STATE OF MAINE
114TH LEGISLATURE
FIRST REGULAR SESSION

Final Report
of the

SUBCOMMITTEE ON THE STRUCTURE OF SUBSTANCE ABUSE ASSISTANCE AND SERVICES IN THE STATE

to the
Joint Standing Committee on
State and Local Government

December 1989

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STATE OF MAINE
ONE HUNDRED AND FOURTEENTH LEGISLATURE
COMMITTEE ON STATE AND LOCAL GOVERNMENT

Committee Preface to the Report

The reader should note that this report is the product of the study subcommittee. The Joint Standing Committee on State and Local Government voted to accept the report of the subcommittee but did not vote to approve or disapprove the subcommittee's recommendations. Two recommendations in particular were the focus of discussion during the committee's review of the report. First, some committee members object to the undedication of the alcohol premium fund. Secondly, while committee members generally agree on the need to consolidate the administration of substance abuse treatment contracts within one office, there is some disagreement on where to place contract administration and other functions. The committee agreed to accept the report as presented here and hopes to reach agreement on the above issues in the committee process during the 2nd Regular Session of the 114th Legislature.

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GLOSSARY OF PARTICIPANTS IN THE SUBSTANCE ABUSE SYSTEM

ADPC	Alcohol and Drug Abuse Planning Committee. The commissioners from the 5 departments listed below make up the ADPC, a group with the function of planning and coordinating substance abuse services for the state. The ADPC also includes a planning director and 2 other professional staff.
OSA	The Office of Substance Abuse proposed in this report.

DEPARTMENTS AND PROGRAMS

DECS/DADES	The Department of Educational and Cultural Services through its Division of Alcohol and Drug Education Services delivers training and other support services to school/community groups.
DHS/ OADAP/DEEP	The Department of Human Services houses the Office of Alcohol and Drug Abuse Prevention which provides or contracts for a full range of substance abuse services, especially treatment related services. OADAP includes the Driver Education Evaluation Program. DHS is also the organizational home of ADPC (see above).
DMHMR/SAS	The Department of Mental Health and Mental Retardation has a one person Office of Substance Abuse Services to work with its other bureaus and other departments in delivering programs.
DOC/CCS	The Department of Corrections uses part of a position in the Division of Correctional Services to administer its substance abuse program contracts and has 4 additional employees located within institutions to deliver services.
DPS/BIDE/ BLE/BOS	The commissioner of Public Safety chairs the ADPC and the department participates in various educational and enforcement efforts through its Bureaus of Inter-Governmental Drug Enforcement, Liquor Enforcement and Safety.

ADVISORY AND NONGOVERNMENTAL

Maine Council	The Maine Council on Alcohol and Drug Abuse Prevention and Treatment is a 30 member advisory committee. The committee consists of 6 ex officio and 2 legislator appointments and 22 public members.

Regional Councils	There are 5 Regional Councils on Alcohol and Drug Abuse in Maine. Each is a volunteer group with a board of directors and an executive director. The director's salary and council activities are paid for by state funds.
NCA	The National Council on Alcoholism in Maine, an affiliate of the national organization, combats alcoholism and other drug abuse through its board of directors and 8 commissions that work on different aspects of substance abuse.
Community service providers	Public and private, for-profit and non-profit, agencies that deliver various treatment and prevention programs. Community service providers include hospitals, mental health agencies, halfway houses and counseling centers.

EXECUTIVE SUMMARY

This study is the result of a review by the Joint Standing Committee on State and Local Government of L.D. 1566, An Act to Establish the Office of Substance Abuse Services within the Executive Department. Subsequent legislative action resulted in approval by the Legislative Council of a study on substance abuse assistance and services provided in the state.

Determining the most effective structure for the delivery of substance abuse services was the primary goal of the study. Oral and written testimony on the structural question were contributed by the departments, community service providers and substance abuse advisory groups.

Proposals received by the committee suggested an increase in the authority of the planning director and the ADPC was the minimum change needed. Many people thought creation of an office within the executive department was the best way to consolidate contract administration and increase the visibility of substance abuse programs. The committee agreed on 3 major findings and 2 major recommendations.

Finding: The ADPC has not been able to deliver substance abuse services efficiently. Development of treatment programs by 3 departments has resulted in a duplication of effort by state agencies and has placed unnecessary administrative burdens on community service providers.

Finding: The ADPC does not have sufficient stature within state government to give substance abuse programs adequate visibility.

Statutory Recommendation: Create an Office of Substance Abuse within the Executive Department. The office would perform planning and contract administration functions, control the development and operation of substance abuse programs, develop a single budget for state substance abuse programs and administer all contracts for substance abuse services. A diagram of the new substance abuse structure appears on page 14.

Finding: Reliance on dedicated revenue diminishes the accountability of the substance abuse service system to the public and the Legislature. The committee finds that the Legislature receives inadequate input on programs funded by dedicated revenues and that over time these programs become less accountable for their performance than programs receiving General Fund revenues.

Statutory Recommendation: Undedicate the Alcohol Premium Fund. Making all appropriations of state dollars from one fund will increase accountability and administrative efficiency of substance abuse programs.

Implementing legislation is included as Appendix B.

STUDY BACKGROUND

During 1st Regular Session of the 114th Legislature the Joint Standing Committee on State and Local Government matters considered L.D. 1566, An Act to Establish the Office of Substance Abuse Services within the Executive Department. In its place, the committee reported out an amended bill to establish a study during the interim. The committee amendment to L.D. 1566 set out the purpose of the study as follows:

> "...to study the current structure of state substance abuse assistance and services throughout the state. The committee shall consider, but not be limited to:
>
> 1. The degree of efficiency of the current delivery system of state substance abuse assistance and programs;
>
> 2. The degree to which the current delivery system of substance abuse assistance and programs meets the needs of substance abusers; and
>
> 3. The type of state delivery system that best meets the needs of substance abusers and the structure of state programs and services that accomplishes this purpose."

In accord with Legislative Council policy, the amended bill was converted to a committee study request. The Committee was authorized to study the issues raised by L.D. 1566 and report to the Legislature (see Appendix A).

STUDY PROCESS

The study subcommittee held 5 meetings during the fall months of 1989. The fifth meeting also included a gathering of the full Joint Standing Committee on State and Local Government. The subcommittee did not focus attention on the enforcement and educational activities of the Department of Public Safety since DPS receives no alcohol premium funds. This report focuses on the substance abuse programs of the Department of Mental Health and Mental Retardation, Education and Cultural Services, Corrections and Human Services.

At the organizational meeting held in September the committee heard initial comments from citizen advocates and 2 state agencies. The committee decided to focus their examination on the efficiency and the effectiveness of the existing delivery system for substance abuse services. A public hearing was scheduled with the goal of obtaining broad public input focussing on these issues.

The morning session of the October public hearing was limited to testimony from the general public. State agency personnel testified during the afternoon. Testimony was received from 3 fairly distinct aspects of the public. Several individuals representing school superintendents and administrators and school/community substance abuse awareness teams spoke favorably about the programs administered by the Division of Alcohol and Drug Education Services of the Department of Education and Cultural Services. Representatives of the Maine Association of Substance Abuse Programs addressed the shortcomings of the existing substance abuse services structure, highlighting difficulties in contract administration. Representatives of the Maine Association of Regional Councils on Alcohol and Other Drugs presented an overview of Maine approaches to providing substance abuse services. Regional council representatives also discussed the current system of substance abuse services and presented an alternative structure designed to address existing problems.

In early November, at its third meeting the committee received reports from staff on the existing process of contracting for services and on the amount of money being spent by state and federal substance abuse programs, Medicaid and other sources of public funds and outlays by insurance companies. The committee used the afternoon session to discuss issues and began formulating recommendations.

In mid-November, the fourth committee meeting was dedicated to discussion of the potential ways of organizing the substance abuse delivery system. Options for dividing functional responsibilities were discussed. The committee selected a structural model featuring a central office with greater responsibilities than the existing system and directed staff to draft a report.

The fifth meeting, held in early December, was split in two segments. During the morning session, the subcommittee reviewed and accepted with minor modification the draft report and implementing legislation. In the afternoon session, the Joint Standing Committee on State and Local Government reviewed and accepted the report of the subcommittee.

ORGANIZATION OF STATE SUBSTANCE ABUSE PROGRAMS

Structure

Determining the most effective structure for the delivery of substance abuse services was one of the primary goals of the study. The committee heard hours of testimony and had access to numerous reports on the past, present and proposed future structure of state substance abuse assistance programs. Oral and written testimony on the structural question was contributed by the departments, community service providers and substance abuse advisory groups.

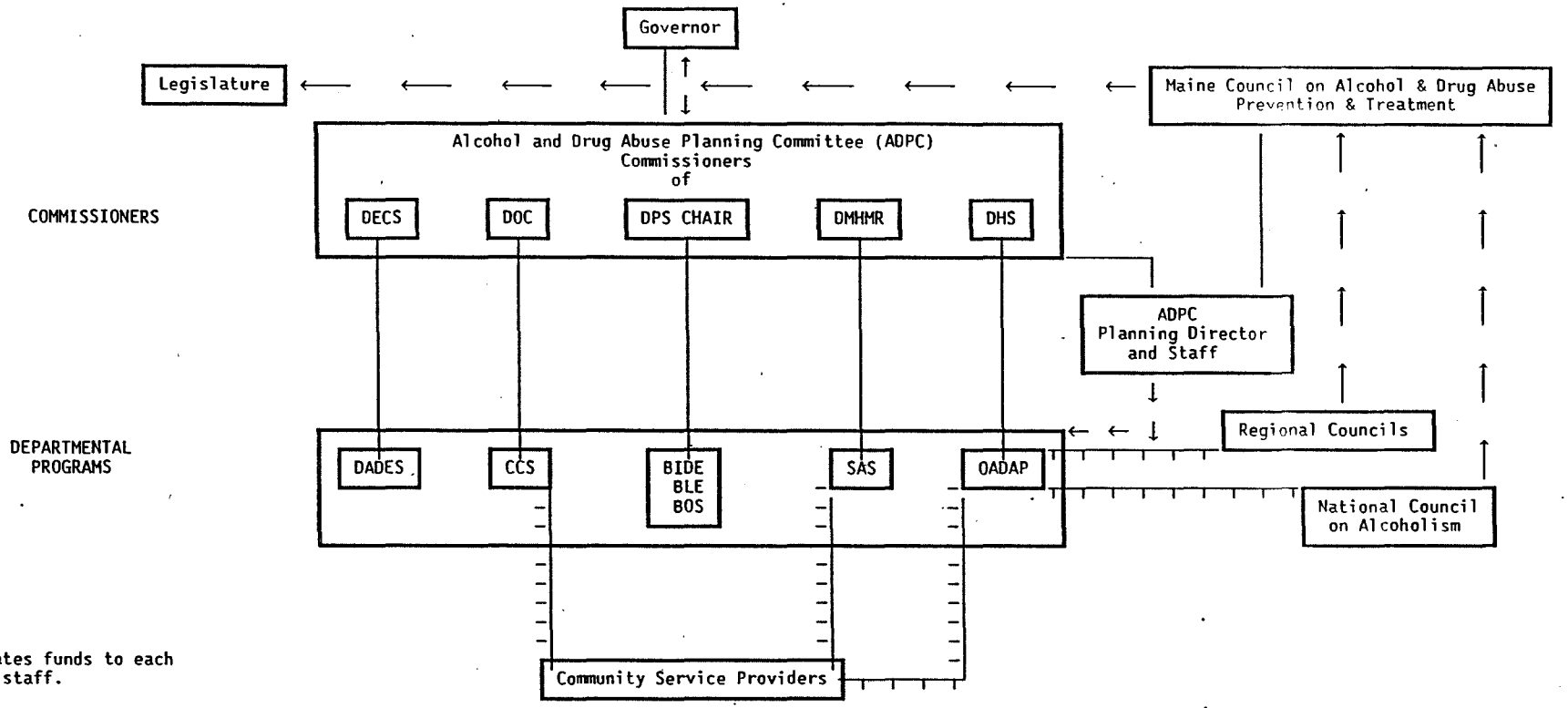
State involvement in substance abuse and the structure used to provide prevention and treatment assistance has taken on many forms over the past 40 years. A brief review of the legislative history is included as Appendix C.

An organizational chart showing the existing structure of state substance abuse service delivery appears on page 5. In the existing structure, the Alcohol and Drug Abuse Planning Committee (ADPC) commissioners are the policy-making body, the Maine Council on Alcohol and Drug Abuse Prevention and Treatment is the advisory body and the ADPC planning director serves as staff to both groups. Under present law the ADPC commissioners select the director with the advice of the Maine Council and the Governor's approval. The planning director and ADPC staff work with substance abuse program directors. Assistant commissioners in the 5 departments and program directors formulate policy options for consideration by their commissioners and make day-to-day operational decisions. ADPC is housed organizationally within DHS.

Substance abuse assistance is provided through a combination of state personnel and contracted services purchased from community service providers. Of the 71 state employees in DECS, DOC, DMHMR and DHS (including ADPC staff) with substance abuse responsibilities approximately 28 provide some type of direct public service such as counseling or providing information and training. The remaining state personnel are split between contract administration (7) and administrative support services (36).

In fiscal year 1990, the Legislature set aside $15,231,881 for substance abuse programs. The largest portion, $11,286,126 or 74% went for contracted services. Direct services received $2,032,266 or 13% and administrative support services received $1,913,489 or 13%. The allocations and appropriations for the fiscal years 1988-1991 are included as Appendix D.

CURRENT MAINE SUBSTANCE ABUSE SYSTEM



Legislature appropriates funds to each department and ADPC staff.

——————— Direct lines of authority
→ → → Advisory/Planning/Coordination
T T T T T T Funding

* DECS – Department of Educational and Cultural Services
DADES – Division of Alcohol and Drug Education Services
* DOC – Department of Corrections
CCS – Division of Community Correctional Services
* DPS – Department of Public Safety
BIDE – Bureau of Inter-Governmental Drug Enforcement
BLE – Bureau of Liquor Enforcement
BOS – Bureau of Safety

* DMHR – Department of Mental Health and Mental Retardation
SAS – Substance Abuse Services
* DHS – Department of Human Services
OADAP – Office of Alcohol and Drug Abuse Prevention

Funding

Funding for substance abuse programs is allocated from 3 sources; the Alcohol Premium Fund, the General Fund and Federal Block Grants. Allocations for substance abuse service by revenue source averaged 42% Alcohol Premium Fund, 29% General Fund and 28% federal funds in fiscal years 1988-91. About 7% of the total allocations to substance abuse programs, approximately $1 million, is channeled through the General Fund by the Driver Education Evaluation Program (DEEP).

Known as the Alcohol Premium Fund, the Alcohol Prevention, Education, Treatment and Research Fund (28-A MRSA §§1701-1704) obtains revenues from a premium on the sale of beer, wine and distilled spirits. As the title indicates, Alcohol Premium Fund revenues are dedicated to various prevention, education, research and treatment programs. Since its creation in 1981, the Alcohol Premium Fund premium has been doubled (P.L. 1985, c. 803) to provide more program funding. In FY 1990, the Alcohol Premium Fund will provide approximately $5.9 million.

The use of dedicated revenues for substance abuse programs has resulted in various problems. In the past, the use of alcohol premium funds exclusively for alcohol treatment programs has been tied to duplicative contracts for drug treatment programs with general fund monies. The established pattern of annually renewing contracts for existing programs funded by the Alcohol Premium Fund has created a situation where expansions or new programs must be funded by general fund or federal dollars. This became evident when the funding for development of a management information system to begin evaluation of treatment programs was funded from the general fund in 1988, even though an evaluation system was a requirement of the 1983 legislation creating the ADPC and the Alcohol Premium Fund was doubled in 1986.

Perhaps the strongest argument against the use of dedicated revenues is the decrease in accountability. Programs funded by dedicated revenues do not compete against other programs for funding in the appropriations process. As a result, the dedicated revenue programs receive less attention from the Legislature than programs competing for general fund dollars. This reduced need to justify programs may partially account for the failure of the ADPC, the state agencies and service providers to develop the treatment program evaluation system mentioned above.

Another problem with the use of dedicated revenues is the reduction in available funds that would occur if treatment problems eventually reduce the consumption of alcoholic beverages. This relationship between the funding of programs and their effectiveness is somewhat perverse in its nature, providing a disincentive for program effectiveness, especially in the absence of effective evaluation. A related problem, the failure of dedicated revenues to increase as rapidly as the costs of programs, has occurred in Alcohol Premium funded programs.

Not all money spent on substance abuse in Maine is accounted for by the state and federal appropriations described above and in Appendix D. Insurance coverage, Medicaid, general assistance payments and out-of-pocket expenditures probably account for the bulk of the dollars spent on substance abuse treatment in Maine. An initial attempt to account for these expenditures is included as Appendix E.

State Agency Roles

Five state departments are involved in substance abuse prevention and treatment: Public Safety, whose commissioner chairs the ADPC; Education and Cultural Services; Human Services; Corrections; Mental Health and Mental Retardation. Appendix D contains a list of department programs. The following paragraphs briefly describe each departments level of effort in the substance abuse area. Department programs are listed in Appendix F and the number of clients receiving various services are included in Appendix G.

The Department of Public Safety is responsible for enforcement of alcohol and drug laws and also is involved in educational programs. The Bureau of Inter-Governmental Drug Enforcement works with federal and local authorities to detect and prevent the use, sales and transportation of both imported and locally grown drugs. The Bureau of Liquor Enforcement is responsible for enforcing alcohol sales laws and is primarily known for its efforts to prevent the sale of liquor to minors. The Bureau of Safety promotes safety and education through its work with the Highway Safety Commission.

The Department of Education and Cultural Services includes the Division of Alcohol and Drug Education Services. The Division considers most of its programs information dissemination. Services are provided to students, faculty, administrators, communities, school/community teams, school-based support groups and the general public by 21 field and support staff. Services are delivered through training institutes, workshops, presentations and personal consultation. The Division also distributes federal Drug Free School pass-through funds. FY'90 Drug Free School allotments of $896,689 went to schools with enrollments totaling 221,950 students.

The Department of Human Services houses the Office of Alcohol and Drug Abuse Prevention and the Driver Education Evaluation Program. OADAP delivers or funds programs in all substance abuse service categories, using 13 administrative and 5 direct service staff. The Bureau of Child and Family Services provides contract administration support for OADAP and some substance abuse contracts of DOC and DMHMR. DEEP is a program to educate, screen and provide treatment to persons convicted of operating motor vehicles under the influence of alcohol (OUI). DEEP provides their service using 6 administrative and 9 direct service staff.

The Department of Mental Health and Mental Retardation has a one person Office of Substance Abuse Services to negotiate and administer 22 contracts with service providers and to coordinate substance abuse programs with other department programs and with other departments. DMHMR focuses on the issue of dual diagnosis, persons with a combination of substance abuse and mental health problems, and provides information on fetal alcohol and drug effects.

The Department of Corrections and its Division of Community Correctional Services coordinates department programs from Augusta through the quarter-time efforts of one staff person. Full-time counselors at the Maine State Prison and Maine Correctional Center supervise some contracts, direct the Chemical Alternatives Program and coordinate educational substance abuse programs for juvenile offenders and DEEP teens. The department utilizes 19 community provider contracts.

State-Funded Advisory Groups

The state funds 3 substance abuse advisory groups; the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, the Regional Councils on Alcohol and Other Drugs and the National Council on Alcoholism in Maine. The roles of each group are discussed below.

Maine Council on Alcohol and Drug Abuse Prevention and Treatment

The Maine Council currently consists of 23 gubernatorial appointees, 2 legislators and 6 ex officio members. The council is the statutorily established advisory group to all 3 branches of government with responsibility to advocate on substance abuse issues, be ombudsman for drug dependent people dealing with State Government, provide information on substance abuse and the opportunity for public input, review and evaluate state and federal policies and serve as the advisory council to state government required by federal law. The council is staffed by the ADPC.

Regional Councils on Alcohol and Drug Abuse

Regional councils are groups of volunteers, each with a board of directors and an executive director. In FY 1989 regional councils received $269,400 in funding from the Office of Alcohol and Drug Abuse Prevention in the Department of Human Services and $5,000 from the Department of Mental Health and Mental Retardation. As a result, there is a regional council for each of the 5 DHS regions and the regional councils focus most of their attention on OADAP treatment programs. OADAP has worked out a set of standard goals and objectives with the regional councils.

National Council on Alcoholism in Maine

The National Council on Alcoholism is a nation-wide non-profit group of volunteers founded to combat alcoholism and other drug addictions. Its Maine chapter consists of a 39 member board of directors and 8 commissions totaling 213 active participants. Each commission works on a different aspect of the substance abuse problem; the current commissions focus on Public Policy, Women, Elderly, BABES, Youth, Higher Education and Native Americans. The Maine chapter is funded by the donations of its 487 general members and a contract with the Office of Alcohol and Drug Abuse Prevention for $60,000. NCA networks with other groups concerned about substance abuse and organizes an annual conference on alcohol and drug abuse prevention. A major focus of NCA activity has been the introduction and operation of the Beginning Alcohol and Addictions Basic Education Studies (BABES) program. BABES teaches children from pre-schoolers through adolescents the life skills needed to make "positive early decisions about the use of alcohol and other drugs."

Community Service Providers

Community service providers receive the bulk of substance abuse funds used to provide direct services to clients. In Fiscal Year 1990, service providers will receive over $11 million, almost 75% of substance program funding. Data on the overhead costs of community service providers were not obtained but estimates range between 10 and 30 percent and will vary by provider and the type of service being provided. Many providers of substance abuse services also provide mental health services and other types of assistance. A list of community service providers and hospitals with substance abuse contracts in Fiscal Year 1990 is included as Appendix H.

Planning

Current law (22 MRSA §7132) directs the ADPC to provide the Legislature with:

> An annual evaluation of the past year's progress and funding recommendations for the coming fiscal year;
>
> A comprehensive plan with biennial updates; and
>
> In every 4th year, an assessment of the costs related to drug abuse and the needs for various types of substance abuse services.

Since its 1983 creation the ADPC has submitted annual progress reports and funding requests to the Legislature. But the department has not yet completed an operational client information system that permits an evaluation of treatment program effectiveness. Evaluation of program effectiveness probably remains a minimum of 2 years away.

In its planning efforts, the ADPC has focused on determining the needs of specific populations and compiling public opinion on various issues, but has not delivered a comprehensive plan or a comprehensive assessment of drug abuse costs

Public Participation

Over the past 6 years public participation in the planning process has occurred in several ways. ADPC's role as staff has permitted their use of public forums held by for the Maine Council on Alcohol and Drug Abuse Prevention and Treatment to gain public input. Annual conferences sponsored by the Office of Alcohol and Drug Abuse Prevention and organized by the National Council on Alcoholism have provided additional public input. Finally, in recent years the annual Blaine House Conference on Alcohol and Other Drug Abuse Prevention, Education, Treatment and Law Enforcement has resulted in discussions between state agency personnel and invited guests from the substance abuse community.

Despite the above efforts, testimony received by the committee indicates that many service providers and others perceive a lack of meaningful response to the public input obtained. Part of this perception may be related to the failure of the ADPC to produce a comprehensive plan that clearly outlines the State's substance abuse prevention and treatment goals. But there appears to be additional concern that state agencies go to the public with a predetermined agenda and fail to respond adequately to requests by the public for changes in their agenda.

Program Coordination

The primary impetus for examining alternatives to the existing substance abuse service delivery system was the concern of community service providers and the regional councils about the contracting process. Historically, 3 state agencies purchase substance abuse services from community service agencies; the Department of Human Services, the Department of Corrections and the Department of Mental Health and Mental Retardation. In fiscal year 1989 Human Services had 54 contracts, Corrections had 19 contracts and Mental Health and Mental Retardation had 22 contracts with community service providers.

The major issue presented was the inefficiency created for community service providers by the involvement of more than one department in purchasing the delivery of similar treatment services. In general, multi-department involvement is reported to create burdens for providers and cause unnecessary expenditures for program administration by providers and state departments. Specific problems identified by community service providers include:

* Repetitious bidding and contract negotiations.

* Multiple contract officers.

* Different reporting formats and reporting requirements.

* Threatened closure of one program funded by 3 departments because of funding withdrawal by one department.

The ADPC has attempted to address these problems by beginning to implement a policy where the Bureau of Child and Family Services, within the Department of Human Services, administers the financial aspects of most contracts with programmatic supervision from the appropriate department. Essentially, only contracts for services provided in an institutional setting and contracts for start-up programs will be administered within the originating department. All other contracts will be administered by the Bureau of Child and Family Services.

This change is expected to decrease the number of contracts from the fiscal year 1989 level of 95, but may create some difficulties in coordinating program and financial oversight. Service providers may have to wait for consultations between the program person in one department and the finance person in DHS. Delays and misunderstandings are likely to increase whenever inter-office communications are involved.

Another major problem with the current programs is the absence of information useful in evaluating the impact of ADPC programs on substance abuse. This problem applies to both prevention and treatment programs. Since treatment programs receive almost three-quarters of the funding and the establishment of an evaluation program was part of the initial directive to the ADPC, the poor evaluation system for treatment programs is a severe problem and of the greatest concern.

FINDINGS AND RECOMMENDATIONS

The committee received testimony that the ADPC does not have the authority under current law to effectively coordinate the activities of the 5 departments. Problems cited include an inefficient process of purchasing treatment services, poor public involvement in planning and the inability to develop a comprehensive plan for substance abuse prevention and treatment programs. In addition, the absence of a person or agency with ultimate responsibility for substance abuse programs has left the general population unsure where to turn for substance abuse information.

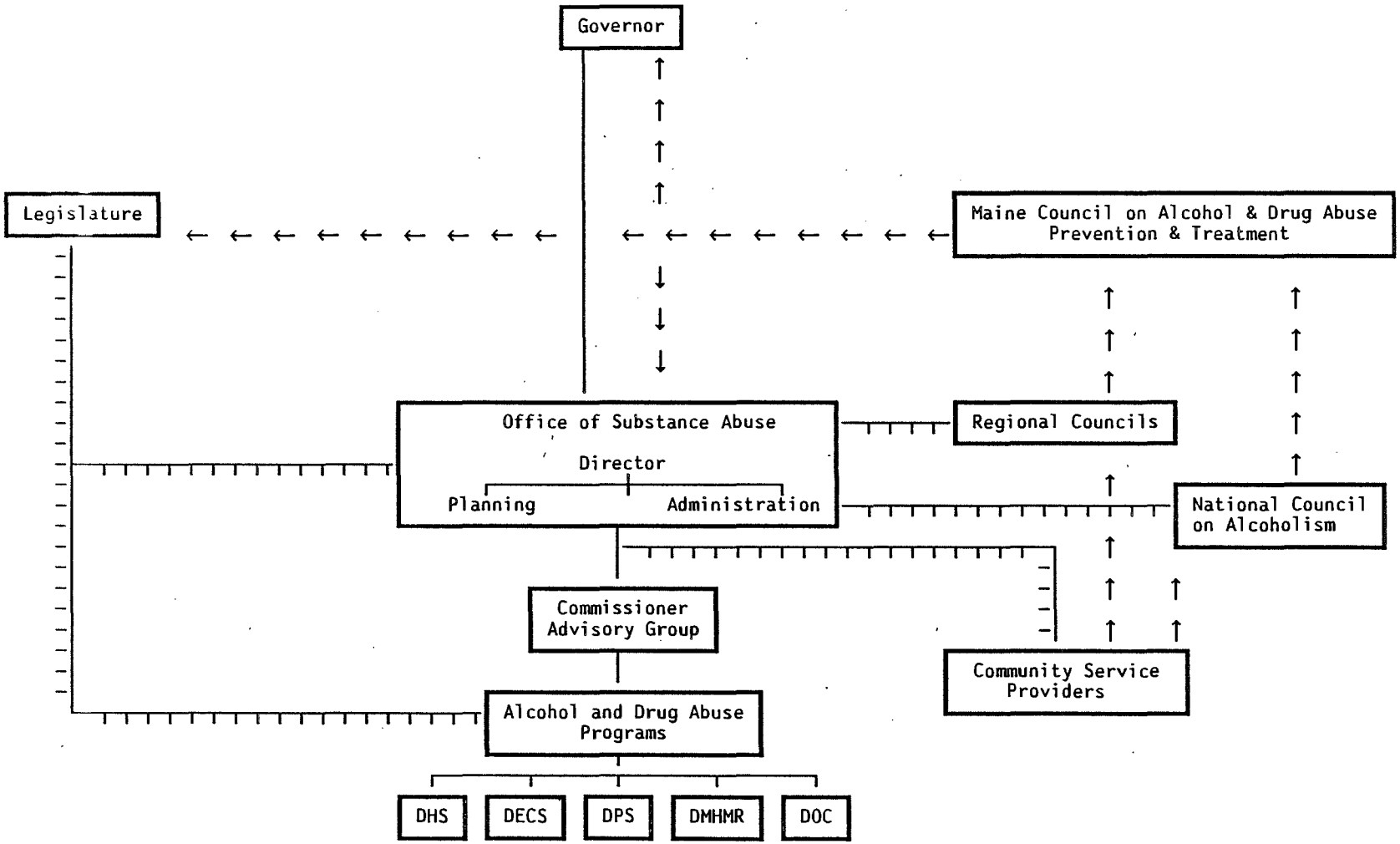
Proposals received by the committee all suggested that the minimum change needed was to increase the authority of the planning director by making program directors in the various departments answer to director. Many people thought creation of an office within the executive department was the best way to consolidate contract administration and increase the visibility of substance abuse programs. Suggestions for increasing public participation would have placed advisory and voluntary groups closer to policymakers and in one case would have placed a Maine Council representative on the policymaking body. The committee considered these proposals and has reached the following findings and recommendations.

Finding: The ADPC has not been able to deliver substance abuse services efficiently. The committee finds that the development and delivery of substance abuse services has occurred without adequate input from the public and without the guidance of the comprehensive plan mandated by statute. The separate development of treatment programs by 3 departments has resulted in the duplication of effort by state agencies and has placed unnecessary administrative burdens on community service providers.

Finding: The ADPC does not have sufficient stature within state government to give substance abuse programs adequate visibility.

Statutory Recommendation: Create an Office of Substance Abuse within the Executive Department. A new Office of Substance Abuse (OSA) should be created in the Executive Department. The office would perform planning and contract administration functions, approve and coordinate the development and operation of substance abuse programs, develop a single substance budget for state programs and administer substance abuse funding for programs in each of the current ADPC departments. A diagram of the new substance abuse structure appears on page 14. Legislation establishing the office is included as Appendix B.

COMMITTEE PROPOSAL – MAINE SUBSTANCE ABUSE SYSTEM



The proposed legislation establishes a substance abuse delivery structure that includes:

* A new Office of Substance Abuse as part of the Executive Department.

* An OSA director appointed by the governor.

* An advisory group composed of the commissioners of the five departments with current substance abuse programs to remain as an Advisory/Coordinating Body to the Director.

OSA functions will include:

* Planning, data collection and evaluation;
* Create a unified budget request and receive the appropriations for contracted services;
* Contract Administration and;
* Approval and coordination of program development with the departments while accepting proposals from departments, advocates and service providers.

Existing staff would be transferred from the departments as their current responsibilities are transferred. Rep. Begley remains concerned about the concentration of all these functions, especially contract administration within one office.

The OSA would recommend funding for all programs based on their fit with the goals and strategies established in the comprehensive plan. Thus OSA would control the service mix being provided with the advice of the commissioners and the Maine Council and would ensure coordination between departments. OSA would fund and administer all contracts with community service providers and would develop and use a uniform process for Request for Proposals (RFP), contract formats, reporting requirements, monitoring and evaluation procedures.

The five departments would work with OSA in planning, developing and maintaining programs and by submitting budget recommendations. The departments and their roles would also include:

DHS - Information clearinghouse, licensing substance abuse programs, Driver Education Evaluation Program (DEEP).

DECS - Continue school/community teams, administer pass-through Drug-Free schools money.

DOC - Provide some direct service in institutions and assist OSA contract administration.

DMHMR- Promote awareness within the department and assist OSA contract administration.

DPS - Continue enforcement programs, participate in educational programs under OSA direction.

In coordinating its own activities with the departments OSA would limit delivery of each type of service to one department whenever possible.

The Maine Council would continue as the Advisory Body to the Governor, the Legislature and to the OSA director.

The regional councils and the National Council on Alcoholism would become contractors of OSA, their specific roles determined by their contracts.

Finding: The State needs a comprehensive plan to guide substance abuse prevention and treatment activities. The ADPC structure has failed to deliver a comprehensive plan during its 6 years of operation. The committee finds the state needs a comprehensive plan that addresses the varied aspects of substance abuse prevention and treatment and establishes a clear state policy. In addition, the public role needs to be clearly defined with adequate and timely opportunity for input.

Administrative Recommendation: The ADPC should identify information and data necessary for comprehensive planning and develop a timely strategy for filling any information and data gaps.

Statutory Recommendation: Amend existing law to require adoption of the comprehensive plan through the Administrative Procedures Act.

Finding: State-funded advisory groups can provide valuable assistance. The committee finds that the Maine Council, the regional councils and the National Council on Alcoholism in Maine are capable of providing valuable assistance to the Office of Substance Abuse in developing the comprehensive plan, in reviewing proposals for program development and in evaluating the effectiveness of substance abuse programs.

Administrative Recommendations: The committee recommends that the regional councils be maintained by OSA funding. Regional councils should assist OSA by performing the following functions:

* Assist the development of a comprehensive state plan;
* Review the effectiveness of existing policies and services and identify unmet needs;
* Review and comment on proposed grants and contracts;
* Increase public awareness and participation;
* Supply general reference information; and
* Advocate for individuals in need of assistance.

The OSA should work to ensure diverse public input from the regional councils and the National Council on Alcoholism.

Statutory Recommendation: The Maine Council should continue in its role as the advisory body to the Governor, Legislature and Judiciary and will be staffed by the OSA.

Finding: Reliance on dedicated revenue diminishes the accountability of the substance abuse services system to the public and the Legislature. The committee finds that the Legislature receives inadequate input on programs funded by dedicated revenues and that over time these programs become less accountable for their performance than programs receiving General Fund revenues.

Statutory Recommendation: Undedicate the Alcohol Premium Fund. The committee believes that making all appropriations of state dollars from one fund will increase accountability, will enable substance abuse programs to compete on their merits for funding and will increase administrative efficiency. With more competition for funding OSA, the departments and the community service providers will have a stronger incentive to develop ways of evaluating the effectiveness of their programs.

Rep. Daggett remains undecided on the issue of undedicating the Alcohol Premium Fund.

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APPENDIX A.

LEGISLATIVE COUNCIL STUDY AUTHORIZATION

STATE OF MAINE

114th LEGISLATURE

LEGISLATIVE COUNCIL

July 6, 1989

Honorable Georgette B. Berube, Senate Chair
Honorable Ruth Joseph, House Chair
Joint Standing Committee on State & Local Government
114th Maine Legislature

Dear Senator Berube and Representative Joseph:

The Legislative Council met last Saturday to establish budgets for the approved interim study requests. The Council has taken the following actions on requests from your Committee:

Structure of Substance Abuse Assistance and Services in the State — APPROVED

5 member subcommittee

4 subcommittee meetings
1 full committee meeting

Redistribution of County Functions — APPROVED

5 member subcommittee

4 subcommittee meetings
1 full committee meeting

The Council also considered your request for $5,000 to bring in outside speakers and consultants during the course of the study. Rather than allocating a lump sum, I would ask that you submit specific requests to the Council for each speaker, which includes a jurisdiction and estimated cost.

The Council's action on all study requests is based on the understanding that the subcommittee will have completed its work by December 1, 1989. This means that the report and any accompanying legislation must be ready to transmit to the Legislative Council on that date.

STATE HOUSE STATION 115, AUGUSTA, MAINE 04333 TELEPHONE 207-289-1615

I would ask that you send information regarding those members who will be serving on the subcommittee as soon as it is available to Sally Diamond.

We appreciate your cooperation in moving quickly to organize the study and look forward to receiving your findings and recommendations. Please call me if you have any questions.

Sincerely,

John L. Martin, Chair
Legislative Council

cc: Martha Freeman, Director, Office of Policy & Legal Analysis

APPENDIX B.

AN ACT TO ESTABLISH AN OFFICE OF SUBSTANCE ABUSE

HP 12/5 OSA
LR#2669
242nrg
Council Approved
Study

SECOND REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

AN ACT to Establish an Office of Substance Abuse

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. 1. 5 MRSA §12004-I, sub-§39, as enacted by PL 1987, c. 786, §5, is amended to read:

39.	Human Services	Maine Council on Alcohol and Drug Abuse Prevention and Treatment	Expenses Only	~~22~~ 5 MRSA ~~§7107~~ §20051

Sec. 2. 5 MRSA Pt. 24 is enacted to read:

PART 24

SUBSTANCE ABUSE PREVENTION AND TREATMENT

CHAPTER 551

OFFICE OF SUBSTANCE ABUSE

SUBCHAPTER I

GENERAL PROVISIONS

§20001. Title

This chapter may be cited as the Maine Substance Abuse Prevention and Treatment Act.

§20002. Purpose

The purposes of this chapter are:

1. Integrated and comprehensive approach. To adopt an integrated approach to the problem of substance abuse and to focus all the varied resources of the State on developing a comprehensive and effective range of substance abuse prevention and treatment activities and services; and

2. Single administrative unit. To establish a single administrative unit within State Government, accountable directly to the Governor, with responsibility for planning, developing, implementing and coordinating all of the State's substance abuse prevention and treatment activities and services.

§20003. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Alcoholic. "Alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.

2. Approved treatment facility. "Approved treatment facility" means a public or private alcohol treatment facility meeting standards approved by the office in accordance with section 20005 and licensed pursuant to Title 22, chapter 1602 and other applicable provisions of state law.

3. Approved public treatment facility. An approved public treatment facility is an alcohol treatment facility operating under the direction and control of the office or providing treatment under this subchapter through a contract with the office under section 20008, or any facility funded in whole or in part by municipal, state or federal funds.

4. Community service provider. "Community service provider" means a provider of alcohol or drug abuse treatment including, but not limited to, need evaluation.

5. Council. "Council" means the Maine Council On Alcohol and Drug Abuse Prevention and Treatment, as established by section 12004-I, subsection 39.

6. Department. "Department" means the Department of Human Services.

7. Dependency related drug. "Dependency related drug" means alcohol or any substance controlled under Title 32, chapter 117, or Title 22, chapter 558.

8. Director. "Director" means the director of the office of substance abuse.

9. Drug abuser. "Drug abuser" means a person who uses any drugs, dependency related drugs, or hallucinogens in violation of any law of the State of Maine.

10. Drug abuse prevention. "Drug abuse prevention" means all facilities, programs or services relating to drug abuse control, education, rehabilitation, research, training and treatment, and includes these functions as related to alcoholics and intoxicated persons. The term includes such functions even when performed by an organization whose primary mission is in the field of prevention of drug traffic or is unrelated to drugs. This term does not include any function defined under subsection 19 as prevention of drug traffic.

11. Drug addict. "Drug addict" means a drug dependent person who, due to the use of a dependency related drug has developed such a tolerance thereto that abrupt termination of the use thereof would produce withdrawal symptoms.

12. Drug dependent person. "Drug dependent person" means any person who is unable to function effectively and whose inability to do so causes or results from the use of a dependency related drug.

13. **Emergency service patrol.** "Emergency service patrol" means a patrol established under section 20024.

14. Incapacitated by alcohol. "Incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has impaired judgment and is incapable of realizing and making a rational decision with respect to the need for treatment.

15. Incompetent person. "Incompetent person" means a person who has been adjudged incompetent by a court.

16. Intoxicated person. "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol.

17. Office. "Office" means the Office of Substance Abuse established under section 20004.

18. Prevention. "Prevention" means any activity designed to educate or provide information to individuals and groups about the use or abuse of alcohol and other drugs.

19. Prevention of drug traffic. "Prevention of drug traffic" means any functions conducted for the purpose of preventing drug traffic, such as law enforcement and judicial activities or proceedings;

A. Investigation, arrest, prosecution. The investigation, arrest and prosecution of drug offenders and offenses; or

B. Detection and suppression. The detection and suppression of illicit drug supplies.

20. Standards. "Standards" means criteria, rules and regulations of the office or the department that are to be met before and during operation of any treatment facility or treatment program.

21. Substance abuse advisory group. "Substance abuse advisory group" means the five commissioners designated in section 20007.

22. Treatment. "Treatment" means the broad range of emergency, outpatient, intermediate and in-patient services and care including career counseling, diagnostic evaluation, employment, health, medical, psychiatric, psychological, recreational, rehabilitative, social service care, treatment and vocational services, which may be extended to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or to a person in need of assistance due to use of a dependency related drug.

23. **Treatment program.** "Treatment program" means any program or service, or portion thereof, sponsored under the auspices of a public or private nonprofit agency providing services especially designed for the treatment of those persons listed in subsection 23.

§20004. Office established

The Office of Substance Abuse is established within the Executive Department to fulfill the purposes of this chapter. The office is directly responsible to the Governor. The office shall be the sole agency of the State responsible for administering this chapter.

§20005. Powers and duties

The office shall:

1. State government. Establish the overall plans, policies, objectives and priorities for all state substance abuse prevention and treatment functions, except the prevention of drug traffic and the employee assistance program established pursuant to Title 22, chapter 254-A;

2. Comprehensive plan. Develop and provide for the implementation of the comprehensive state plan for alcohol and drug abuse;

3. Information. Ensure the collection, analysis and dissemination of information for planning and evaluation of alcohol and drug abuse services;

4. Coordination; organizational unit. Ensure that alcohol and drug abuse assistance and service is delivered as an efficient and coordinated program and, with the advice of the council, shall coordinate all programs and activities authorized by the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended, and by the United States Drug Abuse Office and Treatment Act of 1972, as amended; and other programs or Acts of the State or United States related to drug abuse prevention which are not the specific responsibility of another state agency under federal or state law.

5. Budget. Develop and submit to the Legislature by January 15 of the first year of each biennium recommendations for continuing and supplemental allocations and appropriations from all funding sources for all state alcohol and drug abuse programs;

6. Administer contracts. Administer all contracts with community service providers for the delivery of alcohol and drug abuse treatment services;

7. Uniform requirements. Develop, use and require the use of uniform contracting, information gathering and reporting formats by any state funded substance abuse program. To the extent feasible, information shall maintain compatibility with federal information sharing standards.

8. Reports. By January 15th of each year, report to the Legislature on the accomplishments of the past years's programs, the progress toward obtaining goals and objectives of the comprehensive state plan and other necessary or desireable information;

9. Funds. Have the authority to seek and receive funds from the Federal Government and private sources to further the purposes of this chapter;

10. Agreements. Enter into agreements necessary or incidental to the purposes of this chapter;

11. Cooperation. Provide support and guidance to individuals, local governments and public and private organizations in their alcohol and drug abuse prevention activities;

12. Rules. Adopt rules, in accordance with the Maine Administrative Procedures Act, Title 5, chapter 375, necessary to carry out the purposes of this chapter and shall approve any rules adopted by state agencies for the purpose of implementing an alcohol or drug abuse prevention or treatment program; and

13. General authority. Perform other acts or exercise any other powers necessary or convenient to carry out the purposes of this chapter.

§20006. Director

The Governor shall appoint a full-time director of the Office of Substance Abuse who shall serve at the pleasure of the Governor and shall have a salary fixed by the Governor.

The director must be qualified by training and experience in the field of substance abuse prevention and treatment. The director shall exercise the powers of the office and shall be responsible for the execution of its duties. The director may:

1. Employ and remove staff. Employ and remove staff and assign their duties in accordance with the Civil Service Law;

2. Alternatives. Propose alternatives to current alcohol and drug abuse prevention and treatment programs and services;

3. Investigate. Conduct investigations and studies of any alcohol or drug abuse program or community service provider as necessary; and

4. Gifts. Accept money or gifts from any source to implement this chapter. Any money or gifts the office receives must be accounted for in accordance with the requirements of the Department of Finance.

§20007. Substance abuse advisory group; agency cooperation

The Commissioner of Corrections, the Commissioner of Education and Cultural Services, the Commissioner of Human Services, the Commissioner of Mental Health and Mental Retardation, and the Commissioner of Public Safety shall constitute the Substance Abuse Advisory Group. The commissioners shall elect a chair from among their members and shall meet with the director to provide advice on the development and operation of alcohol and drug abuse prevention and treatment programs. The advisory group shall meet, at a minimum, in alternate months.

State agencies shall cooperate fully with the office and council in carrying out this chapter. No state agency shall develop, establish, conduct or administer any alcohol or drug abuse prevention or treatment program without the approval of the office. The office is authorized to request personnel, facilities and data from other agencies as the director finds necessary to fulfill the purposes of this chapter.

§20008. Comprehensive program on alcoholism and drug abuse

The office shall establish and provide for the implementation of a comprehensive and coordinated program of alcohol and drug abuse prevention and treatment in accordance with subchapters II and III and the purposes of this chapter. The program shall include the following elements:

1. Public and private resources. All appropriate public and private resources shall be coordinated with and utilized in the program.

2. Program. The program must include emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital.

3. Alcoholics and intoxicated persons. The office shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 20017 to 20021. Treatment may not be provided at a correctional institution, except for inmates.

The office shall contract with approved treatment facilities whenever possible, but may contract for the use of any facility as an approved public treatment facility at the discretion of the director.

§20009. Planning

The office shall plan alcohol and drug abuse prevention and treatment activities in the State and shall prepare and submit to the Legislature the following documents:

A. By January 15, 1991, and bienially thereafter, a comprehensive plan containing statements of measurable goals to be accomplished during the coming biennium and establishing performance indicators by which progress toward accomplishing those goals will be measured; and

B. By January 15, 1991, and every fourth year thereafter, an assessment of the costs related to drug abuse in the State and the needs for various types of services within the State, including geographical disparities in needs and the needs of special populations of drug abusers.

SUBCHAPTER II
PREVENTION

§20010. Public Awareness

The office shall create and maintain a program to increase public awareness of the impacts and prevalence of alcohol and drug abuse. The public awareness program shall include promotional and technical assistance to local governments and public and private nonprofit organizations interested in alcohol and drug abuse prevention.

§20011. Information dissemination

As part of its comprehensive prevention and treatment program the office shall support and coordinate the activities of an information clearinghouse within the Department of Human Services and a resource center within the Department of Education and Cultural Services. Together, the information clearinghouse and resource center shall constitute a comprehensive reference center of information related to the nature, abuse, prevention and treatment of alcohol and drugs. The office shall ensure the information clearinghouse and resource center do not perform duplicative services or functions. Information shall be available for use by the general public, political subdivisions, public and private nonprofit agencies and the State.

Functions of the information clearinghouse may include, but are not limited to:

1. Research. Conducting research on the causes and nature of drugs, drug abuse or people who are dependent on drugs, especially alcoholics and intoxicated persons;

2. Information collection. Collecting, maintaining and disseminating knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention;

3. Educational materials. Preparation, publication and dissemination of educational materials; and

4. Treatment facilities. Maintaining an inventory of the types and quantity of drug abuse prevention facilities, programs and services available or provided under public or private auspices to drug addicts, drug abusers and drug dependent persons, especially alcoholics and intoxicated persons. This function shall include the unduplicated count, location and characteristics of people receiving treatment, as well as their frequency of admission and readmission, and frequency and duration of treatment. The inventory shall include the amount, type and source of resources for drug abuse prevention.

§20012. Education

The office shall establish and maintain within the Department of Education and Cultural Services a program of elementary and secondary school education about alcohol and drug abuse. The program shall include community participation and shall be coordinated with available treatment services.

SUBCHAPTER III
TREATMENT

§20015. Evaluation

The office shall collect data and use information from other sources to evaluate or provide for the evaluation of the impact, quality and value of alcohol and drug abuse prevention activities, treatment facilities and other substance abuse programs. Any evaluation of treatment facilities shall include, but not be limited to, administrative adequacy and capacity. Alcohol and drug abuse prevention and treatment services authorized by this chapter and the following federal laws and amendments that relate to drug abuse prevention shall be evaluated:

(1) The United States Drug Abuse Office and Treatment Act of 1972, Public Law 92-255;

(2) The United States Community Mental Health Centers Act, United States Code, Title 42, Section 2688;

(3) The United States Public Health Service Act, United States Code, Title 42;

(4) The United States Vocational Rehabilitation Act;

(5) The United States Social Security Act; and

(6) The United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Public Law 91-616, and similar Acts.

§20016. Standards

Except as provided in section 20008, the office shall only contract for treatment services with approved treatment facilities.

§20017. Acceptance for treatment of alcoholics and intoxicated persons; rules

The office shall adopt rules for acceptance of persons into a treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons.

In establishing rules, the office shall be guided by the following standards.

1. Voluntary basis. If possible, a patient shall be treated on a voluntary rather than an involuntary basis.

2. Initial assignment. A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless the patient is found to require inpatient treatment.

3. Denial of treatment. A person may not be denied treatment solely because that person has withdrawn from treatment against medical advice on a prior occasion or has relapsed after earlier treatment.

4. Individualized treatment plan. An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

5. Coordinated treatment. Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

6. Denial of treatment services. No person, firm or corporation licensed by the Department of Human Services as an alcohol or drug treatment facility, under section 7245, to provide shelter or detoxification service, and which receives any funds administered by the office, may deny treatment to any person because of that person's inability or failure to pay any assessed fees.

§20018. Voluntary treatment of alcoholics

1. Voluntary treatment. An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, that person, a parent, a legal guardian or other legal representative may make the application.

2. Determination. Subject to rules adopted by the office, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to rules adopted by the office, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

3. Outpatient or intermediate treatment. If a patient receiving inpatient care leaves an approved public treatment facility, that patient shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the office shall arrange for assistance in obtaining supportive services and residential facilities.

4. Discharge. If a patient leaves an approved public treatment facility, with or against the advice of the administrator in charge of the facility, the office shall make reasonable provisions for that patient's transportation to another facility or to the patient's home. If that person has no home, the patient shall be assisted in obtaining shelter. If the patient is a minor or an incompetent person, the request for discharge from an inpatient facility shall be made by a parent, legal guardian or other legal representative or by the minor or incompetent, if the minor or incompetent was the original applicant.

§20019. Treatment and services for intoxicated persons and persons incapacitated by alcohol

1. Intoxicated person. An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated and to be in need of help, if that person consents to the proffered help, may be assisted home, or to an approved public treatment facility, an approved private treatment facility or other health facility by the police or the emergency service patrol.

2. Incapacitated person. A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and immediately brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available, that person shall be taken to an emergency medical service customarily used for incapacitated persons. The police or the emergency service patrol, in detaining the person and in taking that person to an approved public treatment facility, is taking that person into protective custody and shall make every reasonable effort to protect that person's health and safety.

In taking the person into protective custody, the detaining officer may take reasonable steps for self-protection. A taking into protective custody under this section is not an arrest. No entry or other record may be made to indicate that the person has been arrested or charged with a crime.

3. Voluntary commitment. A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician immediately. That person may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for that person's transportation.

4. Length of stay. A person, who by medical examination is found to be incapacitated by alcohol at the time of admission or to have become incapacitated at any time after admission, may not be detained at the facility once that person is no longer incapacitated by alcohol, or if that person remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless committed under section 20020. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

5. Shelter. A person who is not admitted to an approved public treatment facility, is not referred to another health facility and has no funds may be taken home. If that person has no home, the approved public treatment facility shall provide assistance in obtaining shelter.

6. Notification. If a patient is admitted to an approved public treatment facility, the family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, the request shall be respected.

7. Official duty. The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable.

8. Further diagnosis and voluntary treatment. If the administrator in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

§20020. Emergency commitment of an incapacitated or intoxicated person

1. **Commitment.** An intoxicated person who has threatened, attempted or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or is

incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not in itself constitute evidence of lack of judgment as to the need for treatment.

2. Application for commitment. The spouse, guardian or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that the physician has examined the person to be committed within 2 days before the date of the application for admission and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the division is not eligible to be the certifying physician. The certifying physician shall be someone other than the person making the written application for commitment.

3. Approval of application. Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian or any other interested person. The person shall be retained at the facility or transferred to another appropriate public or private treatment facility, until discharged under subsection 5.

4. Refusal of application. The administrator in charge of an approved public treatment facility shall refuse an application if, in the opinion of a physician or physicians employed by a facility, the application and certificate fail to sustain the grounds for commitment.

5. Discharge. When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, the administrator shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than 5 days. If a petition for involuntary commitment under section 22021 has been filed within the 5 days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, the administrator may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

6. Opportunity to consult counsel. A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult counsel.

§20021. Involuntary commitment of alcoholics or incapacitated persons

1. Commitment. A person may be committed to the custody of the office by the District Court upon the petition of a spouse or guardian, relative or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and has threatened, attempted or inflicted physical harm on another and unless committed is likely to inflict physical harm on another or is incapacitated by alcohol. A refusal to undergo treatment does not in itself constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within 2 days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the division is not eligible to be the certifying physician. The certifying physician shall be someone other than the person bringing the petition.

2. Petition. Upon filing the petition, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, next of kin other than the petitioner, a parent or a legal guardian, the administrator in charge of the approved public treatment facility to which the person has been committed for emergency care and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

3. Hearing. At the hearing, the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present, unless the court believes that the person's presence is likely to be injurious to that person. In this event, the court shall appoint a guardian ad litem to represent the person throughout the proceeding. The court shall examine the person in open court, or if advisable, shall examine the person out of court.

If the person has refused to be examined by a licensed physician, the person shall be given an opportunity to be examined by a court-appointed licensed physician. If that person refuses and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing that person to custody of the office for a period of not more than 5 days for purposes of a diagnostic examination.

4. Findings. If, after hearing all relevant evidence, including the results of any diagnostic examination by the office, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the office. It may not order commitment of a person, unless it determines that the office is able to provide adequate and appropriate treatment and the treatment is likely to be beneficial.

5. Custody. A person committed under this section shall remain in the custody of the office for treatment for a period of 30 days unless sooner discharged. At the end of the 30-day period, the person shall be discharged automatically, unless the office before expiration of the period obtains a court order for recommitment upon the grounds set forth in subsection 1 for a further period of 90 days, unless sooner discharged. If a person has been committed as an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment, if after examination it is determined that the likelihood still exists.

6. Recommitment. A person recommitted under subsection 5 who has not been discharged by the office before the end of the 90-day period shall be discharged at the expiration of that period, unless the office before expiration of the period obtains a court order on the grounds set forth in subsection 1 for the recommitment for a further period not to exceed 90 days. If a person has been committed as an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. Only 2 recommitment orders under this subsection and subsection 5 are permitted.

7. Petition for recommitment. Upon the filing of a petition for recommitment under subsection 5 or 6, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, next of kin other than the petitioner, the original petitioner under subsection 1, if different from the petitioner for recommitment, one parent or a legal guardian and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection 3.

8. Treatment. The office shall provide for adequate and appropriate treatment of a person committed to its custody. The office may transfer a person committed to its custody from one approved public treatment facility to another, if transfer is medically advisable.

9. Discharge. A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which that person has been committed if either of the following conditions is met:

A. In case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that person is no longer an alcoholic or the likelihood no longer exists; or

B. In case of an alcoholic committed on the grounds of the need of treatment and incapacity, the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition or treatment is no longer adequate or appropriate.

10. Right to contest. The court shall inform the person whose commitment or recommitment is sought of the right to contest the application, be represented by counsel at every stage of any proceedings relating to commitment and recommitment and have counsel appointed by the court or provided by the court, if that person wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel regardless of that person's wishes. The person whose commitment or recommitment is sought shall be informed of the right to be examined by a licensed physician of that person's choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

11. Private treatment facility. If a private or public treatment facility agrees with the request of a competent patient or a parent, sibling, adult child or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer the patient to the private treatment facility.

12. Habeas corpus. A person committed under this subchapter may at any time seek to be discharged from commitment by writ of habeas corpus.

13. Venue for proceedings. The venue for proceedings under this section is the place in which the person to be committed resides or is present.

§20022. Records

1. Registration and records. The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

2. Information for research. Notwithstanding subsection 1, the director may make available information from patients' records for purposes of research into the causes and treatment of alcoholism and drug abuse. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

§20023. Visitation and communication of patients

1. Hours of visitation. Subject to reasonable rules regarding hours of visitation which the director may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel and for continuing contact with family and friends consistent with an effective treatment program.

2. Communication. Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read or censored. The director may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

3. Restrictions. Except to the extent the director determines that it is necessary for the medical welfare of the patient to impose restrictions, and unless a patient has been restored to legal capacity and except where specifically restricted by other statute or regulation, but not solely because of the fact of admission to a mental hospital, to exercise all civil rights, including, but not limited to, civil service status, the right to vote, rights relating to the granting, renewal, forfeiture or denial of a license, permit, privilege or benefit pursuant to any law, and the right to enter contractual relationships and to manage the patient's property.

§20024. Emergency service patrol; establishment; rules

1. Emergency service patrols. The office, counties and municipalities may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated due to the use of alcohol or dependency-related drugs. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall transport intoxicated persons to their homes and to and from public treatment facilities.

2. Rules. The office shall adopt rules for the establishment, training and conduct of emergency service patrols.

§20025. Payment for treatment; financial ability of patients

1. Payment. If treatment is provided by an approved public treatment facility and the patient has not paid the charge, the treatment facility is entitled to any payment received by the patient or to which the patient may be entitled because of the services rendered from any public or private source available to the treatment facility because of the treatment provided to the patient.

2. Liability. A patient in an approved public treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the treatment facility for cost of maintenance and treatment of the patient in accordance with rates established.

3. Finances. The office shall adopt rules governing financial ability that take into consideration the income, savings, other personal and real property and any support being furnished to any other person that that patient is required by law to support.

§20026. Criminal law limitations

1. Laws. No county, municipality or other political subdivision may adopt or enforce a local law, ordinance, regulation or rule having the force of law that includes drinking, being a common drunkard or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

2. Interpretation. No county, municipality or other political subdivision may interpret or apply any law of general application to circumvent subsection 1.

3. Affect. Nothing in this subchapter affects any law, ordinance, regulation or rule against drunken driving, driving under the influence of alcohol, or other similar offense involving the operation of a vehicle, snowmobile, aircraft, boat, machinery or other equipment, or regarding the sale, purchase, dispensing, possessing or use of alcoholic beverages at stated times and places or by a particular class of persons.

SUBCHAPTER IV

MAINE COUNCIL ON ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT

§20051. Membership

1. Members; appointment. The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, as established by section 12004-I, subsection 39, shall consist of no more than 30 members who, excepting members representing the Legislature, shall be appointed by the Governor. At least 2 members of the council shall be current members of the Legislature: one member from the Senate appointed by the President of the Senate to serve at the pleasure of the President and one member from the House of Representatives appointed by the Speaker of the House of Representatives to serve at the pleasure of the Speaker.

2. Qualifications. To be qualified to serve, members must have education, training, experience, knowledge, expertise and interest in drug abuse prevention and training. Members must be residents of different geographical areas of the State, who reflect experiential diversity and concern for drug abuse prevention and treatment in the State.

3. Membership; representation. The Governor shall select members from outstanding people in the fields of corrections, education, health, law, law enforcement, labor and employment, medicine, mental health, mental retardation, science, social sciences and related areas. The Governor shall appoint members to represent nongovernmental organizations or groups and public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. Members must have an unselfish and dedicated personal interest demonstrated by active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research into drug abuse and alcohol abuse. The Governor shall appoint members to meet the following requirements.

A. Two of the private citizen members must be between the ages of 16 and 21 years.

B. At least 4 members must be officials of public or private nonprofit community level agencies who are actively engaged in drug abuse prevention or treatment in public or private nonprofit community agencies or members of the regional alcohol and drug abuse councils located throughout the State.

C. Five members must be the executive directors of the 5 regional alcohol and drug abuse councils located throughout the State.

D. One of the public citizen members must be the President or Executive Director of the National Council on Alcoholism in Maine, Incorporated.

E. Two members must be representatives of public education;

F. Two members must be representatives from the field of mental health and mental retardation,

G. Two members must be representatives from the field of corrections and criminal justice.

H. Two members must be representatives from the field of social services.

I. The Governor shall make appointments to the council to ensure that at least 6 members are persons affected by or recovering from alcoholism, chronic intoxication, drug abuse or drug dependency, having evidenced a minimum of 3 years of sobriety or abstention from drug abuse.

J. One member must be registered as a physician or surgeon under Title 32, chapter 48, subchapter II.

K. Membership may also include, but not be limited to, representatives of professions such as law, law enforcement, pharmacy, the insurance industry, businesses with employee assistance programs and teaching.

4. Term; vacancies. Except as provided in paragraphs A and B, members shall be appointed for terms of 3 years. Any vacancy in the council shall not affect its powers, but must be filled in the same manner by which the original appointment was made. Terms of appointment shall begin and expire on June 1st.

A. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term.

B. Members who are members of the current Legislature and who are appointed by the President of the Senate or the Speaker of the House of Representatives shall serve at the pleasure of the President of the Senate and Speaker of the House of Representatives.

5. Reappointment; termination. Members shall be eligible for appointment only to 2 consecutive terms and may serve after the expiration of their terms until their successors have been appointed, qualified and taken office. The appointing authority may terminate the appointment of any member of the council for good and just cause and the appointing authority shall communicate the reason for the termination to each member terminated. The appointment of any member of the council shall

be terminated if a member is absent from 3 consecutive meetings without good and just cause that is communicated to the chair of the council.

6. Ineligible to serve on the council. The Governor shall not appoint as a member of the council any official, employee, consultant or any other individual employed, retained or otherwise compensated by or representative of the executive branch.

7. Officers. The Governor shall designate one member to chair the council. The council may elect any other officers from its members as it considers appropriate.

8. Subcommittees. The council may appoint from its membership subcommittees relating to particular problem areas or to other matters, provided that the council shall function as an integrated committee.

9. Administrative and financial assistance. The office shall provide the council any administrative or financial assistance that from time to time may be reasonably required to carry out its activities. Any reasonable and proper expenses of the council shall be borne by the office out of currently available state or federal funds.

§20052. Meetings; compensation; quorum

1. Calling meetings. The council shall meet at the call of the chair or at the call of at least 1/4 of the members appointed and currently holding office.

2. Frequency of meetings. The council shall meet at least 5 times a year and at least once every 3 months.

3. Minutes. The council shall keep minutes of all meetings, including a list of people in attendance. The council shall immediately send copies of the minutes to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

4. Compensation. Members of the council shall be compensated according to the provisions of chapter 379.

5. Quorum; council action. A majority of the council members shall constitute a quorum for the purpose of conducting the business of the council and exercising all the powers of the council. A vote of the majority of the members present shall be sufficient for all actions of the council.

§20053. Powers and duties of the council

The council, in cooperation with the office, shall have the following powers and duties.

1. Advise, consult and assist. The council shall advise, consult and assist the executive and legislative branches of the State Government and the Judicial Council, and especially the Governor, on activities of State Government related to drug abuse prevention, including alcoholism and intoxication. The council may make recommendations regarding any function intended to prevent drug traffic. If findings, comments or recommendations of the council vary from or are in addition to those of the office, those statements of the council shall be sent to the respective branches of State Government as attachments to those submitted by the office. Recommendations may take the form of proposed budgetary, legislative or policy actions. The council shall be solely advisory in nature and may not be delegated any administrative authority or responsibility.

2. Serve as advocate. The council shall serve as an advocate on alcoholism and drug abuse prevention, promoting and assisting activities designed to meet at the national, state and community levels the problems of drug abuse and drug dependence. The council shall serve as an ombudsman on behalf of individual citizens and drug dependent people as a class in matters under the jurisdiction of State Government. It shall be a proponent on behalf of drug abuse prevention to the office, Governor, Legislature, public at large and Federal Government.

3. Serve as advisory council. The council shall serve as the advisory council on behalf of the State to the state agencies as required by the federal regulations governing administration of the United States Drug Abuse Office and Treatment Act of 1972, as amended, and the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended; and other Acts of the United States as appropriate. The council shall advise regarding state and federal plans, policies, programs and other activities relating to the drug abuse and drug dependence in the State. The council shall submit its recommendations and comments on the state plan, and any plan revisions, and reports to federal or state agencies. Statements at variance or in addition to those of the office shall be attached to the plan or reports upon submission by the office to agencies of the United States Government and to state agencies.

4. Review and evaluate. The council shall review and evaluate on a continuing basis, in cooperation with the office, for the purpose of determining the value and effect on the lives of people who abuse or are dependent on drugs, of state and federal policies and programs relating to drug abuse and other activities affecting the people who abuse or are dependent on drugs, conducted or assisted by any state departments or agencies.

5. Inform the public. The council shall keep the public informed, in cooperation with the office, in order to develop a firm public understanding of the current status of drug abuse and drug dependence among Maine's citizens, including information on effective programs in the State or nation, by collecting and disseminating information, conducting or commissioning studies and publishing the study results, and by issuing publications and reports.

6. Provide public forums. The council shall provide public forums, including the conduct of public hearings, sponsorship of conferences, workshops and other meetings to obtain information about, discuss and publicize the problems of and solutions to drug abuse and drug dependence. The council may hold a statewide conference, regional conferences and meetings.

PART B

Sec. 1. 22 MRSA chapter 1601 as amended is repealed.

Sec. 2. 22 MRSA §7201, sub-§5 is enacted to read:

5. **Office.** "Office" means the Office of Alcohol and Drug Abuse Prevention established by §7241.

Sec. 3. 22 MRSA chapter 1602, subchapter II as amended is repealed.

Sec. 4. 22 MRSA chapter 1602, subchapter II-A is enacted to read:

SUBCHAPTER II-A

OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION

§7241. Office established

There is created within the Department of Human Services, the Office of Alcohol and Drug Abuse Prevention. The office is established to administer and oversee the operation of the department's alcohol and drug abuse activities, including those related to the abuse of alcohol by motor vehicle operators pursuant to subchapter I and excepting the employee assistance program established pursuant to chapter 254-A. The office shall operate in accordance with the provisions of Title 5, chapter 551 and the alcohol and drug abuse prevention and treatment plan developed pursuant to Title 5, section 20009.

§7242. Definitions

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings.

1. **Approved treatment facility.** "Approved treatment facility" has the same meaning as set out in Title 5, section 20003.

2. **Commissioner.** "Commissioner" means the Commissioner of Human Services.

3. **Department.** "Department" means the Department of Human Services.

4. **Director.** "Director" means the Director of the Office of Alcohol and Drug Abuse Prevention.

5. **Office.** "Office" means the Office of Alcohol and Drug Abuse Prevention established under section 7241.

6. Standards. "Standards" has the same meaning as set out in Title 5, section 20003.

7. Treatment. "Treatment" has the same meaning as set out in Title 5, section 20003.

8. Treatment program. "Treatment program" has the same meaning as set out in Title 5, section 20003.

§7243. Powers and duties

The office shall provide assistance and guidance to individuals, public and private organizations and especially local governments, in their drug abuse prevention activities. In addition, the office shall:

1. Information clearinghouse. Operate the information clearinghouse established pursuant to Title 5, section 20011;

2. Licensing. Establish operating and treatment standards, inspect and issue a certificate of approval for any drug abuse treatment facility or program, including residential treatment centers, which meet the standards promulgated under section 7245 and licensed pursuant to section 7801 and other applicable provisions of law. The office shall periodically enter, inspect and examine the treatment facility or program, and examine their books and accounts. The office shall fix and collect the fees for the inspection and certificate. Insofar as licensing and certification of drug abuse prevention facilities and programs may also be the responsibility of another administrative unit of the department, the office may assign performance of this responsibility to such a unit or make other mutually agreeable arrangements with such a unit for assisting with performance of this responsibility;

3. Training programs. Provide or assist in the provision of training programs for all persons in the field of treating alcoholics, intoxicated persons and drug abusers;

4. Rules. Adopt any rules necessary to carry out the requirements of this subchapter. Any rules shall be adopted in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375 and must be approved by the Office of Substance Abuse in accordance with Title 5, section 20005; and

5. Purposes and authority. Do other acts and exercise other powers necessary or convenient to execute and carry out the purposes and authority expressly granted in this subchapter.

§7244. Director

The office shall be administered by a director appointed under the classified service by the commissioner. The director shall be qualified by training and experience with drug abuse, or alcoholism and intoxication, or have satisfactory experience of a comparable nature in the direction, organization and administration of prevention or treatment programs for persons affected by drug abuse or drug dependency.

The director shall possess full authority and responsibility for administering all the powers and duties of the office provided in section 7243, except as otherwise provided by law. The director shall assume and discharge all responsibilities vested in the office.

The director may employ, subject to the Civil Service Law and within the limits of funds available, competent professional personnel and other staff necessary to carry out the purposes of this chapter. The director shall prescribe the duties of staff and assign a sufficient number of staff full time to the office to achieve its powers and duties. The director may arrange to house staff or assign staff who are responsible to the director and who are to provide direct service to individuals or small groups of individuals needing drug abuse treatment, to operating units of the department, which are responsible for similar functions.

§7245. Standards for public and private alcohol or drug abuse treatment facilities; enforcement procedures; penalties

1. Standards. The office shall establish standards that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged by the office for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients. The standards of treatment may include provision for special education services for any exceptional children, as defined by Title 20-A, section 7001, subsection 2, residing in a facility, under Title 20-A, chapter 303.

2. Inspection. The office periodically shall inspect and examine approved public and private treatment facilities, including books and accounts, at reasonable times and in a reasonable manner. The office may at reasonable times enter to inspect and examine any approved public or private treatment facility which the office has reasonable cause to believe is operating in violation of this subchapter.

3. List. The office shall maintain a list of approved public and private treatment facilities.

4. File. Each approved public and private treatment facility shall file with the office on request data, statistics, schedules and information the office reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules or information as requested, or files fraudulent returns of that material, shall be removed from the list of approved treatment facilities.

5. Procedures. Procedures for the amendment, modification, refusal to issue or renew, revocation or suspension of approval shall be as set forth by the Maine Administrative Procedure Act, chapter 375. In addition, the office may seek injunctive relief in the Superior Court for violation of this section.

6. Refusal of consent prohibited. No approved public or private treatment facility may refuse consent to inspection or examination under this section by the office.

PART C

Sec. 1. 5 MRSA §1664, 4th ¶, as amended by PL 1987, c. 735, §9, is further amended to read:

Part 3 shall embrace complete drafts or summaries of the budget bills, the legislative measures required to give legal sanction to the financial plan when adopted by the Legislature. These bills shall include General Fund appropriation bills and allocation bills for the following: Highway Fund, Inland Fisheries and Wildlife Fund, Federal Revenue Sharing Fund, Coastal Protection Fund, Maine Nuclear Emergency Planning Fund, Maine Endangered and Nongame Wildlife Fund~~,-Alcoholism-Prevention,-Education,-Treatment-and-Research Fund~~ and for the administrative expenses of the Bureau of Alcoholic Beverages and the State Liquor Commission, authorizing expenditures for each fiscal year of the ensuing biennium and such other bills as may be required to provide the income necessary to finance the budget.

Sec. 2. 5 MRSA §1666, as amended by PL 1987, c. 735, §10, is further amended to read:

§1666. Review and revision of estimates

The Governor-elect or the Governor, with the assistance of the State Budget Officer, shall review the budget estimates, altering, revising, increasing or decreasing the items of the estimates as may be deemed necessary in view of the needs of the various departments and agencies and the total anticipated income of the State Government during the ensuing biennium. Such review shall cover all budgets regardless of source of funds, including, but not limited to, budgets related to the Highway Fund, ~~the-Alcoholism-Prevention,-Education,-Treatment and-Research-Fund,~~ the Federal Revenue Sharing Fund, and other special revenue funds. The State Budget Officer, at the direction of the Governor-elect or the Governor shall then prepare a state budget document in the form required by law. The Governor-elect or the Governor shall be fully responsible for all budgetary recommendations made to the Legislature. The Governor shall transmit the budget document to the Legislature not later than the Friday following the first Monday in January of the first regular legislative session. A Governor-elect to his first term of office shall transmit the budget document to the Legislature not later than the Friday following the first Monday in February of the first regular legislative session.

Sec. 3. 28-A MRSA §1701, as enacted by PL 1987, c. 45, Pt. A, §4, is repealed.

Sec. 4. 28-A MRSA §1702, as enacted by PL 1987, c. 45, Pt. A, §4, is repealed.

Sec. 5. 28-A MRSA §1703, sub-§4, as enacted by PL 1987, c. 45, Pt. A, §4, is amended to read:

4. Payment to General Fund. The commission shall immediately pay all premiums it collects under this section to the Treasurer of State to be credited to the ~~fund under section 1702~~ General Fund.

Sec. 6. 28-A MRSA §1704, as enacted by PL 1987, c. 45, Pt. A, §4, is repealed.

Sec. 7. Transition. The following provisions apply to the creation of the Office of Substance Abuse and the transfer of the indicated existing state substance abuse prevention and treatment programs to the office.

1. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, all accrued expenditures, assets, liabilities, balances of appropriations, transfers, revenues or other available funds in an account or subdivision of an account of the Alcohol and Drug Planning Committee, shall be transferred to the proper accounts by the State Controller on the request of the State Budget Officer, and with the approval of the Governor.

2. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, accrued expenditures, assets, liabilities, balances of appropriations, transfers, revenues or other available funds in an account or subdivision of an account of the Department of Human Services, Office of Alcohol and Drug Abuse Prevention, shall be transferred to the proper accounts by the State Controller on the request of the State Budget Officer, and with the approval of the Governor.

3. All agreements, leases, contracts or licenses, issued under the Maine Revised Statutes, Title 22, Subtitle 4, Part 3, prior to the effective date of this Act shall continue to be valid under the terms of issuance until they expire or are rescinded, amended or revoked.

4. All rules adopted under the Maine Revised Statutes, Title 22, Subtitle 4, Part 3, Chapter 1602, sections 7228-7237 or adopted with regard to the above sections prior to the effective date of this Act shall be administered by the Office of Substance Abuse created in this Act and shall continue in effect until rescinded or amended by the office or overturned by a court of law.

5. This Act shall have no effect on the terms of appointment of members of the Maine Council on Alcohol and Drug Abuse Prevention and Treatment.

6. Employees of the Alcohol and Drug Planning Committee, the Office of Alcoholism and Drug Abuse Prevention and the Bureau of Child and Family Services who are transferred to the Office of Substance Abuse shall be subject to the provisions of this subsection.

A. The employees shall retain their accrued fringe benefits, including vacation and sick leave, health and life insurance, and retirement benefits.

B. The employees who are members of collective bargaining units on the effective date of this Act shall remain as members in their respective bargaining units and retain all rights, privileges and benefits provided by the collective bargaining agreements in the respective collective bargaining units with respect to employment in State service until October 1, 1991, while employed with the Office of Substance Abuse Services.

C. The employees who are members of collective bargaining units may remain as members of the Maine State Retirement System.

D. The Bureau of Human Resources shall assist the Office of Substance Abuse Services with the orderly implementation of these provisions.

7. The Office of Substance Abuse created in this Act and any other state agency affected by the provisions of this Act shall determine the best method of resolving any legal, fiscal, personnel or operational conflict created as a result of this Act and shall submit any necessary recommendations for statutory changes to the 1st Regular Session of the 115th Legislature for approval.

STATEMENT OF FACT

This bill is the recommendation of an interim study committee of the Joint Standing Committee on State and Local Government on the Structure of Substance Abuse Assistance and Service in the State. The bill creates substantial changes in the system of substance abuse services supported by the state funds and is divided into 3 parts as follows:

Part A establishes the Office of Substance Abuse, a new Executive Department office created to replace and extend the responsibilities currently accorded to the Alcohol and Drug Abuse Planning Committee.

Under the legislation, the departments currently involved in delivering substance abuse services would lose some of their current responsibilities. The department commissioners would act as an advisory group to the office director.

The director of the Office of Substance Abuse would be appointed by the Governor. Office responsibilities would include:

Devising a comprehensive plan for adoption according to the Maine Administrative Procedures Act;

Developing a unified budget request for all state substance abuse programs;

Approving and administering contracts awarded to community service providers for treatment of alcohol and drug abusers; and

Approval and coordination of program development by the departments.

Part B repeals Chapter 1601 which established the Alcohol and Drug Abuse Planning Committee and the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. The Maine Council is retained in its current role in Part A.

Part B also repeals the law establishing the Office of Alcohol and Drug Abuse Prevention in the Department of Human Services and enacts new provisions to govern OADAP operations. Many current OADAP functions are transferred to the office created in Part A, but OADAP is retained and would administer the Driver Education Evaluation Program (DEEP), the Alcohol and Drug Abuse Information Clearinghouse and the licensing of substance abuse treatment facilities.

Part C undedicates the Alcohol Premium Tax by directing its revenues to the General Fund. Part C also provides for the transition between the existing system and the Office of Substance Abuse.

This bill would take effect 90 days after adjournment of the Legislature.

Funding Summary FY'91 - Office of Substance Abuse Proposal

New Office	FY 91
Positions	(15)
Personnel	492,971
All Other	10,655,540
Capital Exp.	7,361
	$11,155,872

Obtained from the following sources:

	Positions	Personnel Services	
ADPC, Continual	4	161,321	
ADPC, Management Info.	**3**	**65,735**	**New Funds**
OADAP	8	265,915	
Totals	15	$492,971	

	Contract Funds
OADAP	8,150,165
DOC	391,103
DMHMR	1,737,622
Total	$10,278,890

HP/jlj/NRG263

New "Office of Substance Abuse"

Positions and Funding Requirements – FY 91

Positions	(15)
Personal Services	492,971
All Other	10,655,540 (1)
Capital	7361
Total	$ 11,155,872

(1) Of this amount, it is estimated that $10,278,890 will be available to contract/grant for substance abuse services.

Positions and Funding to be Transferred – FY 91

Positions	(12)
Personal Services	427,236
All Other	10,651,040 (1)
Capital	7,361
total	$ 11,085,637 (2)

(1) Of this amount, it is estimated that $ 10,278,890 will be available to contract/grant out for substance abuse services.

(2) In addition, the following three positions and related funding are not authorized or funded in FY 91. These positions relate to the Management Information System and will require a General Fund appropriation in FY 91.

	FY 91
Positions	(3)
- Data Control Specialist	
- Data Control Clerk	
- Clerk Typist II	
Personal Services	65,735
All Other	4,500
total	$ 70,235

Identified Positions to be transferred to the new "Office of Substance Abuse" from the Office of Alcoholism and Drug Abuse Prevention.

- Substance Abuse Diversion Supervisor
- Substance Abuse Program Specialist
- Drug & Alcohol Research Analyst
- Alcohol Reg. Planning Coordinator
- Social Services Prog. Specialist I
- Data Entry Operator
- Clerk Typist III
- Clerk Typist II

Estimated amount of funds to be made available to transfer from OADAP.

	FY 91
Positions	(8)
Personal Services	265,915
All Other	8350,165
total	$ 8,616,080

Office of Alcoholism and Drug Abuse Prevention

FY 91

General Fund – 01325.5

Positions	(13)
Personal Services	430,741
All Other	2,210,100
Capital	1,089
Total	2,641,930

Dedicated Funds – 04325.7

All Other	3,029,244

Block Grant Funds – 09325.5

Positions	(5)
Personal Services	171,265
All Other	3,298,448
Total	$ 3,469,713

Summary - All Funds
Office of Alcoholism and Drug Abuse Prevention

	FY 91
Positions	(18)
Personal Services	602,006
All Other	8,537,792
Capital	1,089
total	9,140,887

Transfer to new "Office of Substance Abuse" from OADAP

Positions	(-8)
Personal Services	(265,915)
All Other	
- funds for contracts/grants	(8,150,165) (1)
- operating funds	(200,000) (2)
	($8,616,080)

Funds Remaining - OADAP Operations — FY 91

Positions	(10)
Personal Services	$ 336,091
All Other	187,627
Capital	1,089
Total	$ 524,807

Estimated Funds to be transferred from the Department of Corrections which will be available to contract/grant out for substance abuse services.

	FY 91
All Other	$ 391,103

Estimated Funds to be transferred from the Department of Mental Health and Mental Retardation which will be available to contract/grant out for substance abuse services.

	FY 91
All Other	$ 1,737,622

APPENDIX C.

Legislative History of Alcohol and Drug Abuse Prevention Programs in Maine

Recent legislative history of alcohol and drug abuse prevention programs in Maine.[1]

The Legislature's involvement in alcohol and drug abuse prevention dates back to 1949, when the 94th Legislature created the Liquor Research Commission for the purpose of studying the impacts of alcohol consumption in Maine.[2] Two years later, in 1951, the Liquor Research Commission recommended to the 95th Legislature that the state increase its education efforts and that further study of guidance centers in other states be undertaken. The Legislature responded promptly by appropriating $25,000 to the Commission for the establishment of educational centers.[3]

The Liquor Research Commission, however, was destined to be short lived. In 1953 the Legislature repealed its statutory authorization, and instead authorized the predecessor of the Department of Human Services to assume the Commission's responsibilities. At the same time, the Legislature created an Advisory Committee on Alcohol.[4]

Between 1953 and 1970, very little additional Legislative activity relative to alcohol and drug abuse prevention was undertaken. In 1961, a commitment law was enacted[5] which allowed individuals suffering from alcohol and drug abuse problems to be committed for up to 90 days at any hospital, and in 1963 the Legislature appropriated small amounts of money to the Department of Health and Welfare to pay for an alcohol counselor within the court system.[6]

In 1970, however, Congressional enactment of the Hughes Act stimulated increased activity at the state level. In response to the Hughes Act's requirement that states' establish a single agency to administer alcohol and drug abuse prevention programs prior to receiving federal alcohol abuse prevention grants, the Legislature established the Maine Commission on Drug Abuse.[7] Two years later, in 1973, the Office of Alcohol and Drug Abuse Prevention (OADAP) was created.[8] OADAP was given full authority for funding decisions and charged with establishing the state's prevention, education and treatment strategy.

OADAP functioned as the sole agency responsible for alcohol and drug abuse prevention programs until 1981, when the Legislature stripped OADAP of its administrative role, created the Alcohol Premium Fund, and allocated money from the premium fund directly to the Departments of Human Services, Mental Health & Corrections, and Education.[9]

In 1982, a Joint Select Committee on Alcoholism Services undertook a study of means to enhance and improve the effectiveness of alcoholism services. In its report, the Committee found, generally, that OADAP's administrative and advisory role was not working and recommended the creation of a small alcohol and drug abuse planning agency that would function separate from the four departments. In 1983, the Legislature responded to those recommendations by creating the Alcohol and Drug Abuse Planning Committee (ADPC).[10]

The substance abuse prevention service delivery system in Maine has remained essentially the same since the creation of the ADPC in 1983, although, in 1988, the Legislature installed the Commissioner of Public Safety as a member and chair of the Committee.[11] Also in 1988, a Subcommittee of the Joint Standing Committee on Appropriations conducted a study on the methods by which the state funded alcoholism and substance abuse programs. The subcommittee made several recommendations, including the creation of an Executive Office of Substance Abuse Services.

Notes:

1. Derived in part from the Maine Association of Regional Council's recommendations to the Subcommittee studying substance abuse assistance and service in Maine. (undated).
2. Private and Special Laws, 1949, c.213.
3. Private and Special Laws, 1951, c.218.
4. Public Laws, 1953, c.270.
5. Public Laws, 1961, c.212.
6. Private and Special Laws, 1963, c.230.
7. Public Laws, 1971, c.379.
8. Public Laws, 1973, c.566.
9. Public Laws, 1981, c.454.
10. Public Laws, 1983, c.464.
11. Public Laws, 1987, c.584.

APPENDIX D.

ALLOCATIONS AND APPROPRIATION FOR FISCAL YEARS 1988-91

SUBSTANCE ABUSE SUBCOMMITTEE

FY 88 - FY 91 SUMMARY

	Contract/Grants	%	Dir. Client Svc. Exp.	%	Program Support	%	Total
All Funds - FY '88							
	$		$		$ 214,202	100.0	$ 214,202
+ ADPC	612,554	80.8	56,067	7.4	89,647	11.8	758,268
+ DOC	774,282	37.8	735,434	35.9	536,479	26.3	2,046,195
+ DECS	7,111,974	83.8	484,854	5.7	894,468	10.5	8,491,296
+ DHS	809,000	93.0			61,256	7.0	870,256
+ DMHMR							
TOTAL	$ 9,307,810	75.2	$ 1,276,355	10.3	$ 1,796,052	14.5	$ 12,380,217
All Funds - FY '89							
	$		$		$ 334,879	100	$ 334,879
+ ADPC	746,238	85	25,472	3	107,864	12	879,574
+ DOC	889,829	38	1,080,931	47	346,989	15	2,317,749
+ DECS	7,191,967	82	752,669	9	809,168	9	8,753,804
+ DHS	766,612	91			73,468	9	840,080
+ DMHMR							
TOTAL	$ 9,594,646	73	$ 1,859,072	14	$ 1,672,368	13	$ 13,126,086
All Funds - FY '90							
	$		$		$ 455,254	100	$ 455,254
+ ADPC	593,156	69	145,065	17	117,201	14	855,422
+ DOC	1,312,366	47	1,094,424	39	402,847	14	2,809,637
+ DECS	8,473,535	84	792,777	8	861,676	8	10,127,988
+ DHS	907,069	92			76,511	8	983,580
+ DMHMR							
TOTAL	$ 11,286,126	74	$ 2,032,266	13	$ 1,913,489	13	$ 15,231,881
All Funds - FY '91							
+ ADPC	$		$		$ 476,615	100	$ 476,615
+ DOC	590,742	80	25,432	3	119,615	16	735,789
+ DECS			1,115,810	76	350,822	24	1,466,632
+ DHS	8,517,935	83	829,970	8	874,557	9	10,222,462
+ DMHMR	1,036,413	93			79,766	7	1,116,179
TOTAL	$ 10,145,090	72	$ 1,971,212	14	$ 1,901,375	14	$ 14,017,677

SUBSTANCE ABUSE SUBCOMMITTEE*

FY 88
(Budget)

	Contract/Grants	%	Dir. Client Svc. Exp.	%	Program Support	%	Total
Alcohol Prem. Fund							
+ ADPC	$		$		$ 91,700	100.0	$ 91,700
+ DOC	370,284	71.8	56,067	10.9	89,362	17.3	515,713
+ DECS			644,893	60.4	423,157	39.6	1,068,050
+ DHS	2,884,877	99.9			177	0.1	2,885,054
+ DMHMR	756,000	93.4			53,546	6.6	809,546
Subtotal	$ 4,011,161	74.7	$ 700,960	13.1	$ 657,942	12.2	$ 5,370,063
General Fund							
+ ADPC	$		$		$ 50,733	100.0	$ 50,733
+ DOC	186,618	100.0					186,618
+ DECS	35,000	23.6	32,219	21.7	81,288	54.7	148,507
+ DHS	2,332,695	90.3	14,833	0.7	223,544	9.0	2,471,244
+ DMHMR	53,000	87.3			7,710	12.7	60,710
Subtotal	$ 2,507,485	85.9	$ 47,052	1.6	$ 363,275	12.5	$ 2,917,812
Fed. Bl. Grnt							
+ ADPC	$		$		$ 71,769	100.0	$ 71,769
+ DOC	55,652	99.5			285	0.5	55,937
+ DECS	739,282	89.1	58,322	7.0	32,034	3.9	829,638
+ DHS	1,620,730	75.9	127,039	5.9	388,270	18.2	2,136,039
+ DMHMR							
Subtotal	$ 2,415,664	78.1	$ 185,361	6.0	$ 492,358	15.9	$ 3,093,383
DEEP							
+ DHS	$ 373,500	37.4	$ 342,982	34.3	$ 282,477	28.3	$ 998,959
Subtotal	$ 373,500	37.4	$ 342,982	34.3	$ 282,477	28.3	$ 998,959
All Funds							
+ ADPC	$		$		$ 214,202	100.0	$ 214,202
+ DOC	612,554	80.8	56,067	7.4	89,647	11.8	758,268
+ DECS	774,282	37.8	735,434	35.9	536,479	26.3	2,046,195
+ DHS	7,111,974	83.8	484,854	5.7	894,468	10.5	8,491,296
+ DMHMR	809,000	93.0			61,256	7.0	870,256
TOTAL	$ 9,307,810	75.2	$ 1,276,355	10.3	$ 1,796,052	14.5	$ 12,380,217

*Data Provided by Office of Fiscal and Program Review

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SUBSTANCE ABUSE SUBCOMMITTEE*

FY 89
(Budget)

	Contract/Grants	%	Dir. Client Svc. Exp.	%	Program Support	%	Total
Alcohol Prem. Fund							
+ ADPC	$		$		$ 221,364	100	$ 221,364
+ DOC	425,783	78	25,472	5	96,427	17	547,682
+ DECS	12,106	1	953,922	81	215,665	18	1,181,693
+ DHS	3,051,598	100					3,051,598
+ DMHMR	766,612	91			73,468	9	840,080
Subtotal	$ 4,256,099	73	$ 979,394	17	$ 606,924	10	$ 5,842,417
General Fund							
+ ADPC	$		$		$ 50,359	100	$ 50,359
+ DOC	173,704	94			11,437	6	185,141
+ DECS	5,120	4	41,251	29	96,185	67	142,556
+ DHS	2,174,280	89	36,617	1	239,632	10	2,450,529
+ DMHMR							
Subtotal	$ 2,353,104	83	$ 77,868	3	$ 397,613	14	$ 2,828,585
Fed. Bl. Grnt							
+ ADPC	$				$ 63,156	100	$ 63,156
+ DOC	146,751	100					146,751
+ DECS	872,603	88	85,758	9	35,139	3	993,500
+ DHS	1,756,489	73	288,051	12	365,321	15	2,409,861
+ DMHMR							
Subtotal	$ 2,775,843	77	$ 373,809	10	$ 463,616	13	$ 3,613,268
DEEP							
+ DHS	$ 209,600	25	$ 428,001	51	$ 204,215	24	$ 841,816
Subtotal	$ 209,600		$ 428,001		$ $204,215		$ 841,816
All Funds							
+ ADPC	$		$		$ 334,879	100	$ 334,879
+ DOC	746,238	85	25,472	3	107,864	12	879,574
+ DECS	889,829	38	1,080,931	47	346,989	15	2,317,749
+ DHS	7,191,967	82	752,669	9	809,168	9	8,753,804
+ DMHMR	766,612	91			73,468	9	840,080
TOTAL	$ 9,594,646	73	$ 1,859,072	14	$ 1,672,368	13	$ 13,126,086

*Data Provided by the Agencies and Compiled by Office of Policy and Legal Analysis

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SUBSTANCE ABUSE SUBCOMMITTEE*

FY 90
(Budget)

	Contract/Grants	%	Dir. Client Svc. Exp.	%	Program Support	%	Total
Alcohol Prem. Fund							
+ ADPC	$		$		$ 243,743	100	$ 243,743
+ DOC	414,241	76	25,432	5	105,764	19	545,437
+ DECS			961,229	79	261,328	21	1,222,557
+ DHS	3,029,244	100					3,029,244
+ DMHMR	763,569	91			76,511	9	840,080
Subtotal	$ 4,207,054	71	$ 986,661	17	$ 687,346	12	$ 5,881,061
General Fund							
+ ADPC	$		$		$ 123,140	100	$ 123,140
+ DOC	178,915	94			11,437	6	190,352
+ DECS	1,240	1	35,282	28	91,153	71	127,675
+ DHS	1,957,055	78	38,807	2	508,199	20	2,504,061
+ DMHMR	118,600	100					118,600
Subtotal	$ 2,255,810	74	$ 74,089	2	$ 733,929	24	$ 3,063,828
Fed. Bl. Grnt							
+ ADPC	$		$		$ 88,371	100	$ 88,371
+ DOC			119,633	100			119,633
+ DECS	1,311,126	90	97,913	7	50,366	3	1,459,405
+ DHS	3,205,473	90	246,175	7	119,500	3	3,571,148
+ DMHMR	24,900	100					24,900
Subtotal	$ 4,541,499	86	$ 463,721	9	$ 258,237	5	$ 5,263,457
DEEP							
+ DHS	$ 281,763	27	$ 507,795	50	$ 233,977	23	$ 1,023,535
Subtotal	$ 281,763	27	$ 507,795	50	$ 233,977	23	$ 1,023,535
All Funds							
+ ADPC	$		$		$ 455,254	100	$ 455,254
+ DOC	593,156	69	145,065	17	117,201	14	855,422
+ DECS	1,312,366	47	1,094,424	39	402,847	14	2,809,637
+ DHS	8,473,535	84	792,777	8	861,676	8	10,127,988
+ DMHMR	907,069	92			76,511	8	983,580
TOTAL	$ 11,286,126	74	$ 2,032,266	13	$ 1,913,489	13	$ 15,231,881

*Data Provided by the Agencies and Compiled by Office of Policy and Legal Analysis

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SUBSTANCE ABUSE SUBCOMMITTEE*

FY 91
(Budget)

	Contract/Grants	%	Dir. Client Svc. Exp.	%	Program Support	%	Total
Alcohol Prem. Fund							
+ ADPC	$		$		$ 243,743	100	$ 243,743
+ DOC	411,827	75	25,432	5	108,178	20	545,437
+ DECS			973,104	80	241,453	20	1,214,557
+ DHS	3,029,244	100					3,029,244
+ DMHMR	760,313	9			79,766	9	840,079
Subtotal	$ 4,201,384	72	$ 998,536	17	$ 673,140	11	$ 5,873,060
General Fund							
+ ADPC	$		$		$ 141,076	100	$ 141,076
+ DOC	178,915	94			11,437	6	190,352
+ DECS			37,202	28	96,287	72	133,489
+ DHS	2,088,053	79	42,198	2	511,679	19	2,641,930
+ DMHMR	276,100	100					276,100
Subtotal	$ 2,543,068	75	$ 79,400	2	$ 760,479	22	$ 3,382,947
Fed. Bl. Grnt							
+ ADPC	$		$		$ 91,796	100	$ 91,796
+ DOC							
+ DECS			105,504	89	13,082	11	118,586
+ DHS	3,098,048	89	255,658	7	120,007	4	3,473,713
+ DMHMR							
Subtotal	$ 3,098,048	84	$ 361,162	10	$ 224,885	6	$ 3,684,095
DEEP							
+ DHS	$ 302,590	28	$ 532,114	49	$ 242,871	23	$ 1,077,575
Subtotal	$ 302,590	28	$ 532,114	49	$ 242,871	23	$ 1,077,575
All Funds							
+ ADPC	$		$		$ 476,615	100	$ 476,615
+ DOC	590,742	80	25,432	3	119,615	16	735,789
+ DECS			1,115,810	76	350,822	24	1,466,632
+ DHS	8,517,935	83	829,970	8	874,557	9	10,222,462
+ DMHMR	1,036,413	93			79,766	7	1,116,179
TOTAL	$ 10,145,090	72	$ 1,971,212	14	$ 1,901,375	14	$ 14,017,677

*Data Provided by the Agencies and Compiled by Office of Policy and Legal Analysis

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APPENDIX E.

SUMMARY OF REPORTED ALCOHOL AND DRUG ABUSE TREATMENT OUTLAYS IN MAINE

ARTHA E. FREEMAN, DIRECTOR
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BRET A. PRESTON, RES. ASST.

STATE OF MAINE
OFFICE OF POLICY AND LEGAL ANALYSIS
ROOM 101/107/135
STATE HOUSE STATION 13
AUGUSTA, MAINE 04333

November 1, 1989

TO: Members, Substance Abuse Assistance Committee

FROM: Patrick Norton, Legislative Analyst

RE: Summary of most recently reported alcohol and drug abuse treatment outlays in Maine.

I have reviewed information on alcohol and drug abuse treatment costs collected from the Alcohol and Drug Abuse Planning Committee (ADPC), the Bureau of Insurance, the Office of Alcohol and Drug Abuse Prevention (OADAP), and the Division of Medicaid Policy and Programs. The information received from each of those agencies is summarized and presented in the attached table. Except for the Bureau of Insurance, as noted below, the agency budget information presented here is for the 1989 Fiscal Year.

The most recent information available from the Bureau of Insurance for alcohol and drug dependency treatment expenditures by insurance companies, non-profit hospitals and medical service providers was for calender year 1988. By statute (24-A MRSA §2842) those providers of substance abuse treatment compensation are required to report alcohol and drug abuse treatment expenditures by calender year, rather than fiscal year.

The Committee should be aware that the costs itemized in the attached table probably represent a low-end estimate of the actual total annual costs for alcohol and drug abuse treatment. The factors contributing to this include:

A. **Lack of comprehensive information on out-of-pocket client costs.** Although some information on out-of-pocket client costs was reported to OADAP, those only represented payments from clients served by the 21 contracts reviewed.

If more comprehensive information on client out-of-pocket expenses were available, including treatment costs paid for privately and insurance deductibles, the estimate of total annual treatment costs could increase substantially.

B. **Incomplete reporting of alcohol and drug abuse insurance claims.** The Bureau of Insurance has estimated that insurance companies reporting expenditures for alcohol and drug dependency claims for 1986 and 1987 represented between 85-90% of the volume, in dollars, of the statewide health insurance business. Since fewer companies reported for calender year 1988 than 1986, it is reasonable to assume that the estimate presented here for insurance payments during 1988 is roughly 10-15% lower than it would be if all companies reported.

C. **Reporting of alcohol or drug related treatment as other types of treatment.** It is likely that some alcohol, drug abuse, and mental health related treatment claims are filed as general medical claims rather than as claims for various types of substance abuse treatment, due to either the social stigma attached to alcohol or drug treatment or for reasons of anonymity. To the extent that this occurs, those alcohol and drug abuse treatment costs would not be reflected in the insurance and Medicaid reported substance abuse treatment expenditures.

Thank you. I hope this information is useful, and I look forward to working with you.

SUMMARY OF THE MOST RECENTLY REPORTED 12 MONTH
OUTLAYS FOR SUBSTANCE ABUSE COMPENSATION IN MAINE

Reporting Agency	Outlays ($)	Percent of Reporting Agency Outlays	Percent of Total Outlays
ADPC[a]			
ADPC	$334,879	2.6%	1.6%
DOC	879,574	6.7	4.2
DECS	2,317,749	17.7	11.0
DHS	8,753,804	66.7	41.6
DMHMR	840,080	6.4	4.0
Subtotal	$13,126,086	100.0%	**62.3%**
BUREAU OF INSURANCE[b]			
Inpatient	$5,414,341	87.8%	25.7%
Outpatient	749,890	12.2	3.6
Subtotal	$6,164,231	100.0%	**29.3%**
OADAP[c]			
Mun. Gov't[d]	$338,944	33.4%	1.6%
United Way	78,829	7.8	0.4
Client[e]	595,009	58.8	2.8
Subtotal	$1,012,782	100.0%	**4.8%**
MEDICAID[f]	$749,648	100.0%	**3.6%**
TOTAL[g]	**$21,052,747**	**100.0%**	**100.0%**

See next page for footnotes.

Footnotes for previous table.

(a). Alcohol and Drug Abuse Planning Committee. Data provided by the agencies and compiled by OPLA. Figures listed are for FY'89 and include allocations for contracts/grants, direct services and program support. For FY'89, program support was 13% of total ADPC costs.
(b). Department of Professional and Financial Regulation, Bureau of Insurance. Calender year 1988 outlays for alcoholism and drug depency claims as reported by 56 Maine insurance companies, non-profit hospitals and medical service organizations pursuant to 24 MRSA §2329, sub-§(9).
(c). Office of Alcohol and Drug Abuse Prevention, Department of Human Services. FY'89 costs for the 21 alcoholism and drug abuse treatment providers under contract with DHS who received any municipal assistance or medicaid payments.
(d). Municipal government receipts include General Assistance and other direct assistance payments from local government.
(e). Client payments represent private, non-insurance compensated payments to providers by clients as reported to OADAP.
(f). FY'89 medicaid payments as reported by the Division of Medicaid Policy and Programs, Department of Human Services.
(g). This total does not include out of pocket client costs for unsubsidized treatment, outlays by insurance companies who have not reported to the Bureau of Insurance, insurance payments for employee group insurance contracts with 20 or fewer employees, or other small contributing sources such as Medicare, Veteran's Administration, HUD, and Food Stamps.

APPENDIX F.

PROGRAMS OF THE ADPC DEPARTMENTS

PROGRAMS OF THE ADPC DEPARTMENTS

Department of Education and Cultural Services

K-8 Elementary Initiative
Curriculum Training
Policy and Procedures Development
Sports Initiative
Highway Safety Program
Safe Community Project
Project Graduation
Student Assistance Team
Refusal Skills
School/Community Team Development
School/Community Team Training
School/Community Team Maintenance
Resource Materials Center
Manage Governor's portion of Drug Free Schools Grant (pilot projects in Skowhegan and Saco)

Department of Human Services

Information Dissemination

Statewide conference of peer counseling programs.
Information, education and training to students and personnel in 3 schools.

Produce & distribute Clearinghouse Exchange newsletter.
Response to requests for information.
Technical assistance in information use.
Fund public awareness speakers, education and seminars.
Concerned Citizen Councils.

Education

Assured juveniles convicted of OUI received education through Chemical Alternatives Program.

Training for trainers workshop.
Prevention education in schools and Big Brothers/Sisters.
Health promotion.
Model prevention program funding.
Fund annual Prevention Conference.
Fund New England Summer School of Alcohol Studies.
Provide education to DEEP participants.

Training

School personnel training.
Funded skill development training.
Fund and manage workshops on substance abuse related topics.

Alternatives to alcohol and drug use

Funds for peer priority newsletter and volunteer youth sponsors program.

Native American fitness program, intertribal youth conference and cultural awareness project.

DHS continued:

Screening/Referral
Outpatient counseling/treatment contracts include screening and referral component.

Identification and referral of students in Auburn program. Provide initial screening for DEEP program.

Outpatient Counseling/Treatment
Funds for education and counseling in non-categorical group homes for adolescents.

Purchase outpatient counseling and treatment services. Children of Alcoholics support group.

Detoxification
Contract for free-standing detoxification services.

Rehabilitation
Contract for free-standing residential rehabilitation services.

Contract for hospital residential rehabilitation. Fund partial day rehabilitation services.

Transitional Residential Accommodations
Contract for halfway house services.

Life Maintenance
Contract for extended care, emergency and shelter services.

Department of Mental Health and Mental Retardation

Information
funds programs to disseminate information on alcohol related birth defects;

Training
trains health care providers in diagnosis of alcohol related birth defects;

trains child care, mental health and alcohol treatment providers in dual diagnosis;

Screening/Referral
funds home-based screening and referral services;

Treatment
together with DOC purchases short-term intensive home-based family counseling and treatment; and

purchases services for dual-diagnosed clients at state psychiatric institutions.

Department of Corrections

The department:

Education

Supports Project CRY;

Treatment

Contracts with facilitators for 10 hours of instruction for each individual (mostly DEEP) going through the Chemical Alternatives Program;

Cooperates with DMHMR to purchase short-term intensive home-based family counseling and treatment;

Purchases counseling and treatment for juvenile offenders under supervision of Probation and Parole;

Cooperates with DMHMR to provide screening and counseling services at Androscoggin, Franklin and Kennebec County jails;

Purchases services for juvenile offenders at Maine Youth Center;

Purchases necessary emergency alcohol treatment services; and

Contracts for halfway house services for adult male offenders.

APPENDIX G.

SUMMARY OF FY'88 ALCOHOLISM PREVENTION, EDUCATION, TREATMENT AND RESEARCH FUND PROGRESS REPORT

October 18, 1989

To: Members, Study of Structure of Substance Abuse Assistance & Services in the State

From: Patrick Norton, Legislative Analyst
Hartley Palleschi, Legislative Analyst

RE: Summary of the FY'88 "Alcoholism Prevention, Education, Treatment and Research Fund" Progress Report.

We have reviewed the Alcohol and Drug Abuse Planning Committee's FY'88 Progress Report. The report includes information on direct services provided, numbers of clients served, actual FY'88 expenditures, and FY'89 budgets for substance abuse related programs offered through the Department of Corrections (DOC), the Department of Educational and Cultural Services (DECS), the Department of Human Services (DHS) and the Department of Mental Health and Mental Retardation (DMHMR).

The attached summary sheet presents tabulations of total FY'88 expenditures and clients served for each of the Program/Service areas included in the report. We have included a third column which indicates the percentage of the total substance abuse expenditure for each category of substance abuse service. The Planning Committee's report did not include any information on the benefits or effectiveness of programs.

A SUMMARY OF THE ALCOHOL AND DRUG ABUSE PLANNING COMMITTEE'S FY'88 PROGRESS REPORT.[1]

PROGRAM/SERVICE AREA[2]	AGENCY	FY'88 CLIENTS[3]	FY'88 COSTS($)[4]	% of FY '88 COSTS
A. ADULTS ONLY.				
Life Maintenance	DHS	2,096	$486,925	5
Detoxification	DHS	1,381	$574,221	6
Transitional Resid.	DHS	339	$810,649	8
	DOC	38	$57,586	
Subtotal (Adults Only)			$1,929,381	
B. ADOLESCENTS ONLY.				
Alternatives	DHS	1,113	$19,007	<1
C. ADULTS & ADOLESCENTS.				
Info. Dissemination	DECS	n/a	$2,076,716	25
	DHS	863	$347,927	
	DMHMR	n/a	$17,000	
Education	DECS	1,053	n/a	2
	DHS	n/a	$103,488	
	DOC	1,190	$43,706	
Training	DECS	n/a	$47,300	1
	DHS	980	$34,085	
	DMHMR	1,920	$44,057	
	DOC	41	$3,899	
Screening/Referral	DHS	8,196	$237,500	5
	DMHMR	259	$223,000	
	DOC	2,360	$37,204	
Outpatient Counseling	DHS	4,973	$2,717,664	40
	DMHMR	1,446	$396,749	
	DOC	2,266	$534,776	
Rehabilitation	DHS	1,413	$764,906	8
	DOC	39	$32,413	
Subtotal (Ad.& Adol.)			$7,662,390	
TOTAL			$9,610,778	

FOOTNOTES ON NEXT PAGE

(1). All data taken from Alcoholism Prevention, Education, Treatment and Research Fund: FY'88 Progress Report, Alcohol and Drug Abuse Planning Committee, January 1989.
(2). The Program/Services listed are from the Planning Committee Progress Report. Three of the Program areas in the Progress Report appear only under the "Adult Program/Services" category; and one appears only under the "Adolescent Program/Services" category. The remaining six program areas have both Adult and Adolescent clients. For purposes of simplification, clients served and expenditures from both the Adult and Adolescent portions of the Report have been combined.
(3). Numbers of clients served are presented here only when the Progress Reports lists the number of individuals served. Some programs had no numbers, others listed hours provided, classes given, etc. as benefits. Where no specific number of individuals served was available, an "n/a" was used in this tabulation.
(4). These figures represent dollar amounts listed in the report as expended in FY'88 for each specific program/service.

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APPENDIX H.

CONTRACTS WITH COMMUNITY SERVICE PROVIDERS IN FY'90

ADRC 11/7/89

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBLE NOW
Region I			
SOUTHERN REGIONAL COUNCIL	78,500	Public Awareness	DHS
SOUTHERN REGIONAL COUNCIL	1,000	FAS-FAE Training, Public Information	DMHMR
BATH/BRUNSWICK MENTAL HEALTH	149,988	Homebased Care	DMHMR[3]
BATH MEMORIAL HOSPITAL*	223,600	Rehabilitation	DHS
BATH MEMORIAL HOSPITAL*	161,900	Outpatient	DHS
BATH MEMORIAL HOSPITAL	8,400	P/P (Alcohol Counseling/ Treatment)	DOC
CHOICE/SKYWARD	439,300	Outpatient	DHS
C.L.I.M.E.	14,500	Reporter/Recorder Dual Diagnosis Initiative	DMHMR
SERENITY HOUSE	191,886	Halfway House	DHS[2]
COMMUNITY HEALTH SERVICES	12,000	Pregnant/Parenting or At Risk Teenager & Substance Abuse. Training, information dissemination, individual consultations	DMHMR
COMMUNITY SCHOOL	69,700	Residential Care	DHS[2]
ARNIE HANSON CENTER - DHRS	306,900	Shelter/Detox	DHS
CAS PORTLAND - DHRS	276,100	Outpatient	DHS
EVODIA HOUSE - DHRS	209,500	Halfway House	DHS
DAY ONE	300,800	6 Month Rehab.	DHS
DAY ONE	90,688	Anti-Drug Intervention Program (MYC)	DOC
DAY ONE	20,000	Homeless Children's Project	DMHMR

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBLE NOW
Region I (cont'd)			
YORK COUNTY COUNSELING*	264,700	Outpatient	DHS
YORK COUNTY COUNSELING*	15,900	Rural Health Centers - Outpatient	DHS
YORK COUNTY COUNSELING	12,000	Treatment and Evaluation Services	DOC
YORK HOSPITAL	30,500	Outpatient/Non-Residential Rehab.	DHS

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBL NOW
Region II			
WESTERN REGIONAL COUNCIL	51,500	Public Awareness	DHS
WESTERN REGIONAL COUNCIL	1,000	FAS-FAE Training, Public Information	DMHMR
ST. FRANCIS HOUSE - DHRS	436,925	Halfway House/Detox	DHS[2]
FREEDOM COUNSELING SERVICES	5,000	P/P (Alcohol Treatment and Evaluation)	DOC
KENNEBEC VALLEY REGIONAL HEALTH	86,600	Outpatient - Rural	DHS
KENNEBEC VALLEY REGIONAL HEALTH	87,549	Kennebec Cty/Franklin Cty Jail Pre-Sentence Evaluation, Screenings Individual, Group and Family Counseling, Community Networking	DOC[4]
NEW BEGINNINGS	[1]25,000	Residential Care	DHS
TRI-COUNTY COUNSELING	177,003	Homebased Care	DMHMR[3]
TRI-COUNTY COUNSELING*	120,800	Outpatient	DHS
TRI-COUNTY COUNSELING*	47,500	Outpatient - Elderly	DHS
TRI-COUNTY COUNSELING*	15,900	Outpatient - Rural	DHS
TRI-COUNTY COUNSELING	84,200	Androscoggin/Oxford County Jail Pre-Sentence Screenings, Individual, Group and Family Counseling, Community Networking	DOC[4]
YWCA INTERVENTION	70,000	Outpatient/Prevention	DHS

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBI NOW
Region III			
KENNEBEC-SOMERSET REG. COUNCIL	45,900	Prevention	DHS
KENNEBEC-SOMERSET REG. COUNCIL	1,000	FAS-FAE Training, Public Information	DMHMR
CRISIS & COUNSELING CENTERS	176,200	Outpatient	DHS
CRISIS & COUNSELING CENTERS	6,802	P/P (Alcohol Treatment & Evaluation)	DOC
CRISIS & COUNSELING CENTERS	208,049	Substance Abuse Assessment and counselors services at AMHI, counseling, shelter linkage capacity in Augusta, Portland and York County.	DMHMR
KENNEBEC VALLEY REGIONAL HEALTH	16,624	CMPRC - Alcoholism Counseling/ Treatment	DOC
NEW DIRECTIONS - KVRHA	348,100	Outpatient	DHS
MID-MAINE MEDICAL CEANTER	30,500	Non-Residential Rehab.	DHS
MOTIVATIONAL SERVICES, INC.	23,760	Support, Linkage, Group Family Care Home	DMHMR
YOUTH AND FAMILY SERVICES	72,600	Outpatient	DHS
YOUTH AND FAMILY SERVICES	159,600	Homebased Care	DMHMR[3]
HEARTHSIDE - KVRHA	100,700	Extended Care	DHS

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBLE NOW
Region IV			
EASTERN REGIONAL COUNCIL	53,300	Prevention	DHS
EASTERN REGIONAL COUNCIL	1,000	FAS-FAE Training, Public Information	DMHMR
AFFILIATED CHEMICAL DEPENDENCY SERVICES	31,164	Fetal Alcohol Syndrome & Fetal Alcohol Effects Prevention. Prevention of FAS/FAE through education to physicians, schools, pre-school projects & public via media. Assists in FAS screening assessments at EMMC. Connects FAS/FAE individuals with existing services.	DMHMR
AFFILIATED CHEMICAL DEPENDENCY SERVICES	65,100	Substance Abuse Assessment and Counseling Service at BMHI	DMHMR
AFFILIATED CHEMICAL DEPENDENCY SERVICES	31,164	FADE Project	DMHMR
AFFILIATED CHEMICAL DEPENDENCY SERVICES	39,437	Alcohol Counseling/Treatment (CCF/BPRC)	DOC
AFFILIATED CHEMICAL DEPENDENCY SERVICES	38,829	Anti-Drug Intervention Program (CCF)	DOC
AFFILIATED CHEMICAL DEPENDENCY SERVICES	85,391	Alcohol Counseling/Treatment (MSP)	DOC
BLUE HILL MEMORIAL HOSPITAL	14,400	Outpatient	DHS
CENTRAL MAINE INDIAN ASSOC.	42,500	Outpatient	DHS
COMMUNITY HEALTH & COUNSELING*	42,300	Outpatient	DHS
COMMUNITY HEALTH & COUNSELING*	116,300	Outpatient	DHS
COMMUNITY HEALTH & COUNSELING	23,335	"Hands On" case management to address community linkage/ substance addiction, mental	DMHMR

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBLE NOW
Region IV (cont'd)			
DOWNEAST HOSPITAL	32,700	Outpatient	DHS
DOWNEAST HOSPITAL	4,725	P/P (alcohol counseling treatment)	DOC
FAMILIES UNITED OF WASHINGTON COUNTY	232,012	Homebased Services. Time-limited family therapy in home to families because of alcoholism or substance abuse.	DMHMR[3]
HOPE HOUSE	402,600	Shelter/detox	DHS
MAYO REGIONAL HOSPITAL*	14,500	Outpatient	DHS
MAYO REGIONAL HOSPITAL*	39,000	Outpatient	DHS
MOUNT DESERT ISLAND HOSPITAL	14,400	Outpatient	DHS
NORTHEAST SUBSTANCE ABUSE SERVICES	11,000	P/P (Rural Alcohol Treatment)	DOC
PASSAMAQUODDY INDIAN TOWNSHIP	33,000	Outpatient	DHS
PENOBSCOT INDIAN NATION	55,700	Prevention	DHS
PLEASANT POINT INDIAN HEALTH	29,200	Prevention	DHS
PROJECT ATRIUM	12,300	Residential Care	DHS
PROJECT ATRIUM	33,224	Residential Care	DOC
ST. MICHAEL'S CENTER	247,810	Homebased Services. Time-limited family therapy deliveredin home to prevent dissolution of families becasue of alcoholism or drug abuse.	DMHMR[3]
WASHINGTON COUNTY PSYCHO-THERAPY ASSOCIATES	27,756	Anti-Drug Intervention Program (DECF)	DOC

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBLE NOW
Region IV (cont'd)			
WASHINGTON COUNTY PSYCHO-THERAPY ASSOCIATES	33,843	Alcohol Services (DECF)	DOC
WCCAS/CAS	16,000	Alcohol Treatment & Evaluation	DOC
WELLSPRING, INC.	31,500	Project Rebound (Adolescent Unit)	DOC
WELLSPRING, INC.	10,000	Community substance abuse prevention services for previously institutionalized (BMHI) individuals.	DMHMR
WELLSPRING, INC.	23,000	Substance abuse counseling, community linkage and referral. Supervision of developmental tutors.	DMHMR
WELLSPRING, INC.*	342,200	Outpatient (Regular Service)	DHS
WELLSPRING, INC.*	162,400	Adolscent Rehabilitation	DHS
WELLSPRING, INC.*	31,100	Rural Outpatient	DHS
LUBEC RURAL HEALTH	25,000	Outpatient	DHS

AGENCY	CONTRACT AMOUNT	SERVICE	RESPONSIBLE NOW
Region V			
AROOSTOOK REGIONAL COUNCIL	40,200	Prevention	DHS
AROOSTOOK REGIONAL COUNCIL	1,000	FAS-FAE Training, Public Information	DMHMR
AROOSTOOK MENTAL HEALTH CENTER	146,445	Homebased Services	DMHMR[3]
AROOSTOOK MENTAL HEALTH CENTER	3,150	P/P (Alcohol Counseling/ Treatment Houlton Cty Jail)	DOC
AROOSTOOK MENTAL HEALTH CENTER	12,600	P/P (Residential Treatment - Limestone)	DOC
AROOSTOOK MENTAL HEALTH CENTER	352,600	Outpatient	DHS
AROOSTOOK MENTAL HEALTH CENTER	31,500	Outpatient - Rural	DHS
HOULTON BAND OF MALISEETS	11,600	Outpatient	DHS
Statewide			
MAINELY FAMILIES, INC.	4,000	Parent Support Groups. Foster prevention and intervention of substance abuse through parent support groups along with related training newsletter and resource library.	DMHMR
MAINELY FAMILIES	24,100	Prevention	DHS
MAINELY FAMILIES	15,452	Support services to the parents of troubled teens.	DOC
NATIONAL COUNCIL ON ALCOHOLISM	64,100	Prevention	DHS
NATIONAL COUNCIL ON ALCOHOLISM	2.000	Fetal Alcohol Syndrome media, education and training.	DMHMR
NCA/ME - PREVENTION CONFERENCE	10,000	Conference	DHS

AGENCY	CONTRACT AMOUNT	SERVICE	NOW
Statewide			
Prevention			
AROOSTOOK MENTAL HEALTH	55,400	Prevention	DHS
BIG BROS/BIG STRS KENNEBEC VALLEY	10,100	Prevention	DHS
DOWNEAST BIG BROS/BIG SISTERS	25,000	Prevention	DHS
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	49,000	Prevention	DHS
NATIVE AMER. YOUTH CONFERENCE	35,000	Prevention	DHS
AIDS ST. ED. PROJECT	15,000	Prevention	DHS

*DHS plans to consolidate these contracts in FY'91 within each agency.

[1]FY'89 allocation carried into FY'90
[2]DOC/DHS dollars consolidated under DHS adminstration
[3]DHS/DOC/DMHMR dollars consolidated under DMHMR administration
[4]DMHMR/DOC dollars consolidated under DOC administration