to the homeless population, including the Maine State Housing Authority (MSHA), the Department of Economic and Community Development, the municipal social services departments, the Department of Mental Health and Mental Retardation (DMH/MR), Community Services, and the Department of Labor, in addition to numerous private organizations.

G. Recommendations

1. DHS has submitted a supplemental budget request for FY '90 for General Assistance reimbursement to cities and towns. This is to provide funds for the Emergency Assistance Program, which has experienced a 20% increase in applications.

2. DHS establish priorities in funding for programs which directly and indirectly affect services to the homeless:

   - First priority is to keep existing services, which the DHS understands to be critical, such as detoxification and rehabilitation services, and to resist cuts to services for the homeless/at risk in Maine.

   - Second priority is to strengthen existing services before expanding services.

3. DHS seek every effort to increase funding available, especially from federal sources. This includes increasing utilization of Medicaid funds, such as: case management for at risk populations (child protective cases, families at risk, AIDS/HIV infected individuals, elderly); adolescent care in therapeutic foster homes; and funding for substance abuse halfway houses under non-medical institution provision.

4. DHS work within the established groups toward adoption of definitions of homeless and "at risk" which will be used by these groups.

   DHS can request adoption of a consistent definition to be used by respective departments, agencies, and organizations. DHS will ensure that the definition is used within DHS programs. The process for doing this must allow for discussion and clear decisions regarding peripheral populations, e.g., institutionalized persons.

5. Develop the mechanism for collecting statistics regarding the definite populations, hopefully within current data collection structures.

   This recommendation also implies the need to determine the data to be collected, based on established goals and client outcomes.

6. DHS will begin developing identifiable outcomes and goals for clients receiving DHS services as a bases for development of programs and services.

   The outcomes will, of necessity, need to consider the individual clients. However, generic outcomes can be developed which would apply to essentially all DHS clients who are homeless or at risk of becoming homeless. The outcomes should address prevention, acute or crisis situations, and remedial or rehabilitative client needs.

7. This description of DHS services will be refined and updated regularly.

   As this report is circulated internally, other DHS services will undoubtedly be added. DHS provides many services to clients without considering the status of their living arrangements. However, these services, in reality, enable individuals to prevent homelessness, or to move them out of that state.

   Hopefully, DHS can encourage the development of similar program descriptions from other agencies on the Task Force. Discussion of services available throughout the state would undoubtedly be a benefit for all.

1. A Report on the Governor's Task Force on The Homeless, July 1983.
2. "Estimating the Numbers of Homeless Persons," unpublished manuscript, Community Service Society of New York, 1981.
3. Governor's Advisory Committee on the Homeless, Boston, Massachusetts, January 1983.
4. The Report of Maine's Task Force to Study Homelessness, February 1986.

## II. SERVICES PROVIDED BY DHS

Following is a more detailed description of services provided by DHS than is given in Section I. Although the questions are not repeated in the text, the descriptions address:

- Who are the clients?
- What are the problems which the clients are facing?
- What services are provided?
- What are the gaps in services? In information?
- With what agencies does DHS work?

### A. Prevention: Services to maintain people in a living environment which at least meets minimal health and safety standards.

#### 1. General Assistance - Prevention

The General Assistance client who requires preventive assistance is usually one who has temporarily lost his income and needs assistance on a short-term basis. This person could be of any age and circumstance who perhaps has lost a week or two, even a month's worth of income through short-term layoff or termination of income. He/she has been financially able to provide for him/herself (and family) and expects to resolve his/her own problems as soon as possible. He/she usually requests assistance for current rent/mortgage, utilities, fuel, and/or food.

In cooperation with towns, the General Assistance Program provides for the basic necessities when the eligible client cannot provide for himself/herself. DHS provides shelter assistance which could be applied to rent or mortgage. Food, current utility payments and fuel are available to prevent a crisis situation. Approximately 8,600 people per month received general assistance in FY '89.

#### 2. Emergency Assistance - Prevention

The Emergency Assistance Program provides assistance for certain types of crisis situations and is for one-time assistance during a twelve-month period. The assistance may provide the key support which prevents a family from becoming homeless.

The eligible client for Emergency Assistance is a person who is receiving AFDC or would be eligible to receive AFDC if he/she chose to apply. The person must have dependent children who live in the household who meet the age/school requirements as set forth by AFDC.

The family unit which would be eligible for this program would have to be deprived of parental support as a result of separation/divorce, death of parent(s), disability of parent(s), or unemployed parent(s).

The Emergency Assistance Program provides for the following crisis categories and amounts per category:

a. Disasters -- Assistance can be used to provide/replace necessary household items. This can also include plumbing, electrical and carpentry work and rental of new living arrangements including a security deposit. Maximum payment is $350.00.

b. Crisis that infringe upon a family's ability to cope with the elements such as inadequate, broken or worn conditions of a well, chimney, septic system, furnace or heating stove. In these cases, the structure or item requiring service must be owned by the applicant or in the process of being purchased by the applicant. Maximum payment is $500.00.

c. Housing crisis due to eviction/foreclosure/condemnation of structure, domestic violence, and unsafe or unhealthy conditions for the child(ren). Assistance may be used for rent or mortgage arrearage or toward a security deposit on a new rental property. Maximum payment is $350.00.

d. Crisis involving actual or potential disconnection of electricity, gas, bottled gas, or water. Assistance may be granted for more than one utility. Maximum payment for one is $300.00, maximum payment for second is $200.00, overall maximum of $500.00 for both.

This program cannot provide for homeless persons (usually a young population) who may be forced to leave their parents' home or a friend's home. In addition, the maximum levels of assistance are not always high enough to meet the needs of the client. For example, $500.00 is not enough to repair a broken furnace or septic system. It is necessary for the client to apply and qualify for other forms of assistance.

3. Nutritional Services - Prevention

When income is marginal, there is a tight balance between expenditures for food and expenditures for shelter. Assistance with food costs increases money available for shelter. Inability to purchase nutritious food places people at risk for health problems and decrease in ability to function productively.

The Food Stamp Program serves about 95,000 people per month in the State of Maine. Food Stamp eligibility is based on the assets and income of persons who live in the same home and purchase and prepare meals together. Household members do not need to be related. Approximately 34% of Food Stamp recipients are elderly. Another 52,000 (aproximately) receive AFDC benefits. The remaining recipients are single individuals, married couples, teens, working persons - in other words persons and households of various compositions. Food Stamps are available to persons with no permanent address (as long as they reside in

Maine). Special provisions allow Food Stamps to be given to persons living in approved alcohol and drug rehabilitation centers and shelters for battered women.

Eligible households are sent Food Stamps on a monthly basis. In Maine, approximately $5,000,000 in benefits are mailed to participants. The average allotment per household is $120.00 per month. The Stamps can be used at almost any grocery store to buy food.

The Department is also responsible for assuring services to pregnant women, breastfeeding mothers and young children under 185% poverty level who are designated as nutritionally at risk. The Women, Infants and Children Supplemental Food Program (WIC) serves over 21,000 clients monthly. WIC services are provided by eleven agencies statewide under contracts with the Department. The program conducts a brief health appraisal and provides health counseling and education regarding use of the food. The WIC program is also trying to integrate smoking cessation programs directed to the needs of WIC mothers. The savings from smoking, in addition to reduction of health risks for mothers and children, will provide additional funds for the family to meet basic needs.

4. Assistance for Families with Dependent Children (AFDC) - Prevention

In order for a family to receive AFDC, there must be a child under the age of 18 who is deprived of parental support because one or both of the parents is not in the home or is unemployed or incapacitated. The child must be living with a relative. Some 18,500 families in Maine receive AFDC.

AFDC is provided in order to assist the family during a time of financial need. Single parents who head the majority of AFDC families are women, many of whom lack the skills necessary to allow them to enter the job market at a wage large enough to support themselves and their children. AFDC provides these families with a small, yet dependable amount of money to meet their basic need of food and shelter.

AFDC is provided through a monthly check to recipients. Approximately $6,000,000 per month in State and Federal funds are sent to recipients. All AFDC recipients automatically receive Medicaid. If everyone in the household is receiving AFDC, the family automatically receives Food Stamps. A major service to AFDC recipients is ASPIRE (described under Remedial/ Rehabilitation).

5. Health Services

When the critical concern of a family is availability of basic items, such as shelter and food, health is a secondary consideration. However, these survival factors place the individual at great risk for developing serious health conditions: communicable diseases (tuberculosis, hepatitis, bacterial and viral infections), anemia, chronic respiratory condition.

The environment in which families reside may be inadequate and present risks, from fire and safety hazards to accidents and leaded paint and soil. Because of inability to obtain adequate housing, the choice becomes working with families to reside as safely as possible within the existing situation or homelessness. For example, a preschool child is discovered to have elevated blood lead levels may be residing in a leaded dwelling, and the landlord may be unwilling to make necessary renovations, or, in the case of a homeowner, may be unable to afford renovations. A major focus of the community/public health nurses working with the family will be on separating the child from the leaded areas and increasing cleaning of the environment.

Additionally the birth of a child may place the family at jeopardy if resources have been marginal. This risk includes adequacy of shelter, concern over basic needs which interfere with family emotional support and functioning. The Department has been working with the hospitals and medical community to establish referrals of high-risk prenatal women and newborns to public health/community health nursing. Risks for referral include "environmental risks," such as single parents, teens, who have inadequate housing, clothing or food. The support given to the families include referrals to appropriate sources, counseling around health issues, and assistance in obtaining services. Services are provided by public health nurses and through maternal and child health grants to local nursing agencies.

Well Child Clinics offer well child care to non-Medicaid children, birth to school entrance, whose families' income are under 185% of the Federal Poverty Level, and who are not under regular primary care. Clinics may be offered in a community or group of communities when there are enough children needing service, a receptive medical provider and adequate personnel. Clinics have been offered for over 60 years, but the services have changed from primarily immunization clinics to providing a full range of screenings recommended by the Academy of pediatrics, as described in Standards for Preventive Health Care. The Bureau of Medical Services provides well child care to Medicaid recipients through their Preventive Health Program (PHP), which also follows these Standards.

Services offered at clinics include health history, measurements (height, weight, head circumference), development assessment, health and safety guidance and counseling, nutrition assessment and counseling, vision and hearing screening, physical examination, blood pressure, blood work for lead and iron deficiency, immunizations, dental education and fluoride. Children with abnormal findings are monitored and referred to a primary physician. Some 100 clinic sites provide services to 10,000 children annually.

People using shelters probably do not have regular health care services. Because of displacement and other risk factor life style, they are at risk for communicable diseases, particularly influenza, pneumonia and hepatitis B. Children in the shelters

may not have received required immunizations. The major risk would be to pertussis (whooping cough). Additional risks include exposure to tuberculosis and HIV infection.

The City of Portland employs a physician assistant and a nurse to serve the shelters and soup kitchens. DHS Immunization Program personnel are working with the City of Portland to develop an immunization program for children at their shelter. In addition people at the shelters who have positive tuberculin skin tests are referred to DHS for follow-up.

Vaccines available through the Immunization Program include measles, mumps, rubella (MMR); hemoephalis influenza B (Hib); and diphtheria, pertussis and tetanus for children, and diphtheria/tetanus for older children and adults. Presently, the Immunization Program does not have vaccines for influenza, pneumonia, or hepatitis B readily available. However, expansion of the program for the homeless should be considered.

6. Teens - Pregnancy and Health Services - Prevention

Teens who are homeless or at risk of becoming homeless frequently come from families in which violence and dysfunction is a norm. This includes a high degree of substance abuse within the families and among the teens themselves. These teens often experience multiple family relationships (e.g., divorces, remarriages). Pregnant and parenting teens may find that shelter previously available to them is not available with the addition of a child.

A major concern is the adequacy of housing which teens may use, including dwellings which are not structurally safe, are overcrowded, or in which the teens are at risk of abuse. Even such arrangements are frequently temporary, placing teens at major risk of becoming homeless. A large percentage of pregnant and parenting teens move in with friends and/or family due to economic instability. This causes mobility and possibly inability to remain in a school system or setting.

The Department needs to begin a combined effort with the Department of Educational and Cultural Services to work with local communities and school systems to address problems of youth including the high rate of school drop-outs. The Department also needs to work with the Department of Corrections regarding juvenile problems.

Approximately 14% of 10-18 year olds in the United States do not have health insurance coverage in the United States. Adolescents who are most likely to be uninsured are males, poor and the near-poor, minorities, those whose parents have not completed high school, and those living in single parent households. This year, the Department, with the assistance of the Citizen's Advisory Task Force, will identify a method of evaluating the problem of uninsured youth in Maine. While the Department begins to examine the problem of uninsured youth, it will also look at the problem of homeless youth.

Services of the teen pregnancy projects vary depending on community need. The core services, however, are similar. All projects provide: 1) care management (i.e., assessment of the client, child and family situation, including medical, educational, emotional, social service, child care, reproductive services, housing needs, referral to appropriate services, and follow-up), 2) individual or group support and counseling, and 3) childbirth and parenting classes. Projects attempt to encourage/improve parenting skills, to prevent further unwanted pregnancies, and to assist to improve the overall economic situation of the teen mothers by encouraging and assisting in the completion of high school education.

Starting July 1990, grantees who receive funds for teen/adolescent programs from the Division of Maternal and Child Health, Bureau of Child and Family Services and the Family Services Program will be collecting information about the adequacy and availability of shelter, including homelessness. The data will be collected annually, starting June 1991, and should be available by October 1991.

The Bureau of Child and Family Services (BCFS) funds 14 agencies statewide to provide services for pregnant and parenting teensbetweena the ages of 12 and 20.

Essentially, each agency provides the following services:

- childbirth education
- counseling (individual and group)
- parenting skills development
- case coordination
- referral to necessary resource (health, vocational, educational)

Gaps in needed services include specific transitional housing programs for the pregnant and parenting teens. The transitional program needs to be long-term in order to provide necessary educational, vocational and emotional support to each client. The goal is to equip these teens with, not only parenting skills, but to be able to provide teens with the work skills to provide financial stability for themselves and for child(ren).

Significant gaps in data still exist:

- Numbers of teens affected
- Number of children affected
- Teens specific living situation (appropriate, inappropriate
- Assessments of appropriate housing based upon caseplan of client.

7. Substance Abuse Prevention

The Office of Alcoholism and Drug Abuse Prevention's (OADAP) mandate is to provide alcohol and drug abuse prevention, treatment and rehabilitation services to Maine's citizens. Most experts agree that approximately 1/3 of all homeless persons have

significant substance abuse problems. Substance abuse treatment providers have historically indicated that lack of housing is a serious impediment to the rehabilitation of many of their clients.

These expert opinions have recently received support from OADAP's Management Information System (MIS). Data for the first quarter of FY '90 indicate that a substantial proportion of those served are homeless or at risk of becoming homeless:

- 52% of those admitted reported their primary residence for the past 6 months was their own home or apartment.
- 28% lived in the home or apartment of a friend or relative.
- 11% had been in a correctional institution.
- 9% had lived in shelters, other institutions or on the streets.

Substance abuse services are an integral part of the array of services required by many homeless persons. These range from emergency shelter, through treatment to long term supportive housing. Treatment services are most effective when accessed relatively early in the development of substance abuse problems. Both outpatient and short term residential treatment are critical mechanisms to enable those at risk of becoming homeless to recover from their problems sufficiently to maintain employment and other social supports necessary to remaining housed. Long and short term residential and halfway house services are necessary to enable homeless substance abusers to attain the skills necessary to sustain themselves in adequate housing. Thus, substance abuse services span the spectrum of services needed by the homeless and those at risk of homelessness.

Many of the substance abuse treatment services provided prevent the futher deterioration of living situations of those at risk of homelessness. Other types of services, such as community prevention activities, also reduce the risk of homelessness. OADAP recently collaborated with the Bureau of Elder and Adult Services to launch the Tenant's Assistance Project (TAP) in subsidized housing for the elderly. This project is designed to train housing managers in more effective ways to deal with substance abuse problems among residents, and to empower the residents to reduce substance abuse. The Office also has a federal grant to develop a community -based prevention program in the Portland Housing Authority's projects.

8. AIDS/HIV Infection - Prevention

The person with HIV infection who is homeless may be in any of the general population groups, such as "street kids" - high-risk adolescents, drug users, transients, persons without family or friendship support, families that include infected women and children, and orphaned/abandoned infected children.

People with AIDS/HIV infection are at risk for becoming homeless for a variety of factors including movement to a locus of treatment and resources available, such as Portland, which may mean loss of job, previous relationships, family support;

displacement/rejection by family, acquaintances, employers; and at risk from other factors, such as substance abuse, which are compounded by an HIV infection.

Currently provided services include:

- Street education and outreach, which is the focus of a grant to the AIDS Project ($23,000).

- Funding to state agencies and departments for staff AIDS education. Funds ($3,000) are available for the Department of Corrections for training jail administrators, probation officers, and training of trainers.

- Funding to Maine AIDS Alliance to conduct AIDS education programs at the local level ($20,000).

- Subsidizing expenses of AIDS hotline. The State Legislature appropriated $5,000 and the CDC cooperative agreement made $19,500 available for hotline services, which includes referral to a variety of support services.

- Funding to support the Maine Consortium for Health Professionals Education to continue AIDS Education for health care providers, especially physicians. This should focus basic knowledge of AIDS/HIV infection and the circumstances which infected people face.

- Work with police departments to develop and distribute HIV/AIDS information to persons convicted of sex and drug crimes.

- Continue needs assessment and development of educational materials for minority groups, such as Native Americans, migrant workers, and refugees, working with Public Health Nursing and DECS.

The Bureau of Child and Family Services currently has contracts with three agencies for AIDS/HIV case management services. These are: The AIDS Project, Portland; Kennebec Valley Regional Health, Augusta; and Eastern Maine AIDS Network, Bangor. Case management is designed to assist HIV infected persons in accessing the health/medical/social services needed, and housing requirements are major considerations of case managers. The present caseload for the agencies is over 175 clients with AIDS or HIV infection.

Gaps in Services include:

- Housing for infected women and their children
- Placement resources for infected children
- Orphaned/abandoned infected children
- Skilled nursing home care

9. Elderly - Prevention

The Bureau of Elder and Adult Services addresses the needs of Maine's elderly population as well as those adults (75% of whom are elderly) who are incapacitated or dependent and in danger. The challenge of meeting the housing, health and social needs of the elderly will increase as Maine population ages. Estimates indicate that the age 65 and older group is the fastest growing age group in Maine. Presently, 17,160 elderly households are considered at risk of becoming homeless.

The needs of Maine's elderly have been the focus of an organized state level and community based Aging Network since the late 1960's. The five Area Agencies on Aging are responsible for evaluating, planning and coordinating services to the elderly. As a result of these efforts, elderly homelessness in Maine has not been widespread. In fact, much of the program and service efforts on behalf of the elderly have been directed toward maintaining their ability to live in the community in order to avoid institutionalization not homelessness. However, the combination of decreasing Federal support during the 1980's and increasing needs of Maine's aging population, especially those at low income levels, will put additional pressure on the Aging Network and elderly homelessness may become a substantial challenge.

Of the estimated 219,000 Maine residents aged 60 and older, 95% (209,000) live in the community.

- The average age is 71
- 25% live alone
- 22% have household income below poverty
- 75% own single family houses
- 10% own mobile homes
- 14% live in apartments

The Bureau of Elder and Adult Services budget includes approximately $13.5 million for community services for the elderly and $3.5 million for guardianship and protective services to incapicated and dependent adults in danger. Housing needs are addressed by home maintenance programs, property tax relief and federally assisted apartment units. Supportive service needs are addressed by a wide range of programs which intervene to assist in independent living. These services include Information and Assistance, Home Based Care, Care Management, Nutrition, Congregate Housing Services, Legal Services, Employment, Adult Day Care, Volunteer Programs, Transportation, Substance and Alcohol Abuse Prevention, and Protective and Guardianship Services. It is estimated that these supportive services assist at least 40,000 elderly people per year.

As Maine's population ages, elderly housing, health and service budgets will be pressed to increase. A less than adequate increase will place additional burdens on the Aging Network, resulting in additional elderly households at risk of homelessness. A critical service gap is anticipated with the possible loss in the near future (5 to 7 years) of federally

assisted elderly apartments when subsidy contracts expire. The development of federally assisted elderly apartments is not keeping pace with demand, and the loss of existing apartments would compound the crisis in affordable housing.

10. Refugees - Prevention

Refugees are people who have been resettled in Maine, and are not able to return to their own country, and who are not yet economically self-sufficient.

Refugees have been relocating to Maine since the mid-1970's. The first influx was from Southeast Asia, primarily Vietnamese and Cambodian refugees. Presently, refugees continue to arrive from these areas, plus multiple other parts of Southeast Asia, Europe and Central and Southern America. The major location of refugees is the southern part of the state. The general assumption is that the refugees will have sponsors.

In addition, in-migration from other parts of the country results in overcrowded housing conditions and the risk of homelessness, as the migrants move in with settled refugees who may be residing in adequate, but not abundant, housing.

The concern is also the increased risk for spread of communicable diseases, such as tuberculosis. Out of a possible 41 cases of tuberculosis in Maine in 1989, seven cases were refugees. Newly arriving refugees are followed by public/community health nurses for tuberculosis testing and follow-up. Services related to tuberculosis are largely provided through the tuberculosis clinics, such as the clinic at Maine Medical Center..

In addition to a focus on communicable diseases, public/ community health nurses conduct a health history and provide case management services, which focus on basic needs and arrangements for health care srvices. This is provided in conjunction with the Refugee Resettlement program and with the assistance of a small federal grant.

In addition, refugee cash assistance provides a minimum income level without regard to family composition. Eligibility is limited to a refugee's first twelve months in the United States. General assistance, administered by towns and cities, may pay rent subsidies for income-eligible refugees.

A present gap in service is the availability of interpreter services for some language groups. While much of the health history and tuberculosis literature has been translated into various languages, interpreters are needed for questions and concerns unique to the individual.

Another gap is housing information and referral sevices, statewide program of housing subsidies based on family size and income.

11. Migrants - Prevention

The Maine State Profile of Migrant and Seasonal Farm workers was developed by the Maine Ambulatory Care Coalition (MACC) with the assistance of the Department's Cooperative Agreement for Primary Care Services staff. Of the 10,000 farm workers in Maine, approximately 4,000 were migrants. In the high impact areas of Hancock, Washington and Aroostook counties, the profile showed a projected need for 6,000 farmworkers with approximately 3,500 migrants. However, the total number of migrant and seasonal farm workers and migrant dependents in these areas would increase the total by an additional 1,500 individuals. Three major crops rely most heavily on the migrant and seasonal workers: blueberries, broccoli and apples. Migrant farm workers are also employed in the egg industry in the central part of the state.

The major concentration for migrant and seasonal farm workers in the state is that of workers harvesting blueberries in Hancock and Washington Counties. According to the Maine State Profile of Migrant and Seasonal Farmworkers developed by MACC, approximately 3,000 migrant and 2,000 seasonal farm workers work the 19,000 acres six days a week during harvesting season, which lasts 4-6 weeks.

The migrant and seasonal farmworkers employed to harvest the blueberry crop in Washington and Hancock counties receive some services through a Rakers' Center. Programs provided through the Center include general assistance, food stamps, legal assistance, WIC and Social Security assistance. Health services have also been delivered as part of this Center under a contract from the New England Farm Workers Council. The health services had been administered and delivered by the Division of Public Health Nursing until 1988 when they were administered by the Washington-Hancock Community Agency (WHCA). The medical care itself has been delivered for several years by residents from the Maine-Dartmouth Family Practice Residency Program.

In January of 1989, the Maine Ambulatory Care Coalition submitted a grant proposal to the Bureau of Health Care Delivery Assistance, U.S. Public Health Service. The grant proposal includes forming a non-profit corporation which will subcontract for health services to migrant and seasonal farm workers in Washington and Hancock counties. In addition, the grant proposal included new and expanded health services for the broccoli workers in Aroostook County and apple pickers and egg farm workers in Androscoggin County (Leeds-Turner area). Although initial response from the U.S. Public Health Srvice has been supportive, a final decision is pending.

12. Family Violence Victims - Prevention

Victims of family violence often, because of the control dynamics of the relationship, have no means to provide shelter/food for themselves and their children when the decision is made to leave the abusive household.

The Department contracts with 9 community agencies to provide education on the dynamics of family violence and information on available services to community agencies, institutions, schools, private organizations and individuals.

Additional funds are needed for educational/informational services; especially for the implementation of school-age prevention programs statewide. At present, the Department has no mechanism for assessing the efficacy of education/information initiatives.

13. Children - Prevention

Children at risk of becoming homeless include: abused and neglected children who have been placed in state protection or custody, runaways, the children of family violence victims, and children who have been asked to leave home by their parents..

In recent years, the Department has witnessed a marked increase in the occurrance and level of family dysfunction. As substance abuse, neglect and physical and/or sexual abuse threaten family stability, children become at risk of homelessness, either through removal from the home or, as teenagers, choosing to strike out on their own.

Children who are removed from the home and placed in state custody are case managed by the Bureau of Child and Family Services (BCFS) Child Protective or Substitute Care units. Although every attempt is made to find an appropriate placement, limited resources and the serious nature of the child's problems make finding appropriate residential placements extremely difficult. In addition, unless a child is involved in the criminal justice system and placement is a condition of their probation, the state has little leverage in making children accept placements. As a result, older children, generally aged 15-18, may refuse services and choose their own living arrangements.

Teenagers who have chosen to leave home or for whom appropriate placements are not available, or who refuse placement services, are at high risk of homelessness due to their lack of resources, education, job skills and life-coping skills. The dilemma is how to adequately provide the support services needed by families at risk before the situation deteriorates.

The following services, provided directly by BCFS staff, reduce the risk of homelessness by either keeping families intact or providing appropriate placement when children cannot stay at home:

- Child Protective Services: Caseworkers coordinate services to help stabilize families and reduce the risk of removing a child. Typical services include mental health counseling, homemaker services, public health nursing for parent skills training, protective day care, etc.

- Substitute Care Services: Provides case management services for children placed in state custody. Although not living at home, children for whom stable long term foster care or adoption can be arranged are not at risk of homelessness. This unit serves an average of 1,858 children per year.

The following services, purchased by contract, work to modify the dynamics that lead to homelessness for children:

- Child Abuse and Neglect (CA/N) Councils: Provide an assortment of primary prevention activities to promote awareness of abuse issues, educate children about personal safety and assist communities in building family support systems. The 16 Councils receive a total of $274,835 in state support.

- Homebased Family Counseling: DHS contributes $218,500 toward the support of 9 programs statewide. Programs provide intensive time-limited intervention and counseling to families at high risk of having a child removed from the home. (Jointly funded with DMHMR & Department of Corrections).

- Parents Anonymous: Establishes local self-help support groups and parenting education classes for parents at risk of abusing their children. Services are open to the general public and are provided by PA's trained volunteers. DHS allocates $101,080 to PA.

- Mental Health Services: DHS provides $1,041,115 annually to purchase counseling services for children who are open cases of the child protective or substitute care systems. Funds may also support treatment for the perpetrator in cases of intrafamilial abuse where family reunification is part of the case plan. Successful treatment helps to stabilize families, reducing the risk of out-of-home placement and/or facilitating reunification.

- Homemakers: Along with traditional Homemaker services, a limited amount of the $2,581,780 available to Homemaker programs is used to provide parenting skills classes to DHS referrals.

The Department works with the Maine Association of Child Abuse and Neglect Councils; Mental Health Providers Coalition; Homemakers Coalition; Interdepartmental Council's (Homebased Family Services Work Group; Residential, Group and Community Care Committee; Committee on Child Sex Abuse; Children's Policy Committee); Child Welfare Advisory Board; Maine Foster Parents Association.

Gaps in needed services include:

- Prevention: The majority of BCFS services are available only after families are involved in the protective/custody systems. Very little is available as a support system for the general public to prevent the family dysfunctions that lead to the removal of children. For services that are available through BCFS, demand far exceeds availability.

- Mental Health: Counseling is available only for children who are open cases of the protective or substitute care systems. Although protective cases are closed by BCFS as soon as it is determined that jeopardy has been eliminated, research in the field confirms that therapy for victims and perpetrators of abuse is a long term process. Research also indicates clear risks that unresolved abuse issues can lead to future offending behavior and/or dysfunction. Funding is needed for an average of 1-2 years. DHS funds lapse three months after the closing of the case and DMHMR does not provide funds for this population.

- Appropriate Placements: For children who must be removed from their homes, more resources are needed for stable long term placements.

Gaps in information/data include:

- Primary prevention activities designed to support families and reduce the incidence of child abuse and neglect are difficult to measure. There are no statistics to prove the relative success of one approach over another.

- Although BCFS has statistics showing the number of children currently in custody, statistics do not indicate the number of children for whom no appropriate placement is available, those waiting for foster home placement, or the number who refuse placement services.

- There are no accurate statistics for the number of homeless children not known to BCFS caseworkers. Although children's shelters keep records to show their monthly utilization, this number is not an unduplicated count. Statistics do not include numbers of children not accepted for services (usually due to substance abuse and/or behavioral problems), or the number of homeless children who do not seek shelter services.

B. Acute/Crisis Services: Services to assist individuals when an abrupt change in circumstances threaten or cause loss of shelter and other necessities of life.

1. General Assistance - Acute

The General Assistance client who requires crisis assistance is the person whose circumstances have changed abruptly and are out of his/her control. This could be a person who lost his/her job and has been denied unemployment compensation as well as a woman who has separated from her spouse. Usually rent/mortgage payments are behind and the client is facing an eviction or foreclosure. Some clients have experienced a disaster such as a fire and could not or did not plan for an emergency situation. Persons in this category may have been financially capable to care for themselves on a month-by-month basis, but could not afford to accumulate any savings or could not afford any insurance payments.

The eligible person for General Assistance who needs emergency assistance can receive assistance for rent/mortgage payments, shelter, food, fuel, utility payments, etc. Welfare administrators generally prefer that persons who are in an established rental unit or housing remain there. If a person is in a rental unit which he/she cannot afford and less costly housing is available, the administrator may provide for the less costly housing. Also, if a person needs emergency assistance for housing and has no established housing, shelters may be utilized as well as rooming houses. If the client owns his home, capital repairs of furnaces, septic systems, etc. may be allowed.

Municipalities work primarily with Community Action Program (CAP) agencies and the Department of Human Services. The Emergency Assistance Program is utilized if the applicant has children and is eligible for the program. Also, they rely on power companies for utility payment arrangements, Home Energy Assistance Program (HEAP), and Emergency Crisis Intervention Program (ECIP). Food banks are also utilized for supplemental food.

Unless persons in need actually pay for assistance, there are no numbers of persons in need. The General Assistance Program is a "safety net" for most people in most emergency situations; however, depending upon the particular circumstances and upon the particular welfare administrator, needs may not always be met.

2. Health Issues - Acute

Health care costs and lack of insurance place a number of people at risk for losing the ability to meet their basic shelter, clothing and feeding needs. This places them at risk for becoming homeless. People in the population include teens, especially pregnant or parenting teens; families whose employer does not provide insurance benefits or who rely on unemployment benefits; families who have high medical costs due to chronic conditions or children with abnormalities.

A 1986 study by the Human Services Development Institute, University of Southern Maine, estimates that 13% to 15% of Maine's population between the ages of 18 and 64 years lack health insurance coverage, thereby creating a problem of access to basic health care needs.

The largest initiative for the uninsured, the Maine Health Program (MHP), is scheduled to begin in FY 1991. The new program is funded entirely with state funds.

Initially, MHP will cover children at income levels to 125% of federal poverty guidelines and adults, to 95%. During its first year, it is estimated that 5,751 children and 6,816 adults will enroll. The cost of health care services for this population is projected at $9,946,885. It is anticipated that total enrollment will rise to almost 29,000 by 1993 with a correspondingly substantial rise in program costs.

Participants will receive a benefit package similar to the Medicaid package. Obstetrical services will not be covered since SOBRA coverage under Medicaid already exceeds the MHP income criteria.

The status of health care available for and utilized by the homeless needs to be clearly identified. Possibly educational programs regarding the life situation of the homeless need to be developed for health care providers. These should include of follow-up, modification of immunization schedules to maximize the present visit, and modifying medication schedules, with a focus on distribution on site. A primary concern in delivery of health services is how health/medical practices fit into the life cycles of the homeless.

As health care becomes more available through expanded coverage, the economic barrier will be lessened. However, people who are not comfortable with providers generally will not use the system unless providers treat as the homeless individuals, without discrimination. This needs to be discussed with all personnel in the health care setting, from receptionist to physician.

Because of the factors which contribute to homelessness - low economic status, dysfunctional background, distrust of the "system," and underlying disabilities or chronic conditions -- the homeless person will frequently seek care at a more advanced stage of disease. This undoubtedly increases the utilization of emergency rooms and increases cost to the health care system.

The situation may be exacerbated by the type of health condition which is being presented. AIDS/HIV infection, or other infectious diseases, may influence the reception of the homeless person. These factors need to be included in the educational programs.

3. Teens - Acute

The teens in crisis are those for whom the tenuous arrangements have collapsed completely. A major gap in services is availability of shelters for teens with behavioral or mental health problems. Activities of DHS focus more on prevention and remediation than on emergency/acute services specifically targeted toward youth. See notes under Substance Abuse.

4. Substance Abuse - Acute

OADAP funds four adult emergency shelter programs with a total of 48 beds. They are designed to provide basic food, shelter and referral services to intoxicated homeless persons. OADAP also funds one program for 15 beds of extended shelter. This program provides supportive services in a safe treatment, or who are seeking permanent housing after treatment.

While the emergency shelter beds typically operate at capacity, the addition of more such beds is not a priority need. However, there are no emergency shelter beds for intoxicated adolescents. With the possible exception of one "low barrier" shelter in

Portland, adolescent shelters will not admit intoxicated youth, turning them into the streets.

OADAP also purchases a variety of outpatient crisis intervention services which can respond with supportive counseling, assessment and referral.

5. Elderly - Acute

In spite of the efforts of the Aging Network, there are occasions when persons aged 60 and older need the assistance of homeless shelters. Preliminary information indicates that elderly at homeless shelters may have exhausted their income resources and may also suffer from years of substance abuse and/or personality disorders.

Acute elderly homelessness is estimated to be within a range of 30 and 100 persons, based on information provided by Portland and Bangor area shelters, the regional offices of Adult Services, and the five Area Agencies on Aging.

The Adult Services component of the Bureau of Elder and Adult Services provides case study, advocacy, preparation and placement, court social service, case supervision and management, and counseling to incapacitated and dependent adults in danger, within an annual budget of $3.5 million. It provides services to approximately 3,700 adults annually.

The regional offices of Adult Services indicate that additional structured living environments such as adult foster homes would assist the placement of those elderly homeless suffering from substance abuse and/or personality disorders.

The Bureau cooperates with the Department of Mental Health and Mental Retardation, and with other Department of Human Services agencies such as the Office of Drug and Alcohol Prevention.

6. Migrant - Acute

Presently existing Community Health Centers in the Leeds-Turner area of Androscoggin County and the Harrington-Machias area of Washington County, provide some backup health services. Transportation to hospitals and other health services is arranged through the Washington-Hancock Community Agency (WHCA) which is administratively responsible for the Rakers' Center.

When a migrant farm worker is in need of health care, numerous barriers exist. As a result of the farm worker's economic position, prevention is not sought and health care is postponed until absolutely required. Often, if a farm worker seeks health care, lost wages will result. For instance, in Maine's Washington and Hancock Counties, the Rakers' Center serves the migrant population operating during weekdays but not on weekends. This may be a barrier for the migrant farm workers in these counties.

7. Crime Victims Assistance Program - Acute

The federal victims assistance program is designed to address the crisis social service needs of crime victims, including victims of child abuse, sexual assault, spouse abuse, family survivors in homicide cases, and survivors of drunk driving accidents. The trauma of victimization in personal crimes is heightened when the victims are being forced to leave their home in order to protect themselves. The BCFS's victim assistance program provides funds for emergency shelter for spouse abuse victims, access to funds for short-term, emergency housing needs of sexual assault victims. The program's state office can approve short-term emergency housing assistance (financial) for other crime victims on a case-by-case basis.

The program works with:

- The Federal Victim Assistance Program;
- The U.S. Attorney's Office;
- State Police, local law enforcement;
- The State Attorney General's Office;
- The eight District Attorney's officers;
- The community-based Family Violence and Rape Crisis programs;
- The Department of Corrections;
- MADD of Maine;
- Community service organizations and agencies.

Victims of personal crimes also often need assistance in returning to their own homes. Persons whose homes have been burglarized, or who have been victimized in their own homes need to be able to replace locks, broken doors and windows, install alarms, etc. in order to secure their home. No funds are currently available for these services.

The extent of homelessness caused by crime victimization is unknown. Current crime report protocols do not routinely indicate the needs of the victims. Informal arrangements with some law enforcement agencies are being proposed by the state office to provide needs information to the program.

8. Family Violence Victims

Clients are predominantly battered women and their children, some of whom are referred by child protective and adult protective services' caseworkers.

When a domestic violence victim determines that a abusive relationship is no longer tolerable, she may not have timely access to a family violence shelter due to geographical concerns (distance to the shelter/transportation need) or the non-availability of a shelter bed at a shelter that is accessible; causing the family to become homeless.

The Department contracts with community agencies to provide emergency shelter and counseling services at 8 sites statewide that provide shelter to family violence victims for up to 30 days per shelter stay. For areas where a 30-day shelter program is not available (geographically or no shelter beds are available), contract agencies arrange for time-limited services in "safe homes" where shelter is provided in a private home for usually not more than 3 days. Contract agencies will also arrange for and fund time-limited shelter services in motel rooms. The contract agencies located in Machias and Caribou have cooperative agreements with shelter programs in New Brunswick (Canada) when clients cross the border for services. The contract agency located in Sanford also cooperates with a similar program in New Hampshire. The network of family violence shelter programs maintain nearly 100 percent occupancy rates across the state.

A transitional housing program needs to be developed to provide low-income subsidized housing and support counseling for up to one year. For women who are not ready to address their abuse and who would neither benefit from nor desire admittance to a 30-day shelter program, funding needs to be available to pay for short-term shelter. Alternative housing arrangements need to be made for clients who need 24-hour supervision.

9. Children - Acute

Clients at risk of homelessness include children in the Department's custody or protection for whom appropriate family placements are not available, children who refuse placement services, and children who choose or who are asked to leave the home due to family conflict, but who are not open cases of BCFS.

Children who are removed from abusive homes and placed in temporary state custody are case managed by BCFS child protective services. The first placement for these children is frequently a shelter or emergency foster home. Although shelter care is intended to be temporary while more stable family-setting care is arranged, limited resources may result in extended stays in a shelter facility or "shelter shuffling" from one temporary situation to another.

Children who are in permanent custody of the state and case managed by the substitute care unit face the same limitations in locating long-term stable placement. In addition, since BCFS has little leverage in making a child accept placement services (unless that child is involved in the juvenile justice system), children may refuse services and elect to make their own living arrangements. Although they are still technically case managed by BCFS, they may be choosing transient lifestyles in substandard housing.

This population appears to be on the increase. Statistics for 1984-1989 show an average of 1,858 children per year who are in the care or custody of the state. Of that number, an average

134 or 7% are reported as either living independently, living with non-relatives (but not a foster home or other placement), or "whereabouts unknown." Although no statistics specific to the population refusing services are captured, it is assumed that these three groups represent the majority of these children. This number has steadily increased in the last five years, from 5.7% in 1984 to 8.6% in 1989.

Services provided directly include:

- Child protective services - case manages children who are in temporary state custody.

- Substitute Care services - case manages children who are in permanent state custody.

- Licensing Services - licenses Residential Care Facilities, Emergency Shelters for Children, Shelters for Homeless Children, and Foster Homes.

- Foster Home Recruitment.

BCFS allocates $1,097,852 in 13 contracts for residential care, including 3 group homes, 4 emergency shelters, 3 emergency foster care agencies, and 2 therapeutic foster care agencies. Slots are purchased in all contracts for BCFS protective children; in emergency shelters and emergency foster homes limited slots are also purchased for low income children not involved with BCFS. Only 1 facility is designed for the general population of homeless children, and that is an overnight (as opposed to 24 hour) emergency shelter in Portland.

BCFS also provides child welfare payments on behalf of children in state custody who are placed in one of the following BCFS licensed settings:

- Group Homes - supervised family-style living arrangements for an average of 6-8 children referred by DHS or DOC. Treatment and education are not provided in-house.

- Residential Treatment Centers - Campus style supervised living arrangement with in-facility education and treatment components. Accepts referrals from schools, DHS and DOC.

- Emergency Shelter - Supervised short term living arrangement for an average of 8-10 children. Although this is a time-limited service (maximum 30-day stay, as per licensing), intended for crisis intervention, in fact, children frequently bounce from shelter to shelter due to lack of other options. This service is for walk-ins as well as referrals.

- Emergency Foster Homes - Time-limited supervised living with a family. 30 day limit; open to state referrals and designed as an interim placement until a more permanent placement is found.

- Therapeutic Foster Home - Foster care with parents who have received special training in dealing with DHS and DOC referrals.

DHS currently works with the Maine Shelter Network, Maine Association of Group Care Providers, Maine Coalition for the Homeless, IDC-Residential, Group and Community Care Committee, and the Maine Foster Parents Association.

Gaps in needed services include:

- Transitional Living Centers - a step between shelter and group home placement, where children can stay for more than 30 days while assessments are done and decisions made for future placement.

- Behavioral Stabilization Unit - to house and treat children who have behavior problems that make other residential placements unsuccessful.

- A residential/transition facility for teenage parents and their infants.

- Child protective case management services for families not yet in crisis, but for whom support services might help avoid future conflict and family separation.

Gaps in information/data include:

- Although BCFS has statistics showing the number of children currently in custody, statistics do not indicate the number of children for whom no appropriate placement is available, those waiting for foster home placement, or refusing placement services.

- There are no accurate statistics for the number of homeless children not known to BCFS caseworkers. Although children's shelters keep records of their monthly utilization, this is not an unduplicated count and does not include children not accepted for service or homeless children who do not seek shelter services.

- All shelters show below maximum utilization in spite of known numbers of homeless children on the street. Research needs to be done to find what prevents children from using shelter services and what services children need and would accept.

C. Remedial/Rehabilitation: Services to allow the individual to become as self-sufficient as possible.

1. General Assistance - Remedial

The General Assistance client who falls into the Remedial category is someone who either has no income and probably won't for a long time or someone who has a fixed income which does not provide for all his needs. This is usually an unemployable person due to various reasons, disabled persons, AFDC parents with no other source of income, or the elderly. The person who falls into this category usually lacks skills to increase income or have income at all. The person needs long-term financial assistance. Some municipal officials may discourage persons from applying for assistance which may be long term.

All basic necessities are to be met by the General Assistance Program. Those receiving remedial assistance usually receive rental assistance, utility assistance and food.

A lack of information or network of resources in smaller communities of where to refer ongoing clients for other potential resources is a problem as client records are kept at the local level so numbers of clients who fall into this and other categories are not readily available.

2. ASPIRE - Remedial

The ASPIRE (Additional Support for People in Retraining and Education) Program is designed to assist AFDC and Food Stamp recipients obtain the skills they need to become economically self-sufficient.

A major outcome of the increased self-sufficiency is stable, adequate, safe housing.

Through a case management system, each individual receives pre-training, training, education, job search, job placement and/or support services assistance. They need to obtain employment in their local labor market.

ASPIRE services are provided through cooperative agreements and contracts with the Department of Labor's Job Training System local private, non-profit agencies and the Department of Human Services' Bureau of Income Maintenance staff. All individual services are coordinated with local, State and federal resources.

3. Teens - Remedial

Teens involved in the remedial programs are those who have had crises, such as teen pregnancy, a substance abuse, or self-destructive behavior, and who are in remedial programs.

DHS has several programs which focus on pregnant and parenting teens. The Family Services Program and Public Health Nurses/Community Health Nurses work together to provide case

management and health promotion, helping clients work toward self-sufficiency. The Family Services Program serves teens on AFDC who are in their third trimester of pregnancy or who are parents. Public/Community Health Nurses serve pregnant and parenting teens and their infants who are at risk of or who have a health problem. The Family Services Program served 970 teens in FY 1989. Public Health Nursing has served 538 teens ages 15 to 19, and Community Health Nursing programs served 452.

In addition, several child care programs for students enrolled in high school are funded by DHS. Child care programs allow student parents to complete their education and to gain skills and confidence in parenting their children. These factors are steps to self-sufficiency.

4. Substance Abuse - Remedial

OADAP funds 52 long and short term residential treatment beds and 90 halfway house beds for longer term rehabilitation. These services typically address the needs of persons who can be fully reintegrated into a productive life style. OADAP also funds 47 extended care beds. Extended care is designed to provide long term (one year or more) supportive residential services to persons who require an extensive period of sober living in order to reverse the long term psychological and psychological effects of chronic alcohol or drug abuse. Given the extremely deteriorated condition of these individuals, it is expected that most of them will require continuing supportive care in order to maintain sobriety.

OADAP also supports two transitional housing programs targeted at adolescents who have completed treatment but who have limited independent living skills and no safe living environment to return to.

The Office has just initiated a federal block grant program to provide loans of up to $4,000 to groups of four or more recovering persons who wish to establish a drug and alcohol free group living home. The homes will not have staff, but will be resident operated with one cardinal rule: the residents must refrain from drinking and drugging.

There is a great need for group homes, transitional living programs, boarding care services and other safe, supportive residential arrangements for recovering persons. All too often persons leave treatment only to return to the street or to living with actively drinking or drugging friends and cannot sustain their sobriety in that environment.

5. Elderly - Remedial

Upon referral by shelter operators, elderly homeless are provided with the Aging Network services previously detailed under Prevention and Crisis Intervention. Although the Aging Network effectively advocates and intervenes on behalf of persons aged 60 and older, it is important that all homeless shelter operators be

advised of the services available. Also, preliminary information indicates a need for additional structured living environments for those elderly homeless suffering from substance abuse and/or personality disorders.

The regional offices of Adult Services indicate that additional structured living environments such as adult foster homes would assist the placement of those elderly homeless suffering from substance abuse and/or personality disorders. The Bureau cooperates with the Department of Mental Health and Mental Retardation, and with other Department of Human Services agencies such as the Office of Drug and Alcohol Prevention.

6. Refugees - Remedial

As soon as refugees arrive and have immediate survival needs met, the focus changes to preparing them to utilize their skills and develop new ones toward self-sufficiency.

Employment services, English language training, and short-term case management services are purchased from a private agency.

The Diocesan Human Relations Services' Refugee Resettlement Program is responsible for the resettlement of 90% of the refugees in Maine.

Longer-term case management (beyond the first twelve months in the U.S.), interpreting services, mental health counseling to more fully address the barriers to self-sufficiency, are areas in which there are gaps in services.

7. Family Violence - Remedial

Under current judicial and law enforcement systems, some victims of domestic violence cannot be protected from their abusers and must leave their homes to protect themselves and their children. Protection from abuse orders are not consistently accessible statewide and difficult, if not impossible, to enforce. Unless treatment services are provided the batterer, the violence will continue and victims will continue to leave their homes to be safe.

The Department contracts with community agencies to provide "community response" services directed at providing a system-wide community approach to assisting victims of domestic violence. To accomplish this, agencies provide advocacy and education to public institutions such as the judicial and law enforcement systems. Some agencies coordinate the provision of treatment services for abusers that are provided by trained mental health clinicians.

The availability and issuance of protection from abuse orders should be achieved in a consistent manner statewide. The arrest of perpetrators of domestic violence should be enforced consistently statewide in accordance with the State criminal code. The State lacks the resources for providing treatment services for batterers (as a condition of parole funded by Corrections/ Medicaid/private insurance).

The Department has no mechanism for assessing the efficacy of "community response" programs. Treatment for batterers is not funded by the Department and no data exists.

8. Children - Remedial

The clients at risk are protective and custody children who have transitioned from temporary shelter/residential care to foster homes, adoption, appropriate group home placement, appropriate independent living, or who have been reunited with their families.

In order for children in the care or custody of BCFS to have a positive placement outcome, the needed resources must be available. Needed resources include foster homes, adoptive homes, group home placements that match the child's needs, and mental health and other support services for children transitioning to independent living or returning to their families. Although BCFS provides case management services to move children toward these outcomes, availability of appropriate services is limited.

This is an even larger problem for those children who are not open cases of BCFS but who are among the homeless. Although BCFS purchases a limited number of slots in children's emergency shelters for the low income homeless children not open as BCFS cases, no remedial or rehabilitation services are funded by BCFS for this population.

Services provided directly include:

- Child protective services - case manages children in temporary state custody and attempts to place them in appropriate in-family settings.

- Substitute care services - case manages children in permanent state custody with the goal of providing stable in-family placement or adoption.

- Licensing services - provides licensing for residential care facilities, emergency shelters for children, shelters for homeless children, group homes and foster homes.

- Foster home recruitment.

Services include:

- BCFS provides payments to foster families for the care of protective and custody children. For the years 1984-1989, an average of 57% of children in care or custody (1,083 children per year) were in foster homes.

- BCFS provides child welfare payments to support children in Group Home settings. Although some of these children are still in crisis and may be waiting for a more appropriate placement or foster care there are appropriate placements for many other children. Included in the more difficult to place group are older children approaching 18 years of age and those

who need to be placed in long-term group homes with training components for life-coping skills and transitioning to independent living.

- Children who are being reunited with their families, as part of a case plan managed by BCFS, are eligible for all of the purchased support services listed in the Prevention section (mental health counseling, home-based family counseling, protective day care, etc.).

DHS currently works with the Maine Association of Group Care Providers; IDC - Residential, Group and Community Care Committee and the Maine Foster Parents Association.

Gaps in needed services include:

- More services are needed to assist older children in custody to make the transition to independent living.

- Resources for longer term shelter for homeless children not open to the BCFS protective or custody systems.

- More foster homes.

Gaps in information data include:

- Although BCFS has statistics showing the number of children currently in custody, statistics do not break out the number of children for whom there is no appropriate placement, those waiting for foster home placement, or refusing placement services.

# Chart of DHS Homeless Services

| Topics | Prevention | Acute/Crisis | Remedial/Rehab. |
|---|---|---|---|
| General Assistance | P Temporary loss of incomes.<br>S Food, utility payments, fuel 8,600 people/month in FY '89. | P Abrupt change in circumstances.<br>S Home Energy Assistance Program. Emergency Crisis Intervention Prog. | P No income for long time or inadequate fixed income.<br>S Basic necessities. |
| ASPIRE | --- | --- | P Lack job skills.<br>S Training<br>Case management |
| Emergency Assistance | P Crisis in family AFDC eligible have dependent children. One-time assistance/yr.<br>P/S -Disasters-household items, living arrangements.<br>-Inability to cope-housing items (furnace, etc.)<br>-Housing crisis-rent, mortgage, deposit.<br>-Utility disconnection - payment | --- | --- |
| Nutritional Services | P Lack of funds for food.<br>S Food Stamps-95,000 people/month; 34% are elderly; 52,000 receive AFDC; $5M/yr. av. $120/household per mo.<br>WIC - 185% poverty 21,000 clients. | --- | --- |

P = Problem
S = Service

| Topics | Prevention | Acute/Crisis | Remedial/Rehab. |
|---|---|---|---|
| AFDC | P Child under 18 yrs. deprived of parental support.<br>S 18,500 families Receive Medicaid $6M/mo.; financial aid. | --- | --- |
| Health Issues | P Substandard residence, health risks:<br>S Safety education. Newborn referrals. Well child clinics. Preventive Health Program. Immunization Tuberculosis | P Lack of insurance Maine Health Prog. provides education re. homeless.<br>S Maine Health Prog. Medicaid increases 4/90. | --- |
| Teen Pregnancy and Health Services | P 14% 10-18 year olds no health insurance:<br>S Pregnancy - Case Management Support and Counseling Childbirth and parenting classes<br>BCFS grants | P Collapse of support: | P Have experienced crisis.<br>S Family Services, Nsg.<br>970 Teens - FY '89<br>DPHN - 538<br>CHN - 452 |
| Substance Abuse | P 1/3 homeless have SA problem<br>9% lived in shelter, streets<br>S Counseling, shelters, Tenants Assistance and Program | P Lack of shelter<br>S 4 adult shelters, 48 beds.<br>1 extended shelter, 15 beds. | P Need shelter.<br>S Extended care group homes. |

P = Problem
S = Service

| Topics | Prevention | Acute/Crisis | Remedial/Rehab. |
|---|---|---|---|
| AIDS/HIV Infection | P Infection compounds other factors.<br>S Street education $23,000<br>Corrections for education-$3,000<br>Hotline - $24,000<br>Educ. Programs<br>Minorities, including migrants<br>Case management | --- | |
| Elderly | P 17,160 households at risk of becoming homeless. Increasing pressure on the Aging Network<br>Service gap 5-7 yrs<br>S Home maintenance programs<br>Home based care<br>Legal services<br>Adult Day Care<br>Volunteer Programs<br>40,000 served/yr. | P 30-100 persons homeless.<br>S Adult Services - 37,000 adults annually | P Need support<br>S Shelter operator referrals. |
| Refugees | P Adjustment<br>S Communicable disease followup.<br>Cash assistance | --- | P Language, lack skills<br>S Education, job skills<br>English |
| Migrants | P Seasonal 10,000 Farmworkers 4,000 of which are migrant<br>S Rakers' Center services<br>Grant proposals | P Lack of health care<br>S Health Centers<br>Rakers' Center | --- |

P = Problem
S = Service

| Topics | Prevention | Acute/Crisis | Remedial/Rehab. |
|---|---|---|---|
| Crime Victim Assistance | --- | P Victims escape from shelter for protection.<br>S Short-term emergency housing assistance. | |
| Family Violence Victims | P Risk of violence.<br>S Educational programs re. family dynamics. | P Leave shelter due to violence.<br>S 8 shelters funded by DHS, 30 days shelters | P Need protection<br>S Community response system. |
| Children | P Abuse and neglect<br>Placement - teens may choose to leave/not accept placement, adequacy of placement.<br>S Child Protective<br>Substitute Care<br>CA/N Councils - 16<br>Homebased Family Counseling - 9<br>Parents Anonymous<br>Mental Health<br>Homemakers | P Appropriate placement not available. Youth reject placement. 1,858 in custody/year, 7% live independently.<br>S Case Management.<br>13 contracts for residential care; 3 group homes, 45 shelters, 4 emergency foster agencies, 2 therapeutic foster care. | P In transition.<br>S Child protective<br>Substitute care<br>Licensing<br>Foster families<br>Reunite with families |

P = Problem
S = Service