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Maine Department of Human Services

Response to

Homelessness in Maine

Report II

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

Prepared by the Office of Planning, Research & Development
March 1991

Homeless

I'm homeless
I've got nothing
I sleep in the cold and rain
My soul rips apart
And I stare at reality
I've had nothing for a long time
I don't know where I stand
Living in another world
Filled with darkness and fear.

By Mark Greenberg (1959-1989)
Son of Irwin Greenberg, M.D., Director, Bureau of Health (1987-1988)

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INTRODUCTION

The Department of Human Services: Response to Homelessness in Maine, Report II, documents the Department's services related to prevention of homelessness through support services for people at risk, to acute services for the homeless and to remedial services toward more stable living situations. The first report was published in February 1990.

This second Department of Human Services report:

- describes the issues around the homeless and at risk populations which must be considered in planning for service delivery;

- describes the DHS approaches to addressing the needs of the homeless and at risk populations in its clientele;

- provides information regarding DHS services as a resource for other groups which are addressing the issues of the homeless and at risk populations.

While the Department of Human Services works closely with a number of other agencies and organizations, this report is primarily about the clientele and 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.

Because the Department supports multidisciplinary approach to addressing the factors behind homelessness, the DHS created a Task Group on Homelessness in 1989 to present a current description of DHS involvement in services to the homeless, to coordinate DHS resources for the homeless and to advise the Commissioner's Office on initiatives. The Task Group includes those units within DHS which provide direct or indirect services to assist homeless individuals:

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

The Office of Alcohol and Drug Abuse Prevention (OADAP) was in DHS when the Task Group started. Many of the pertinent activities were transferred to the new Office of Substance Abuse (OSA) July 1990. At present, OSA continues to be a Task Group member.

The Department has active representation on the Interagency Task Force on Homelessness and Affordable Housing, including participation in the recently completed field visits in Lewiston and Leeds, and on subcommittees drafting the report to the legislature. Many of the issues of concern to the Department of Human Services are also issues of concern to the broader group. Therefore, this document can be used as a reference in the larger, overall attack on the problems of homelessness. Parts of this report may be included in the larger report.

DHS programs are coordinating with the other departments and organizations 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.

This document should be used as a resource:

Section I presents a brief overview of the broad problem.

Section II describes issues around homelessness for specific populations.

Section III gives details about DHS services, including some services for specific populations. Services described here include shelter (Housing) as well as support services needed to keep families at risk from becoming homeless (Financial Assistance, for example).

Section IV describes the DHS focus on two priority populations: victims of family violence and teenagers.

Section V is a cross-reference between specific populations and services provided. For example, services for the Elderly are referenced to services, such as Housing, Case Management.

Homelessness is a singular problem - inadequate or unsafe shelter - which has multiple factors and requires multiple and flexible solutions.

Part of the problem is the existing service delivery mechanisms which result in provision of services to individuals as defined by problem categories. However, people present various "mixes" of factors.

The problem must be addressed from the perspective of an individual or the eligibility and service restriction implicit in many public and private programs will continue to fragment services available and be barriers to resources which could be available to the individual.

I. OVERVIEW

A. A PROBLEM OF DEFINITION

The definition of "homeless" is a concern for the multiple groups and agencies which are dealing with the needs of this population. Possibly "homeless" should be defined in various levels of acuteness, such as:

- o 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.
- o persons without an address which assures them of at least the following thirty days' sleeping quarters which meet minimal health and safety standards.
- o persons at risk of entering either of the above groups.

Unless distinction is made with the text, this document addresses all three groups as people who are homeless. In conjunction with wording used by the Interagency Task Force, references are made to "people who are homeless rather than "the homeless." People are individuals first; homelessness describes their present - and hopefully short-term - living status.

B. WHAT IS THE PROBLEM?

Accurate estimates of the population size are difficult to determine because:

- o people find temporary and makeshift shelters in various places;
- o people who are institutionalized on a time-limited basis, such as hospitals and jails, may not have a permanent residence to which to return;
- o people remain in shelters a very short time and move between shelters;
- o the population may fluctuate with seasons and weather conditions, economic factors, and mass displacement from usual sites of residence.

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.

In addition to Maine's network of emergency shelters, and 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 people who are 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, there are gaps in the availability of shelter beds and services, especially for women, youth, persons with chronic alcohol and other drug abuse problems or who have mental illness.

People experiencing the extreme measures of homelessness need sustained treatment for their mental illness or alcohol and other drug 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.

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. 1990 census data is expected to be available about March 1991.

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.

C. WHAT DOES DHS PROVIDE?

The Department of Human Services is deeply concerned with the increasing numbers of people who are homeless 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.

Traditionally, the public often associates the "hands-on" crisis-oriented services, such as shelters and soup kitchens, as the main area of assistance required by people who are homeless. However, the Department of Human Services is making a coordinated effort through many of its bureaus and offices to provide services to people who are potentially homeless in order to reduce the need for crisis services, and to provide remedial programs which assist people in leaving short-term shelters and moving into home-type environments. DHS provides services:

To maintain people in a living environment which at least meets minimal health and safety standards. Homeless prevention programs aimed at the portions of the population that is potentially homeless.

To 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.

To allow the individual to become as self-sufficient as possible and to reduce dependence on private or government support.

D. WHAT ARE THE GAPS IN SERVICES AND INFORMATION?

In spite of programs from DHS and other agencies, homelessness remains a problem. Most of these programs are able to provide services to only a portion of the people who may become homeless. The Department is continuing to coordinate with other departments and groups which provide services to people who are homeless to increase the effectiveness of service delivery across the continuum of the homeless aid system.

Major problems exist in defining gaps:

- o the lack of consistent definition of homelessness, or clear description of the target population;
- o the lack of consistent data systems to determine the size of the population or the services provided to that population;
- o the lack of clearly defined outcomes for either the people in the homeless population or the services provided.

E. RECOMMENDED ACTIONS

DHS will address the following recommendations through the DHS internal Task Group and by working with the Interagency Task Force.

1. DHS use the following priorities in funding programs which directly and indirectly affect services to people who are homeless:
   - first priority is to keep existing services, which the DHS understands to be critical for people who are homeless/at risk in Maine.
   - second priority is to strengthen existing services before expanding services.
2. DHS define action to address homelessness in the priority populations of family violence victims and teens. These populations appear to "fall through the cracks" in the service delivery system, and are of special concern to DHS.
3. DHS seek to increase available funding, 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 alcohol and other drug abuse halfway houses under non-medical institution provision.
4. DHS work with 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. DHS 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 identify outcomes and goals for homeless or at risk clients receiving DHS services as a basis 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.

II. DESCRIPTION OF POPULATIONS

A. OVERALL CHARACTERISTICS

The characteristics of Maine's homeless have been evolving:

- from the late 1960's on, women began to increase as a homeless population in large urban centers largely due to family violence situations.

- the race and age composition of men in public shelters changed markedly in the mid-1980's, getting younger, with a much larger representation of minorities.

- by the end of the 1980's, an increasing proportion of people who are homeless are chronically disabled, partially as a result of the movement toward deinstitutionalization.

- forces responsible for mass displacement through the 1970's and 1980's unemployment or underemployment, scarcity of affordable housing, deinstitutionalization of the mentally disabled, social service cutbacks, and the culling of disability rolls created 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 meaningful or gainful employment.

- teenagers, especially young, pregnant women with no family support and young men lacking job skills, form an increasing proportion of people who are homeless.

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

Most experts agree that approximately 1/3 of all homeless persons have significant alcohol and other drug abuse problems, which may contribute to homelessness. Alcohol and other drug abuse treatment providers have historically indicated that lack of housing is a serious impediment to the rehabilitation of many of their clients.

Data from OADAP's Management Information System (MIS) 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.

Specific populations may have specific needs related to homelessness. The population groups specifically described in this report are: children, teenagers, adults and their families who are victims of family violence, elderly, and migrant and refugee populations.

B. CHILDREN

Children at risk of becoming homeless include:

- o runaways,
- o the children of family violence victims,
- o children who leave home due to family conflict.
- o children in the Department's custody or protection for whom appropriate family placements are not available,
- o children who refuse placement services.

In recent years, the Department has witnessed a marked increase in the occurrence and level of family dysfunction. As alcohol and other drug abuse , neglect and physical and/or sexual abuse victimization threaten family stability, children become at risk of homelessness, either through removal from the home or, as teenagers, choose to leave on their own.

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 the medical community to establish referrals of high-risk prenatal women and newborns to public health/community health nurses. Risks for referral include "environmental risks," such as single parents,

teens, and those 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.

For children placed in custody of the Bureau of Child and Family Services (BCFS) Child Protective or Substitute Care units, the first placement 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.

Although every attempt is made to find an appropriate placement, limited resources and the serious nature of a child's problems may make finding appropriate residential placement 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. Although they are still technically case managed by the BCFS, they may be choosing transient lifestyles in sub-standard 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.

In order for children in the care or custody of BCFS to have a positive placement outcome, the needed resources must be available! Included are foster homes, adoptive homes, group home placements that match the child's needs; and mental health, alcohol and other drug abuse, and other support services for children transitioning to independent living or returning to their families.

Another problem is those children who are not open cases of BCFS but who are among people who are 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, very few remedial or rehabilitation services are funded by BCFS for this population.

C. TEENS

While the teen age group is included as "children," there are specific concerns around homelessness among this group (13-19 year olds). 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 alcohol and other drug abuse within the

families and among the teens themselves. These teens often experience multiple family relationships (e.g., divorces, live-in parental relationships, 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 or relatives due to economic instability. This results in mobility and possibly inability to remain in a school system or setting.

Teenagers who have chosen to leave home, 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 Department has been represented on an interdepartmental committee, including the Department of Education and the Department of Mental Health and Mental Retardation, to explore methods of coordinating services to pregnant and parenting teens. A model case management, coordinated system of services is planned as a demonstration in one community. One of the overall goals of this project is to reduce drop-outs among this population.

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.

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 and for teens with 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.

D. FAMILY VIOLENCE VICTIMS

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

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.

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 unavailability of a shelter bed at a shelter that is accessible, causing the family to become homeless.

The State's family violence programs provide support for many women who never actually reside in a shelter. This support includes advice regarding legal and economic options. Shelter personnel may have conferences with women in person or over the phone. State and community funded family violence services are supplemented by volunteers who provide a variety of services such as crisis hotlines. In addition, Dover-Foxcroft and Rockland areas have "safe homes" for short term placement. Other issues which affect usage of a shelter include:

- cultural differences/distance
- availability of programs, such as Displaced Homemakers, ASPIRE
- shelter is not appropriate for every woman (special population, other problems of alcohol and other drug abuse or mental fitness, composition of current shelter population, age of children).

The true picture of need is not developed. Battered women have various levels of function and participate in the health/social/mental health system of different levels. For example, many receive services privately and are not part of any statistical documentation. According to the Maine Department of Public Safety Crime in Maine report for 1989, assaults between family members constituted 31.5% (2,885) of reported assault.

E. ELDERLY

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. These efforts have helped to prevent elderly homelessness in Maine from becoming widespread. 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 (vs. institutions):

- 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

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 alcohol and other drug abuse and/or mental illness.

Acute elderly homelessness is estimated to be within a range of 50 to 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 Bureau of Elder and Adult Services budget includes approximately $12.5 million for community services for the elderly. These services include information and assistance, nutrition, legal services, employment, adult day care, volunteer programs, transportation, alcohol, and other drug abuse prevention, home care programs, and protective and guardianship services. These support services assist approximately 40,000 elderly people each year. Housing needs are also addressed by other state agencies by home repair programs, property tax relief programs, and federally assisted apartment units.

F. REFUGEES

Refugees are people who have been resettled in Maine, are not able to return to their own country, and are not yet economically self-sufficient. Refugee cash assistance provides minimal income level without regard to family composition for up to a year of arrival in the United States.

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, Northern Africa, and Central and South 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.

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.

G. MIGRANTS

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.

DHS is working with the Maine Ambulatory Care Coalition as they develop grant proposals. In addition, public health nurses provide services to migrants.

III. DESCRIPTION OF SERVICES

Following is a description of services provided by DHS. Specific details of eligibility and services for which a person may be eligible are available from DHS offices. These factors may change with changes in federal and state statutes, rules, and resources.

A. FINANCIAL ASSISTANCE

1. General Assistance

Assistance is provided by municipalities using funds administered by the DHS Bureau of Income Maintenance (BIM) and municipal funds. These funds provide the means for local government agencies to keep people who are potentially homeless in their homes. In FY '90, more than half of the $8.5 million in budgeted general assistance funds was spent on housing and utilities.

The General Assistance client is usually:

- o one who has temporarily lost income, such as through layoff or termination, and needs assistance on a short-term basis. This person could be of any age, has been financially able to provide for him/herself (and family) and expects to resolve his/her own problems as soon as possible.

- o 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.

- o a victim of 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 able to care for themselves on a month-by-month basis, but could not afford to accumulate any savings or could not afford insurance payments.

- o without income, probably will not have income for a long time, or has a fixed income which does not provide for all his needs; 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.

The person eligible for General 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.

The General Assistance Program is primarily administered at the local level. DHS oversees the administration of the program, provides reimbursement on a percentage basis, and provides direct assistance to residents of unorganized territories. Approximately 14,000 people per month received general assistance in FY '90, a 6.3% increase in average monthly caseload during FY 1990.

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 apply for assistance, there is no count 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 needs may not always be met.

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.

Eligibility for persons in a family violence shelter is determined the same as for other applicants. The expenses for their basic necessities are calculated against their income for the 30-day period beginning with the date of application. They are to apply in the municipality where the shelter is located. The municipality from which the applicant came may be contacted for payment. Disputes between municipalities as to which is responsible for payment are settled by the Department. Confidentiality is of prime concern. Potential harm to the applicant is a possibility if residents of the applicant's municipality learn of the circumstances. Some municipalities which host the shelters accept responsibility for payment to avoid alerting the other municipality of the situation.

2. Emergency Assistance

The Emergency Assistance Program, administered by the Bureau of Income Maintenance, provides assistance in 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 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:

- 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.

- 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.

- 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.

- 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.

If a situation arises due to domestic violence whereby the applicant and children need another place to live, the Emergency Assistance (Family crisis) Program may be available. All other criteria (the applicant must be receiving AFDC or would be eligible for the program if he or she applied) must be met. If the other criteria are met, a maximum of $350.00 toward a back rent or toward a security deposit on a new rental property would be allowed.

3. Assistance for Families with Dependent Children (AFDC)

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 20,500 families in Maine receive AFDC, an increase of 11% in FY 1990.

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.

The AFDC program, administered by the Bureau of Income Maintenance, provides monthly checks to recipients, totaling $8,106,000 per month in State and Federal funds, a 25% increase in funding in FY 1990. AFDC recipients automatically receive Medicaid, and approximately 95% of AFDC households are eligible for Food Stamps. A major service to AFDC recipients is ASPIRE (described under Employment).

Since January 1, 1989, a pregnant woman is potentially eligible for the AFDC Prenatal Program. When financial eligibility for the unit (all individuals expected to be in the household when the child is born) is met, the pregnant woman is eligible. Payment can begin in the sixth month of pregnancy. The amount of payment is based on the

income of the pregnant woman. If the pregnant woman is living with the father of the unborn child, eligibility for the unit must be based upon unemployment or disability and these factors must be verified.

If the pregnant woman is under 18 years of age, she is considered to be a potential minor parent. If her parent(s) are in the household and are excluded from the assistance unit, some of their income and all of their assets will be excluded from determining the amount of payment once the child is born. If they are included in the unit, all income and assets will be used to determine eligibility once the child is born. Grandparent(s) of the unborn child may apply for the assistance if they are the caretaker relative(s). There is no age requirement for the specified relative.

Aid to Families with Dependent Children (AFDC) would be available to a person in a violence shelter if that person meets all the eligibility factors. The absence of the second parent must be established initially and must be expected to last for a period of at least thirty days beyond the date of application for the program. Income, assets, etc. must be within established guidelines.

While DHS has an active program to obtain child support payments, applicants have the right to claim good cause for refusing to cooperate in obtaining child support. Establishing paternity and securing support is considered against the best interests of the child if:

- o The applicant's or recipient's cooperation is reasonably anticipated to result in:
  - any physical harm to the child for whom support is to be sought
  - any emotional harm to the child for whom support is to be sought
  - any physical or emotional harm to the caretaker relative with whom the child is living which reduces capacity to care for the child adequately.
- o The child for whom support is sought was conceived as a result of incest or forcible rape.

The decision to grant good cause is determined by the AFDC Income Maintenance Unit after review of evidence presented. Clients may appeal a decision which is also reviewed by the Support Enforcement and Location Unit.

B. CASE MANAGEMENT

Under Medicaid, case management is defined as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services." The concept of case management is to actively assist individuals to obtain - and follow through with - needed services on a planned basis. A number of DHS programs include a case management component. Various programs within DHS and other departments (such as Department of Mental Health and Mental Retardation) are working with Bureau of Medical Services toward Medicaid reimbursement for specific case management services to specific populations as a way to expand current provider resources.

DHS programs which presently offer case management services include:

- o Bureau of Child and Family Services for children in the care/custody of DHS.

- o Family Services Program which uses the education, training, and supportive resources available to enable teen parents to move from isolation toward the mainstream and eventual employment, such as through the ASPIRE/JOBS Program. (Served 971 teens in FY 1990, a 23% increase in monthly caseload from FY 1989; 40% remained in school.)

- o Public Health Nursing, Bureau of Health, with a focus on families with newborns or children with special needs, and people with communicable diseases.

- o Services to teenagers are under the Division of Maternal and Child Health and the Bureau of Child and Family Services, which focus on assessment of client, child and family situations, medical/health, emotional, child care, education, housing needs.

- o The ASPIRE Program, under the Bureau of Income Maintenance, which focuses on pretraining, education, job search, job placement and/or support services assistance.

- o The Bureau of Child and Family Services' contracts with three agencies for AIDS/HIV case management services (the AIDS Project, Portland; Kennebec Valley Regional Health, Augusta; and Eastern Maine AIDS Network, Bangor) 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.

- o The Bureau of Elder and Adult Services case management services for Adult Protective and Guardianship program clients.

C. HEALTH SERVICES

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

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

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

- o Objectively addressing the persons health condition as presented, including possibly more advanced stages of disease, and infectious condition (eg., HIV/AIDS, hepatitis).

A primary concern in delivery of health services to persons who are homeless is how health/medical practices fit into their life cycles.

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, or chronic respiratory condition.

People using shelters probably do not have regular health care services and emergency rooms are frequently the only source of care. General assistance pays for emergency care at Medicaid rates. Although most homeless individuals would be eligible for Medicaid and/or SSI, many do not apply for these benefits. Where there are outpatient clinic services, or health centers, these may be utilized. Because of displacement and other risk factor life style, people who are homeless are at risk for communicable diseases, particularly influenza, pneumonia and hepatitis B. Children in the shelters may not have received recommended immunizations and, therefore, are at high risk for vaccine preventable diseases. 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.

Well Child Clinics offer well child care to non-Medicaid children, birth to school entrance, whose families' incomes are under 185% of the Federal Poverty Level, and who are not under regular well child care. Clinics have been offered for over 60 years, but the services have generally changed from primarily immunization clinics to providing a full range of procedures. Some 100 clinic sites provide services to 10,000 preschool children annually. The Bureau of Medical Services provides screening, diagnosis and treatment services to 20,000 Medicaid recipients birth to 21 years through their Preventive Health Program (PHP).

Vaccines available through the Immunization Program include oral polio; measles, mumps, rubella (MMR); haemophilus 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 people who are homeless should be considered.

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 new state funded initiative for the uninsured, the Maine Health Program (MHP), began October 1, 1990. Initially, the plan for MHP will cover children at income levels to 125% of federal poverty guidelines and adults, to 95%. Enrollment is done through the Bureau of Income Maintenance. Participants will receive a benefit package similar to the Medicaid package. Obstetrical services, long term care and case management services will not be covered since SOBRA coverage under Medicaid already exceeds the MHP income criteria. The major concern here is the availability of resources to provide the planned services.

Even when health care is more available through expanded coverage, the economic barrier will be lessened. However, people will not use the system unless providers treat people who are homeless as individuals, without discrimination. Problems of forms, income and asset disclosure, and availability of help to complete necessary sign-up forms are issues which need to be addressed.

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 risk from other factors, such as substance abuse, which are compounded by an HIV infection.

A major focus of the DHS is education to prevent the spread of AIDS. The education is focused on people at risk and at providers of services to these populations: physicians, law enforcement agencies.

Community Health Centers in the Leeds-Turner area of Androscoggin County and the Harrington-Machias area of Washington County, provide some backup health services for migrants. 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 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.

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, case management and referral for multiple health problems. This is provided in conjunction with the Refugee Resettlement program and with the assistance of a small federal grant.

D. HOUSING

1. General Factors

For some people, the lack of shelter is the issue. However, 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 an inability to obtain adequate housing, the choice becomes enabling families to reside as safely as possible within the existing situation or becoming homeless. For example, a preschool child who is discovered to have elevated blood lead levels may be residing in a leaded dwelling. The landlord may be unwilling to make necessary renovations, or, in the case of a homeowner, may be unable to afford renovations. In pursuing legal recourse against the landlord, the family risks eviction. A major focus of the community/public health nurses working with the family will be on separating the child from the leaded areas and facilitating cleaning the environment.

2. Children

There is increasing public concern about homeless street children, especially adolescents. Many of these children have problems that bar them from traditional children's shelters: violent or suicidal behavior, fire-starters, sexual perpetrators, and alcohol and other drug abusers. The Department should plan for shelters adequately staffed and trained to handle the severe combinations of problems these children present.

The Bureau of Child and Family Services (BCFS) licenses Residential Care Facilities, Emergency Shelters for Children, Shelters for Homeless Children, and Foster Homes.

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:

- o 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.

- o residential treatment centers - campus style supervised living arrangement with in-facility education and treatment components (including alcohol and other drugs). Accepts referrals from schools, DHS and DOC.

- o 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.

- o 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.

- o 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.

3. Family Violence

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.

There are limitations on the shelter's ability to provide safe or secure shelter; largely due to various regulations and practices:

- o Housing Authority regulations require police or hospital documentation of violence for specific benefits.

- o funding is available to provide rent and security deposit only once, but the women may need to relocate more frequently.

- o access to addresses is too easy through post offices. Also, parts of DHS release client addresses (even though the name is protected by other DHS programs).

The establishment of units of secure transitional housing, in cooperation with the Maine State Housing Authority and HUD, needs to be explored. The current emergency shelters for family violence victims are only for 30 days duration. There is an extreme need for longer term shelter (at least 1 year) that is safe and connected to the social, medical, job/education, child care, transportation, parenting and life skills, substance abuse and mental health services these families may require. Transitional housing units could serve not only family violence victims and their children but pregnant and parenting teens and female substance abusers who may have been in a 28 day program but require a stable and supportive living arrangement to be reunited with their children and maintain sobriety. Two projects in York and Aroostook counties have opened in the past two years: more are desperately needed.

4. Elderly

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.

Because several state agencies have a common interest in programs that benefit the elderly, the Bureau of Elder and Adult Services has formed the Housing Resource Committee, to work on elderly housing and support services, such as:

- o the preservation and development of affordable rental units financed by Maine State Housing Authority, Farmers Home Administration and the U.S. Department of Housing and Urban Development, and the maximum use of available HUD 202 funding;

- o the development of group homes for developmentally disabled or chronically mentally ill people and adult protective clients;

- o the delivery of support services which enhance the opportunity for older people to remain as independent as possible in the community;

- o the provision of home repair and home maintenance programs financed by Maine State Housing Authority, Farmers Home Administration and the Maine Department of Community Services.

The Committee will also be helpful in identifying housing goals and objectives for the Bureau's State Plan and other DHS initiatives.

Upon referral by shelter operators, elderly homeless are provided with the Aging Network services. 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 knowledgeable about the services available.

Also, the regional offices of the Bureau of Elder and Adult Services indicate that additional structured living environments such as specialized adult foster homes and boarding homes would assist the placement of those elderly homeless suffering from alcohol or other drug abuse and/or mental illness. The Bureau cooperates with the Department of Mental Health and Mental Retardation, and with other agencies, such as the Office of Substance Abuse.

5. Alcohol and Other Drug Abusers

Prior to July 14, 1990, responsibility for allocating and administering substance abuse purchased services rested with the Office of Alcoholism and Drug Abuse Prevention within DHS. On that date, this responsibility was legislatively reassigned to the newly created Office of Substance Abuse (OSA) within the Executive Department.

OSA 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. OSA also funds one program for 15 beds of extended shelter. This program provides supportive services in a safe environment for those who are waiting for 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.

Because returning to the family situation is often potentially harmful, OSA 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. OSA also purchases a variety of outpatient crisis intervention services which can respond with supportive counseling, assessment and referral.

OSA 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. OSA 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.

Consistent with a federal block grant program, OSA maintains a revolving loan fund 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.

E. FOOD/NUTRITION

When income is marginal, there is a tight balance between expenditures for food and expenditures for shelter. Inability to purchase nutritious food places people at risk for health problems and decreased the ability to function productively.

Maine's Food Stamp Program, administered by the Bureau of Income Maintenance, serves over 102,000 people per month, a caseload increase of 16% in FY'90. 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 58,000 (approximately) 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 used by persons living in approved alcohol and drug rehabilitation centers, shelters for battered women and other shelters approved by FDA.

Eligible households are sent Food Stamps on a monthly basis. In Maine, approximately $5,300,000 in benefits are mailed to participants, an increase of 35% in FY 1990. The average allotment per household is $120.00 per month. The Stamps can be used at almost any grocery store to buy food.

Residents of shelters for battered women and children may be eligible for Food Stamps. An eligible resident who has authorized the shelter management to act as an authorized representative, can use the coupons to purchase meals prepared at the shelter; the shelter management can then act as an authorized representative to purchase food with the coupons.

In addition, persons at the shelter can receive food stamps as a separate household on the basis of their income and assets only. If they have left a household containing the person who abused them which has already received benefits for the particular month, they may receive an additional allotment as a separate household once for that calendar month.

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 22,000 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.

There has been a steady increase in home delivered meals and congregate meals over the last ten years. Close to 25,000 elderly people were served by these two programs in FFY 1989. Food Stamps may be used to access some of these programs. Soup kitchens approached by FDA may be able to accept Food Stamps within the next year.

F. EMPLOYMENT

The ASPIRE (Additional Support for People in Retraining and Education) Program, administered by the Bureau of Income Maintenance and 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.

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.

G. PROTECTION

1. Victim Assistance Program

The federal victims assistance program under the Bureau of Child and Family Services 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.

2. Children

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:

- o 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.

- o 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:

- o 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.

- o 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).

- o 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.

- o 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.

- o 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.

3. Family Violence Victims

The Department (BCFS) 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, as well as to provide services through shelters and safe homes. They would like to be able to reach the women and children who come into emergency shelters (other than their own). They would also like to be able to provide more outreach and training to the emergency shelter operators, including recognizing symptoms of violence. Requests for training are increasing from schools, hospitals, law enforcement agencies, homeless shelters. Training of other service providers can support the woman to reach out for assistance sooner, before escalation of violence to a crisis level. A major issue is lack of resources (personnel) and "level" funding.

The Department contracts with these 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.

The Department now has an ex officio member on the newly formed Maine Commission on Domestic Abuse. The Department must play an active role in increasing public information and education about family violence and will work closely with the new Commission in accomplishing this task.

4. Elderly

The regional offices 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 million. They provide services to approximately 3,700 adults annually.

H. ALCOHOL AND OTHER DRUG ABUSE

Alcohol and other drug 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 alcohol and other drug 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 abusers to attain the skills necessary to sustain themselves in adequate housing. Thus, alcohol and other drug abuse services span the spectrum of services needed by people who are homeless and those at risk of homelessness.

Many of the abuse treatment services provided prevent the further 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. OSA 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 alcohol and other drug abuse problems among residents, and to empower the residents to reduce abuse. The Office also has a federal grant to develop a community-based prevention program in the Portland Housing Authority's projects.

I. SERVICE GAPS

Many of the gaps in data and service delivery recognized by DHS personnel are also recognized by the Interagency Task Force.

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

- Data for some programs are collected by non-DHS personnel. For example, General Assistance statistics are maintained locally, and the data are not readily available.

- There is no common way of defining homeless among the DHS programs, nor a universal way to collect this information.

- 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.

- 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 DMH&MR 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.

- There is increasing public concern about homeless street children, especially adolescents. Many of these children have problems that bar them from traditional children's shelters: violent, suicidal, fire-starters, sexual perpetrators and substance abusers. The Department should plan for shelters adequately staffed and trained to handle the severe combinations of problems these children present.

- 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.

- Gaps in needed services include specific transitional housing programs for the pregnant and parenting tens. 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 their child(ren).

Gaps in housing focus on need for shelter for special populations, such as children and teens, domestic violence victims, persons with alcohol and other drug abuse problems. In addition to emergency shelter, support services need to be available to provide assistance over a longer period of time.

IV. PRIORITY POPULATIONS

After reviewing the status of specific populations and the services available, the DHS Task Group decided to focus on increasing services to specific populations of family violence victims and pregnant and parenting teens. Descriptions of these populations are given in Sections II and III. Brief summaries of issues and suggested actions are presented here.

A. FAMILY VIOLENCE

It is not possible to estimate the number of women and children in need of family violence services. Some women and children have resources to obtain other shelter and supports privately, and some women obtain support services from the shelter network without residing in the shelter itself. The nine community agencies which provide shelter and "safe homes" served 2,345 clients (women and children in FY'90). These services include shelter for up to 30 days, consultation re. economic, legal and educational/skill development.

The major funding for the family violence shelters is provided by DHS, with a total DHS expenditure of $1,213,000 in FY 1990.

Issues around family violence include:

- Need to secure safe shelter for a woman/family, including protection of address.
- Increasing referrals to Family Violence programs, so that program personnel are seeing more people with shorter and less intense services.
- Level funding to the programs which requires personnel to balance direct service and education to communities.
- Need for shelter personnel to establish better connections with other shelters, including providing education to shelter providers re. family violence, its symptoms, and available resources.
- Need for longer term shelter that is safe and is connected to multiple services.
- Limited funding to pay a rental deposit for housing, especially if a family has to move again, for security reasons.
- Various regulations which limit access to shelters and benefits.

The Department will explore methods of expanding shelter services to meet the demand for service. On a number of occasions, all shelter beds are full, leaving families needing secure shelter dependent on alternative solutions. Women and children in domestic violence situations are at great risk and there should be adequate emergency shelter to meet their needs.

The suggested plan includes:

- Working with the Family Violence Coalition to develop creative housing alternatives, for emergency basis.

- Working with the Family Violence Coalition and specific agencies to create transitional housing, up to a year. This can be done in conjunction with the Maine State Housing Authority, HUD, and local housing units.

- Looking for additional resources for educational programs re. family violence.

- Reviewing the regulations and practices which present barriers to service or jeopardize security/safety.

B. TEENS

Teens in general have critical issues around homelessness. Specific target populations of teens include pregnant and parenting teens for whom appropriate placement is not available, and teens who refuse to accept placement arranged by DHS. Because of need for assistance related to shelter, education/job skills, social services and health, case management designed to move teens toward self-sufficiency is a critical focus of DHS services to teens.

DHS-funded services were available to teens, as follows:

- About 600 pregnant and parenting teens were served through programs funded by the Division of Maternal and Child Health in FY'90, including the Adolescent Pregnancy Coalition and Local Action Council.

- 971 parenting teens were served through Family Service Program in FY 1990, with 40% remaining in schools.

- Bureau of Child and Family Services served 1,437 households which included pregnant or parenting teens in FY'90 through the network of community based special services. These included child care, parenting skills, life skills training, education and career counseling, mental health and emotional support services, alcohol and other drug abuse services and family violence services.

- 2,328 calls were received on Birthline "hotline" in FY'90. DHS funds this "hotline".

- 10,500 teens received family planning services through DHS supported clinics.

The issues around teens include:

- Ability to make choices re. placement, including not accepting planned placement under the Bureau of Child and Family Services and possibly choosing to live in an unstable situation.

- Pregnancy/parenting responsibilities without the skills or support services.

- Pregnant/parenting teens who must leave present shelter due to pregnancy or presence of a child.

- Compounding problems, such as substance abuse, emotional dysfunction and mental illness.

- Lack of definitive numbers of teens who are homeless or at risk.

- Lack of mental health services.

A suggested plan for addressing teen issues related to homelessness includes:

- Review of data from DHS programs related to shelter.

- Development of mechanism for regional/community input into planning and resource development.

- Conducting a survey with present programs to determine alternate resources.

- Work with the Teen and Young Adult Advisory Committee.

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V. MATRIX OF DHS SERVICES TO HOMELESS PEOPLE

TOPICS	Children Teen	Family Violence	Elderly	Refugees/ Migrant
GENERAL DESCRIPTIONS (p.4-10)	Child. p.5 Teens p.6	p.7	p.8	Ref. p.9 Mig. p.10
A. FINANCIAL ASSISTANCE (p.10-14)				
General Assistance - Sudden or temporary loss of income; long-term lack of or inadequate income. Pays for food, utility payments, fuel - 14,000 people/ month in FY 1990.		p.11		
Emergency Assistance - Crisis in AFDC eligible family: disasters, housing crisis, utility disconnection. One-time assistance in 12 month period.		p.12		
AFDC - Child in family under 18 years, deprived of parental support. 20,500 families, $8m./month.	Child. p.13 Teens p.13	p.14		
B. CASE MANAGEMENT (p.14-15) Assist families to get to/use services.	Teens. p.15		p.15	
C. HEALTH SERVICES (p.15-18) Health risks, access issues, well child clinics, insurance, communicable diseases (AIDS, hepatitis, tuberculosis).	p.15,16 Teens p.17			p.17 p.18
D. HOUSING (p. 18-22) Hazards, restrictions of length of stay in shelters, transitional housing.	Child. p.18, 19 Teens (OSA) p.21	p.19-20	p.20-21	
E. FOOD/NUTRITION (p.22-23) Lack funds for food. Food Stamp Program, WIC, Elderly.	p.22	p.22	p.23	
F. EMPLOYMENT (p.23) Training for job placement, ASPIRE				

TOPICS	Children Teen	Family Violence	Elderly	Refugees/ Migrant
G. PROTECTION (p.23-25) From variety of abuse situations, Child Protection and Substitute Care, Adult Protective.	p.24-25	p.25	p.25	
H. ALCOHOL AND OTHER DRUG ABUSE (p.26) Treatment services, elder abuse.			p.26	
PRIORITY POPULATIONS	Teens p.29-30	p.28-29		

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