THE MAINE STATE PLAN FOR ALCOHOL AND DRUG ABUSE SERVICES

by the

OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

June, 1978

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ERRATA

References are made in several places throughout the Plan to OADAP's decision to defund the Mid-Coast Rehabilitation Center in order to provide for some measure of outpatient services in Region IV.

Since these sections were written, the Commissioner of the Department of Human Services has indicated that Mid-Coast will be funded if sufficient funds can be located within the Department's budget.

PART I

SYSTEM DESCRIPTION

PART I: SYSTEM DESCRIPTION

A. Management System

1. The Office of Alcoholism and Drug Abuse Prevention (OADAP), under MRSA 22 § 7101 et.seq. (Appendix A, enabling legislation) is empowered to establish Maine's overall planning, policy, objectives, and priorities for all alcohol and drug abuse functions except prevention of drug traffic. Generally, these functions are developed on a consensus model.

This office uses the following five steps in establishing regulations affecting alcoholism and drug abuse. Notice of the content of the regulations under consideration and the fact of a public hearing is published. A public hearing is conducted. Sixty days are allowed for public comment. After comments are considered, the Attorney General's Office approves the form of the final regulations. The last step is to file the approved regulations with the Secretary of State.

More than simply publishing notification of content and public hearing on regulations is required. This office takes an active stance in notifying individuals and organizations affected by regulations, through direct contact and explanation. Regional Councils, the substance abuse advisory bodies in each of Maine's five regions, are notified through their executive directors. Both the Maine Association of Alcoholism Program Directors and the Youth Oriented Substance Abuse Programs are involved in discussing proposed regulations. These two organizations are the representative bodies for Maine's treatment programs. The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, the advisory council to this office, is also involved in major changes, plans and policy affecting alcohol and drug abuse. In addition, the mental health center directors' association, the court administrator's office, the police chiefs' association and others are involved when action affects them.

General planning, policy development, and priority setting occur in much the same way as the promulgation of regulations, although without the legally required formal five-step process. This office develops working plans, objectives, and changes. These working documents are then submitted for review to various organizations involved in alcohol and drug abuse. The four dominant organizations are the Regional Councils, Maine Association of Alcoholism Program Directors, Youth Oriented Substance Abuse Programs, and the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. These and other groups react to working documents and negotiate changes. A fairly well agreed upon product results from this consensus-oriented process.

The broadest participation comes in the state planning process. Working papers are distributed; public hearings are held; meetings with various groups mentioned above are held; input is incorporated into a draft plan; and hearings are again held on the draft of the final plan. During that process the HSA, SHPDA, SHCC and the Maine Human Services Council, an advisory group to the Department of Human Services concerned with human services in general and Title XX in particular are consulted.

The results of numerous public hearings and individual work sessions are then incorporated into the final plan. Again consensus is generally achieved.

Internally, policy is developed through collateral work groups, with the person responsible for the functional area under question responsible for the output of the group. The Director of the office retains responsibility for final decisions. The primary individuals responsible for policy development are the Drug Program Specialist, Alcoholism Program Specialist, and Grants Manager and they have the broadest interest in policy development. Secondary responsibility for policy development rests with the Prevention Coordinator, Occupational Program Specialist, and Manpower and Training Specialist. Responsibilities are secondary only in the sense that they overlap and are narrower than the drug and alcohol functions.

With the exception of the HSA, SHPDA, SHCC, and the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, the other groups mentioned above have an informal relationship with this office. Although it is to our benefit to have general support, most groups do not have a legislative sanction with respect to this office. The HSA, SHPDA, and SHCC have review and approval power over the State Plan and function in accordance with their national legislation.

The Regional Councils are advisory to this office on both alcohol and drug abuse. This office created and staffed these councils when this office was established in 1973. The intent in regionalizing was to have a vehicle where local citizens would have a voice in the decisions the state agency made. As the councils matured, this office withdrew its direct staffing and funded them to hire independent executive directors.

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment is the legislatively mandated advisory group to this office (Appendix A). The Council's mandate parallels the mandate of this office, giving the Council the function of advising this office, the Governor, and the legislature on all matters relating to alcohol and drug abuse. Although the Council's scope of authority ends with advice, this office benefits by having support and, therefore, carefully weighs advice given. The Council maintains its relationship to the HSA, SHPDA, and SHCC through this office.

2. The Department of Human Services administers the SSA program through its Office of Alcoholism and Drug Abuse Prevention.

State Drug Abuse Authority:	Department of Human Services
Designated Operating Agency:	Office of Alcoholism & Drug Abuse Prevention
State Alcoholism Authority:	Department of Human Services
Designated Operating Agency:	Office of Alcoholism & Drug Abuse Prevention
State Mental Health Authority:	Department of Mental Health and Corrections
Designated Operating Agency:	Bureau of Mental Health

3. Charts 1 and 2 show the organizational structure of the Department of Human Services and the Office of Alcoholism and Drug Abuse Prevention. This office, although located within the Bureau of Rehabilitation, shares only the services of the Business Office. All other functions are held internally in this office. The organizational integrity of this office is protected by statute (Appendix A).

4. State enabling legislation (Appendix A) provides the Director, Office of Alcoholism and Drug Abuse Prevention with full authority and responsibility for administering all of the powers and duties of the office. Within any organization, however, an employee is subject to a chain of command. Although decisions are made by the Director of the office, they are subject to review. In practice, both the Director, Bureau of Rehabilitation, and the Commissioner of Human Services operate by exception, but retain the power to overturn decisions made by the Director, Office of Alcoholism and Drug Abuse Prevention.

5. Internally this office, as operating agency for both alcohol and drug abuse, holds a largely integrated staff. Grants management, prevention, planning, training and manpower, and occupational programming are integrated. Drug and alcohol treatment concerns are held separate and exercise marked influence on the integrated components. The regional advisory groups and the state-level advisory council are all integrated.

6. The allocation of time by function is the basis used for compliance with the administrative cost restrictions imposed by NIAAA and NIDA on this organization as described above.

B. Planning System

The overall responsibility for planning of alcoholism and drug abuse-related programs rests with the Office of Alcoholism and Drug Abuse Prevention. The Director of this office bears the primary responsibility for plan generation and approval. For the specific activities pursuant to plan-generation, he utilizes all professional central office and regional staff. Thus, they make a direct contribution of their expertise and particular awareness to the total plan. The size of the present agency staff does not permit a full-time plan-generation assignment to be made. Overall coordination of the staff for plan-generation purposes rests with the OADAP Grants Manager.

State Planning Process

The process by which state plans are produced for alcoholism and drug abuse programming can be separated into three major phases. The first is the "Information-Gathering Phase" and, by its very nature, operates year-round. During the second phase, "Initial Proposal-Development," plan sections are written and arranged into the prescribed format. Phase three "Review and Revision," lays open the whole process and accompanying documentation to public scrutiny and respective government agency examination. Afterward, revisions are made and the plan eventually receives final approval as a satisfactory operating document for the coming year.

Chart 3 illustrates the path and concurrent activities of state plan development process for this office.

CHART 1

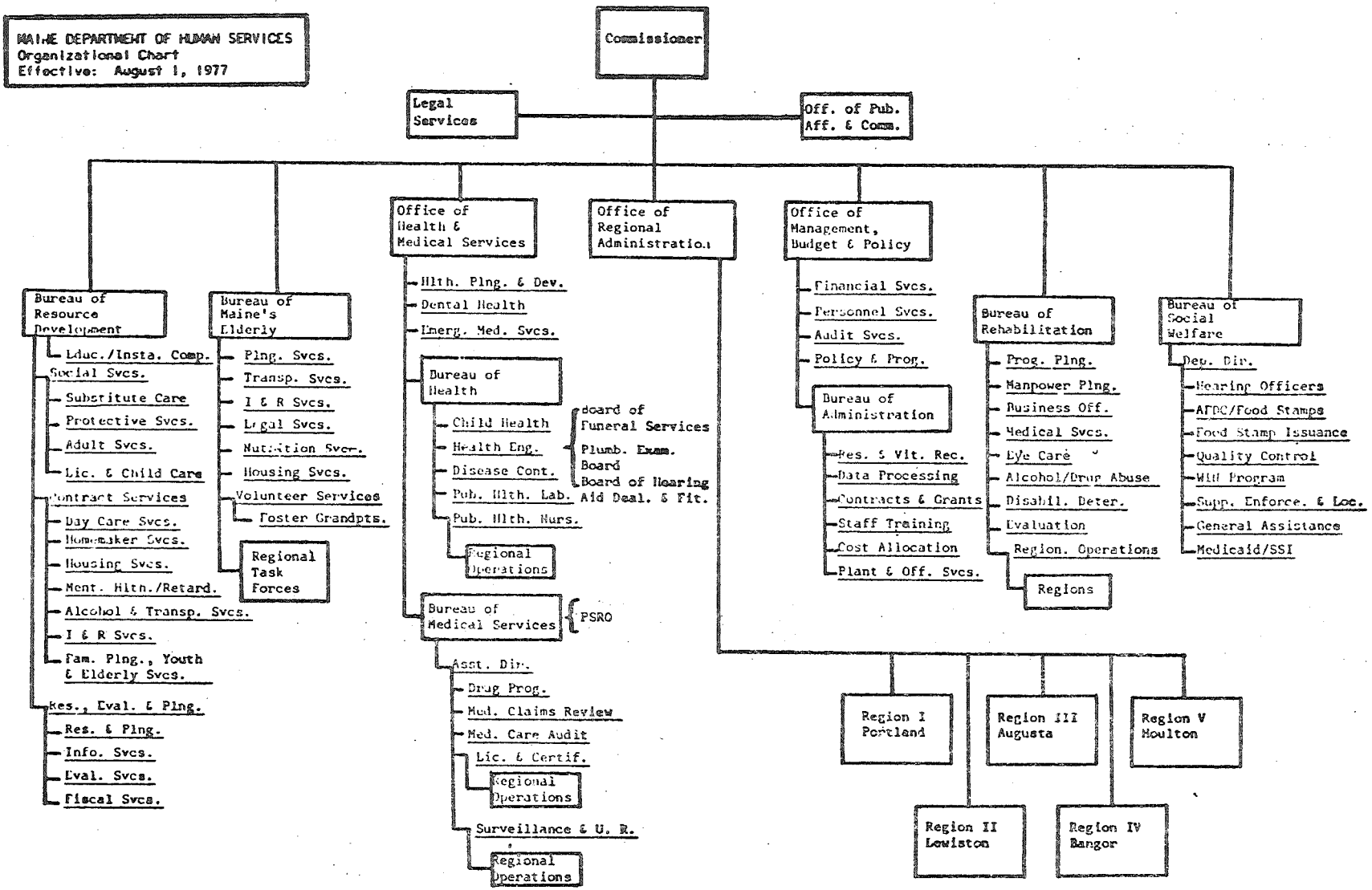
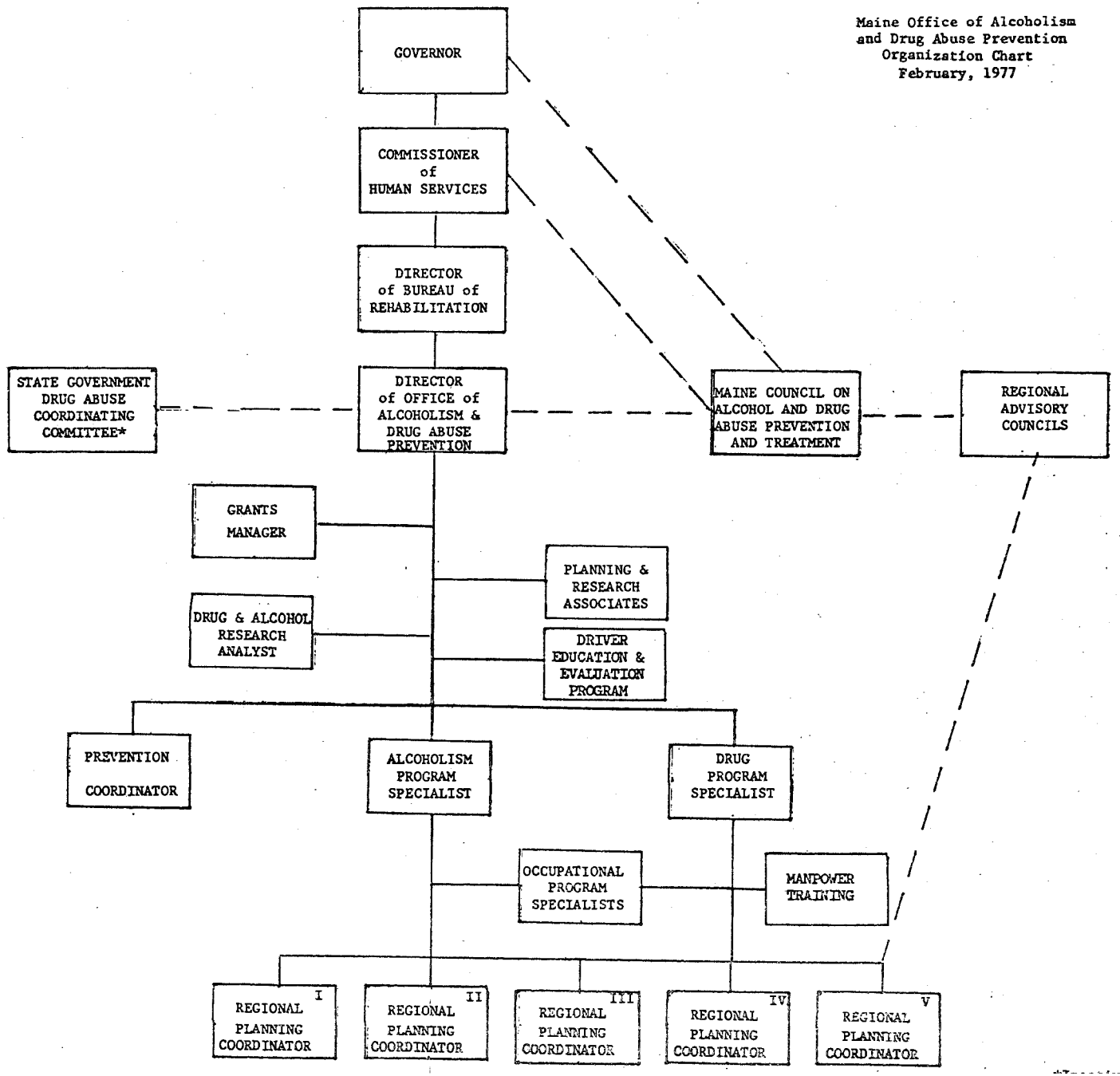

MAINE DEPARTMENT OF HUMAN SERVICES
Organizational Chart
Effective: August 1, 1977
Commissioner
Legal Services
Off. of Pub. Aff. & Comm.
Bureau of Resource Development
Educ./Insta. Comp.
Social Svcs.
Substitute Care
Protective Svcs.
Adult Svcs.
Lic. & Child Care
Contract Services
Day Care Svcs.
Homemaker Svcs.
Housing Svcs.
Ment. Hlth./Retard.
Alcohol & Transp. Svcs.
I & R Svcs.
Fam. Plng., Youth & Elderly Svcs.
Res., Eval. & Plng.
Res. & Plng.
Info. Svcs.
Eval. Svcs.
Fiscal Svcs.
Bureau of Maine's Elderly
Plng. Svcs.
Transp. Svcs.
I & R Svcs.
Legal Svcs.
Nutrition Svcs.
Housing Svcs.
Volunteer Services
Foster Grandpts.
Regional Task Forces
Office of Health & Medical Services
Hlth. Plng. & Dev.
Dental Health
Emerg. Med. Svcs.
Bureau of Health
Child Health
Health Eng.
Disease Cont.
Pub. Hlth. Lab.
Pub. Hlth. Nurs.
Regional Operations
Board of Funeral Services
Plumb. Exam. Board
Board of Hearing Aid Deal. & Fit.
Bureau of Medical Services
PSRO
Asst. Dir.
Drug Prog.
Med. Claims Review
Med. Care Audit
Lic. & Certif.
Regional Operations
Surveillance & U. R.
Regional Operations
Office of Regional Administration
Region I Portland
Region II Lewiston
Region III Augusta
Region IV Bangor
Region V Houlton
Office of Management, Budget & Policy
Financial Svcs.
Personnel Svcs.
Audit Svcs.
Policy & Prog.
Bureau of Administration
Res. & Vit. Rec.
Data Processing
Contracts & Grants
Staff Training
Cost Allocation
Plant & Off. Svcs.
Bureau of Rehabilitation
Prog. Plng.
Manpower Plng.
Business Off.
Medical Svcs.
Eye Care
Alcohol/Drug Abuse
Disabil. Deter.
Evaluation
Region. Operations
Regions
Bureau of Social Welfare
Dep. Dir.
Hearing Officers
AFDC/Food Stamps
Food Stamp Issuance
Quality Control
WIN Program
Supp. Enforce. & Loc.
General Assistance
Medicaid/SSI

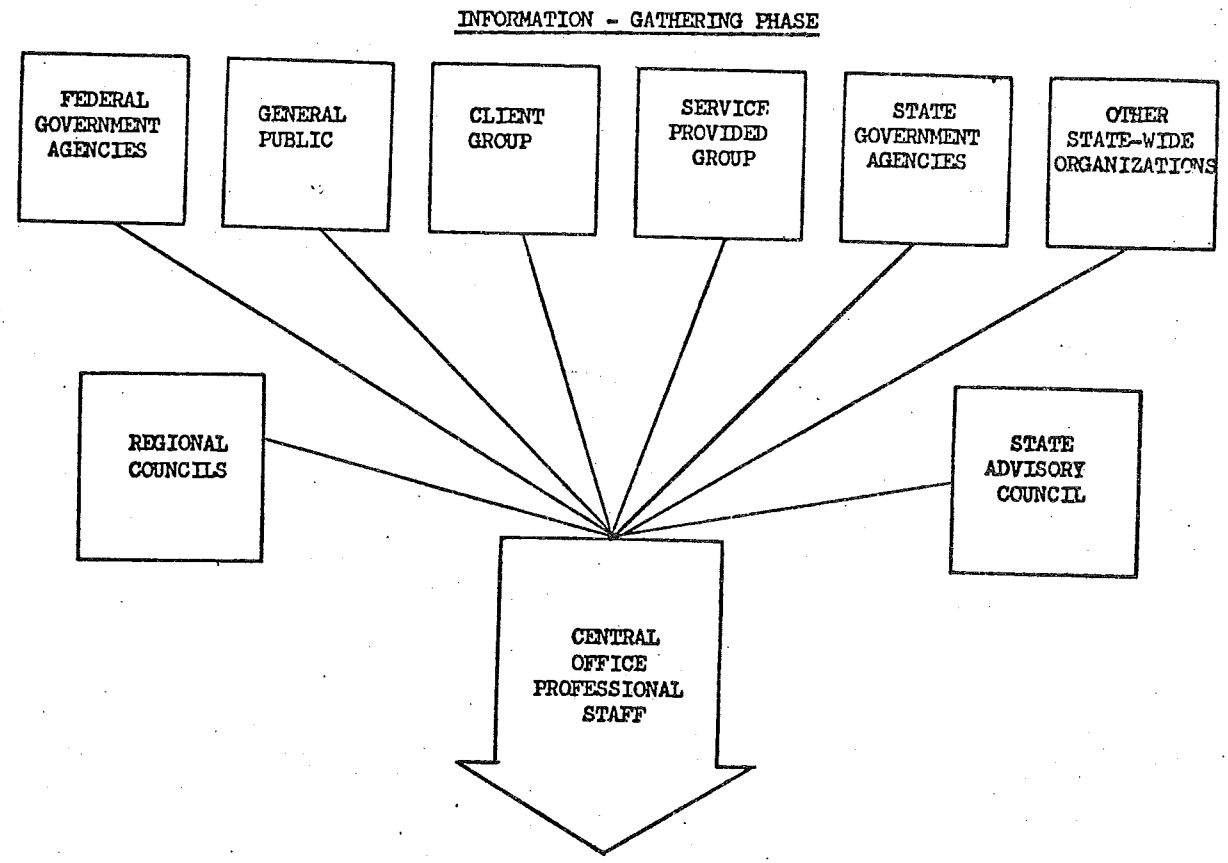
CHART 2

Maine Office of Alcoholism
and Drug Abuse Prevention
Organization Chart
February, 1977



State Plan Development Process

CHART 3



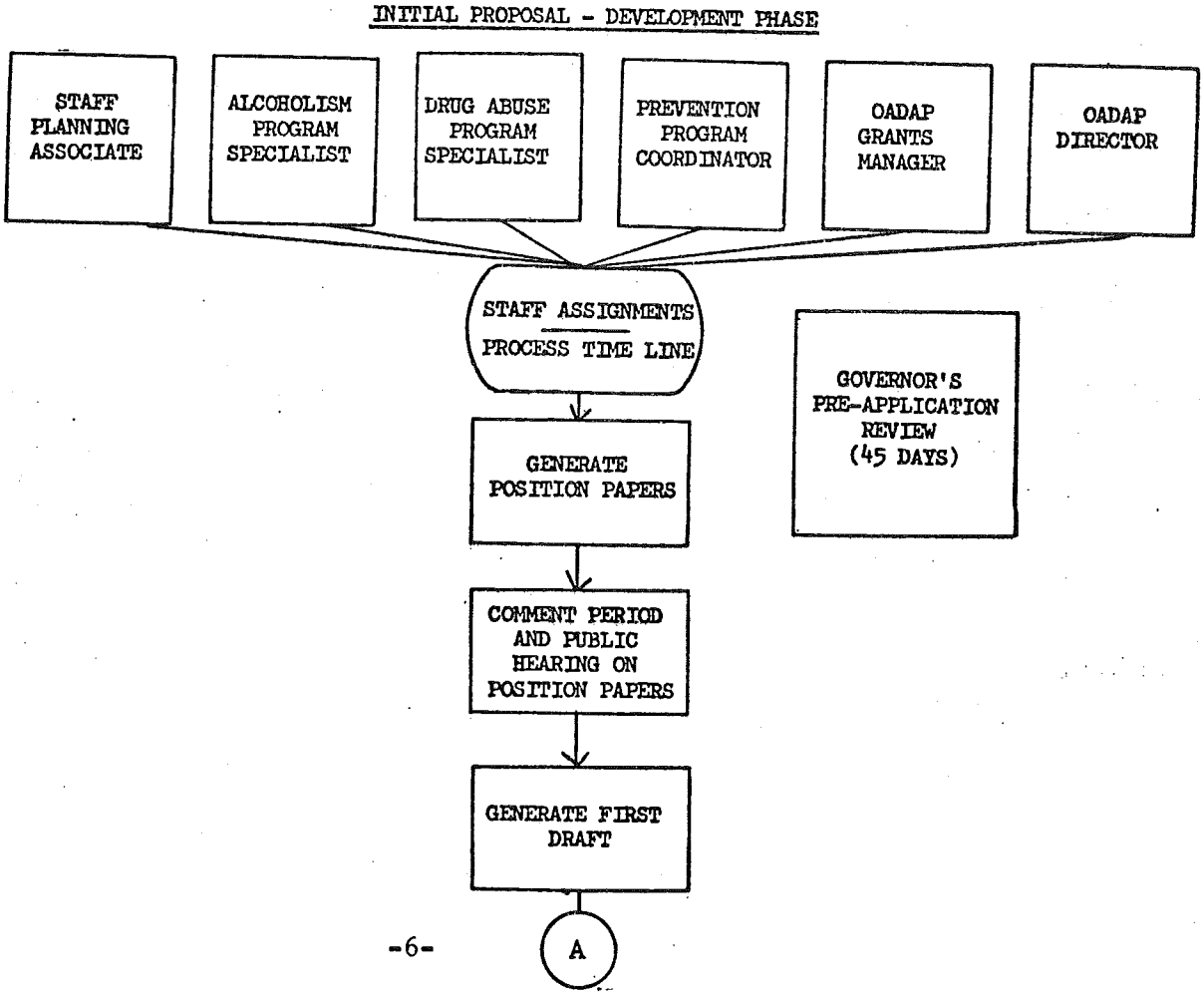
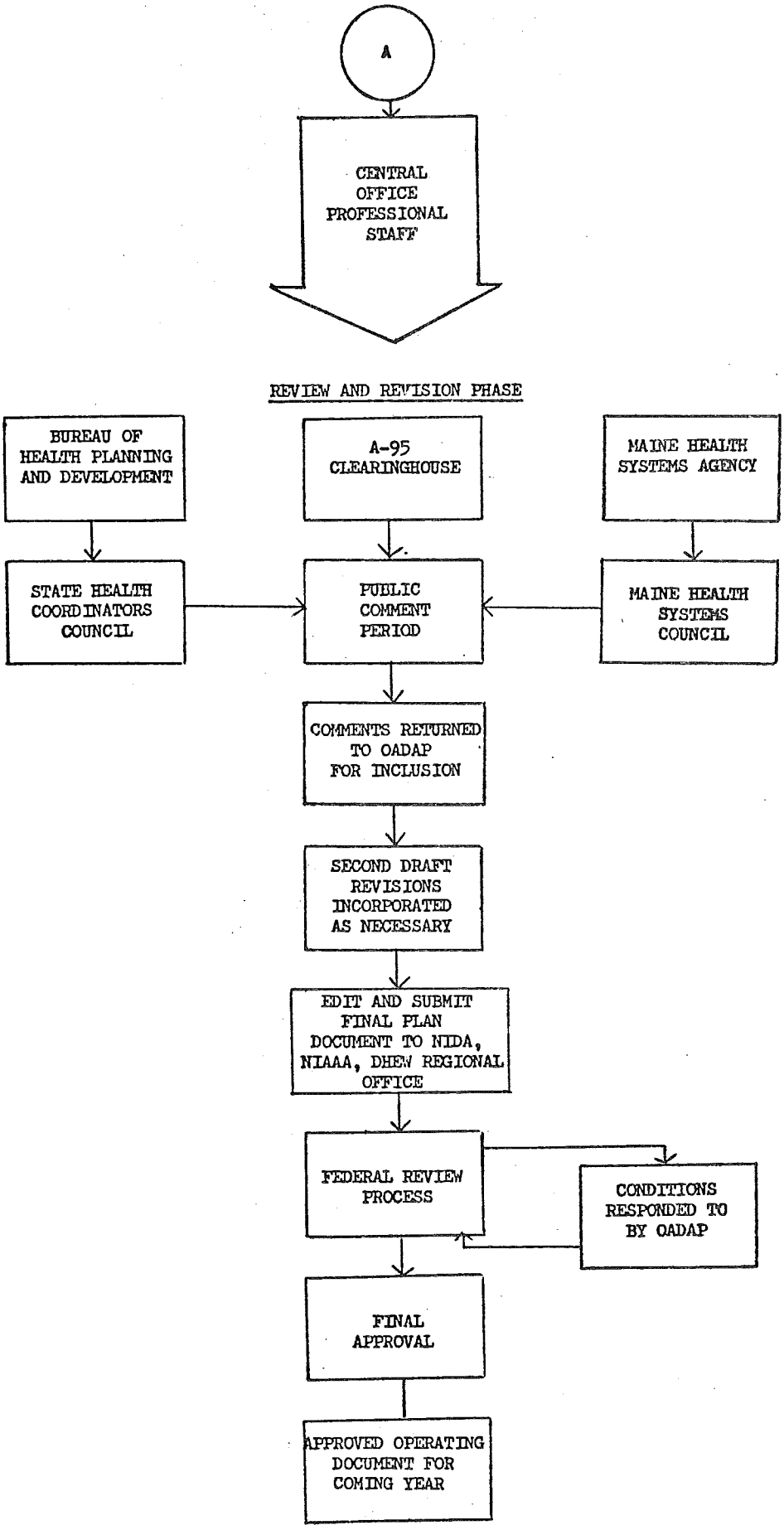


CHART 3 (continued)



The "Information-Gathering Phase" involves the year-round participation of central-office staff in meaningful interchanges of system information. The small size of our staff causes much face-to-face contact with "real world" situations for everyone. The eight input sources for central-office professional staff are essential in different ways to the overall planning process.

The "Federal Government Agencies" group is made up primarily of the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the U. S. Department of Health, Education and Welfare, Region I, office. Other agencies having some membership in this group would be the Office of Management and Budget, General Accounting Office, Law Enforcement Assistance Administration, National Institute of Mental Health, U. S. Departments of Labor, Agriculture and Justice, etc. Their main purpose is to offer information and assistance programs, publish guidelines, initiate requests for proposals and supply financial and technical assistance. They usually function in concert with the state to answer to demands created by the problems of alcohol and other drug abuse. The major value of this group, as it applies to the state plan, is in the provision of guidelines upon which to structure documentation and future program activities. This review process helps Maine's effort to be more consistent with nationally emergent policy and direction.

The general public is actually all of us. We either pay taxes or receive services, and in many respects do both simultaneously. This is the population which possesses service needs, and in which the commitment to satisfy those needs must exist or originate. They provide the tax dollars and cause their representative legislature to appropriate funds for the operation of our services. They also function as the de facto beneficiary of any service so provided. Unfortunately, their value in the planning process is somewhat diminished by apathy and a disturbingly low level of awareness concerning drug and alcohol issues. Citizens who do stand up to be counted tend to represent extremes and seldom produce beneficial direction. The large amount of misinformation circulating within the general public sphere usually turns the group's potential value into a liability. Efforts directed toward this group, outlined in the prevention, education and information-related sections of this plan, may, if successful, turn this situation around.

The client group clearly consists of all persons currently in a treatment status and less clearly includes persons who still need to enter treatment or have completed a treatment program. Their sole purpose is to benefit from the services provided them. They are the group we are trying to reach or have already helped. Their value to the planning process is realized indirectly through the observation of treatment effects and directly through interviews and their own participation in post-recovery activities such as aftercare and client evaluation surveys. They sometimes comment about services (usually in the form of complaints) directly to this office. They provide personal-experience input to the planning process.

The service-provider group is made up of all layers of hierarchy in the alcoholism and drug abuse-related service delivery system. The most vocal members of this group are the program directors who have formed two statewide organizations known as the Maine Association of Alcoholism Program Directors and the Youth Oriented Substance Abuse Program Directors' Association. This gives them a unified voice for direct communication with OADAP staff. The service-provider group establishes and operates services for delivery to the client group. This group's primary function is to deliver quality services which minimize risk to the client, while maximizing potential for a complete recovery experience. Its value to the overall planning process is indirectly realized through the various evaluations of service delivery (grant applications, licensure inspections and management information system reporting).

The service providers make a direct contribution to the planning process by contact with central office staff via professional association and technical assistance efforts. Their inclusion in the planning process is most important since they are the "doers" in their own communities, and we would be little more than just another bureaucratic planning shop with great aspirations, but little real potential for change, without their support and efforts. They will of course, be operating with some self-interest on the part of their agencies, but often, client concerns outweigh whatever negative effect this might have on the process. Their direct contact with the client group (particularly during "crisis" moments in the client's life) provides a valuable experiential perspective to the planning effort.

Agencies comprising the "State Government Agencies" group include all of the units of state government other than this office which interact with, or have some interest in, our own efforts. They include the Bureaus of Health Planning and Development, Rehabilitation, Resource Development, Budget, and Social Welfare. The Departments of Mental Health and Corrections, and Indian Affairs are in this group along with various offices located in the Executive and Legislative Departments. Their basic purpose is to carry out the desires of the legislature and Governor in accordance with the will of the people. Each one of the agencies was established to perform a specialized function in the administration of state government. Their value to the planning process runs the gamut from purely administrative (accounting system, personnel policy, internal audits, etc.) to primary review responsibility such as the Bureau of Health Planning and Development's staff relationship to the State Health Coordinating Council, and the Governor's grants coordinator. When common problems confront two or more of our agencies, solutions must generally be developed by joint effort. Thus, our planning process is broadened to include their concerns.

The "Other Statewide Organizations" group includes such well-known entities as the Maine Police Chiefs' Association, Maine Municipal Association, Goodwill Industries, American Cancer Society, National Council on Alcoholism and the programs of Alcoholics Anonymous, Al-Anon and Alateen. These last three groups would fit into all of the groups shown in the flow chart, but they are truly statewide and have a major influence on most of the state's alcoholism-related activities. Their work is quietly carried out avoiding affiliation, while providing a sincere form of cooperative effort.

These statewide organizations provide for a broad-based forum of information and activity for a vast number of special-interest areas. Their functions are unique to any given group, while the total blend of their efforts would be a reasonably good representation of the society in which we live. The value of this group to the planning process is manifested in its diversity of perspectives and generally easy access through group headquarters staff.

Regional Councils blanket the state with five planning regions. Their major focus is restricted to alcoholism and drug abuse-related matters. They provide a community planning capability for the central office program. Each council has a full-time staff person employed for day-to-day functioning (one exception exists in the central Maine area where a full-time staff position does not presently exist) and a Board of Directors who guide these private non-profit groups. Membership in each council is open to all concerned citizens within any given region, while board members are elected to serve as a corporate function. The councils perform many activities in collaboration with the central office. Among them are reviewing grants, regional planning for services, monitoring provider agencies and responding to community concerns about alcoholism and drug abuse-related issues. No formal process of sub-state planning has been instituted for at least two years. However, during the next twelve months, some activities aimed at reviving this practice are expected to take place. This will need to occur so that we will be able to move along toward goals stated elsewhere in this plan which relate to the client-oriented comprehensive treatment program.

The State Advisory Council (more formally known as the "Maine Council on Alcohol and Drug Abuse Prevention and Treatment") serves in an advisory capacity to the Governor and the central office for issues relating to alcohol and drug abuse prevention and treatment. Their functions and membership are addressed in another section of this plan. Their value is tied directly to their ability to meet regularly and engage in meaningful discussions which produce resolutions for action by the Governor and this office. Over the last twelve months, this group has been active and productive. During the last round of grant-review activity, the volunteer participation by the council members was nothing less than outstanding.

The central office professional staff collects and assimilates the vast quantity of information received from the above eight groups. Formal staff meetings are held at least monthly during which issues are raised, assignments are made and solutions reported to the group.

Additionally, meetings are held between appropriate staff professionals to develop strategies or program plans to respond to planning initiatives or crisis-resolution needs. A five-step planning process has evolved which facilitates these team problem-solving sessions. A brief outline of this process follows:

STEP 1: Inclusion: Who? How? What? When? Why?
Action at this step defines the problem and/or establishes policy.

STEP 2: Goal-Setting: Who? What? How? When? Why?
The goal-setting step establishes the set of alternative solutions to the problem and/or defines the alternative steps of policy implementation. The result is a choice of preferred alternatives.

STEP 3: Task Development: Method? Who?
This step specifies who will do what and in what order.

STEP 4: Implementation: As a dynamic step, implementation describes doing the task(s) assigned in Step 3.

STEP 5: Evaluation/Change: This final step implies an assessment of the success of the first four steps and a built-in commitment to use the assessment to change the process and/or the policy.

Direct contact is maintained throughout the year with all sources of information. Many special projects are undertaken as joint efforts between professional staff and members of these groups. While most activities specifically related to generating the state plan occur during the last four months of the plan year, certain activities such as needs assessments and action-plan development necessitate twelve-month efforts.

The "Initial Proposal Development Phase" consists of all activities specifically directed toward generating the plan document. This year the first step was the organization of staff specialists into a work group and generating a time line for accomplishing plan-oriented assignments. Concurrent with initialization of the project, approval to submit the plan and accept federal funds had to be obtained from the Governor. His careful scrutiny of program operations and requirements resulted in his approval to go ahead with our plan submission.

The next step in the process consisted of writing a position paper for each of the action-plan segments. These papers were distributed to more than 400 individuals and organizations for written comment. At the end of the comment period, a full day of public hearings was held during which comments received were discussed and additional information was collected.

Upon completion of the public-comment step, staff members began to assemble the first drafts of all plan components. Bureau of Health Planning and Development staff members met with OADAP staff to establish a method for accomplishing plan review in the time available before submission. The Health Systems Agency involvement this year will be minimal because of the need to establish review criteria and a process for conduct of the review. They will, however, receive a draft copy at the same time it is made available to the other review authorities.

The first draft was edited and collated for submission to all reviewing authorities prior to June. In order to compensate for the minimal staffing at the Bureau of Health Planning and Development, the plan was submitted in sections as they became available in smooth copy form. This enabled their staff reviewer to more effectively examine the document and prepare summary information for the State Health Coordinating Council.

This procedure minimized the slight differences in plan format designated by federal guidelines and prescribed by the reviewing authority.

The "Review and Revision Phase" includes all activity involving review by the general public and the specific coordinating agencies other than OADAP. The final portion of this phase occurs after submission of the plan to the National Institutes on July 15th.

Ultimate responsibility for review at the state level rests with the State Health Coordinating Council. In Maine, there is only one Health Systems Agency so that a wasteful duplication of effort would occur if both agencies were conducting separate reviews. Since the funding involved is allocation money and not directly used for community project support, this review arrangement appears to be in compliance with federal intent as described in Public Law 93-641.

The State Planning Office coordinates the A-95 review process; 45 days are required for sign-off. During this time, notice of the plan's availability is published. Comments and inquiries are directed to OADAP and responses are given as appropriate.

Prior to final submission of the completed plan to the appropriate federal agencies, changes are incorporated to reflect the responses received during the review processes. At the same time the plan is submitted, it is also distributed in its final form to all persons who have been responsible for any phase of its development.

Once the plan has been received by the National Institutes, any further activity is coordinated through the OADAP grants manager. This includes answering correspondence about the plan, complying with federal review requirements and ensuring that conditions placed on the award of any funds are met.

Once approval has been received, actual plan implementation rests with the total staff in general. Specifically, the various staff specialists accomplish their respective plan parts. Work on development of the next plan will have already begun.

C. Support System

Responsibility for providing technical assistance on alcohol and drug issues to local organizations and to community-based service providers is shared by OADAP Regional Coordinators and the OADAP central office staff. The Regional Coordinators respond to requests from local government representatives, citizen groups and individuals related to planning and development of needed services and resolution of problems with existing services. In responding, the Coordinator may secure the involvement of OADAP central office staff members who have expertise in planning, development and evaluation of services. The OADAP Prevention Coordinator, Research Associates, Grants Manager and Occupational Program Consultant provide assistance on both alcohol and drug issues. The OADAP Alcohol Program Specialist and the Drug Program Specialist provide assistance in their particular program areas.

The technical assistance needs of service providers are identified by direct requests from programs and as a result of monitoring and evaluation processes conducted by OADAP. Both Regional Coordinators and central office staff deliver the needed assistance, each in his/her specific areas of expertise. Typical areas for assistance include fiscal management, grantsmanship, alcohol and drug treatment, evaluation, prevention, training, occupational programming, confidentiality regulations and other legal issues such as involuntary commitment.

D. Monitoring System

I. General

OADAP currently maintains several different information systems to meet its overall management information needs. One system provides information on clients receiving alcohol abuse treatment. A separate system reports on clients receiving drug abuse treatment. These two systems will be described briefly below. A third system based on required quarterly reports provides information on the financial transactions of all OADAP-funded agencies. A fourth system, in cooperation with the Secretary of State, monitors compliance with the Driver Education and Evaluation Program requirements. Treatment program quality is monitored by the licensing/approval process. Finally, the overall performance of funded programs is monitored by quarterly progress reports and the annual grant review process.

In addition to these systems which directly monitor performance, OADAP maintains a Community Monitoring System (CMS) which contains data on selected events related to drug and alcohol abuse, such as arrest rates. Statistical analysis of the changes in these data can provide information about the impact of the total alcohol and drug abuse treatment/prevention effort on communities.

In addition to these systems monitoring external matters, OADAP has several systems to monitor internal performance. Staff performance is monitored through the state personnel appraisal system. Financial matters are monitored by the Grants Manager in accordance with the state's fiscal system. A complete description of OADAP's fiscal management procedures appears elsewhere in this plan.

Each of the alcohol and drug information systems is managed by a separate staff person. These individuals generate routine and exception reports for distribution to the respective program specialists, grants manager, and the director as appropriate. The information system staff persons also answer special requests for information from OADAP central office and regional staff and from external sources. Various methods, including special surveys, searches of other state agency records, and special manipulations of existing data are utilized to fulfill these requests. A separate, but important function of the information staff persons is to maintain contact with reporting programs and offer technical assistance in the respective reporting processes.

II. Alcohol Information System

The original OADAP Program Monitoring Treatment Effectiveness System (PMTES) became operational in April, 1974. This system, with modifications, existed until June 30, 1977. During this time it provided information on selected demographic characteristics, amount and type of services received, and degree-of-problem status for clients admitted to OADAP-funded treatment programs. Because of a variety of problems, data for the period June 30, 1977 through December 31, 1977 were collected but were not processed. The system was evaluated, and several points emerged. One was that there was a considerable amount of overlap between the client and services information provided by PMTES and that provided by NIAAA's National Alcoholism Program Information System (NAPIS). A second was that approximately one-third of the programs reporting on PMTES also reported on NAPIS. A third was that financial data and services data lacked comparability, and computation of unit costs was an extremely difficult process. Programs already utilizing NAPIS strongly urged OADAP to eliminate the separate and rather differently defined state system in favor of a combined state/federal system based on NAPIS. These factors made converting to NAPIS an attractive alternative.

At this time it was also discovered that it would no longer be possible to continue to use the same data processor. Changing processors meant that the system had to incur conversion costs to modify software and train processing personnel. Since these costs were unavoidable, whether or not the system was converted to NAPIS, the conversion to NAPIS was financially more feasible.

A consultant was hired to fully assess the alternatives and to assist us in designing and implementing the final system. The decision was made to convert to a slightly modified NAPIS system. This system is called the Maine Alcoholism Program Information System (MAPIS). The system differs from NAPIS in the following ways:

- a question on the client's current employer has been added to the confidential client information retained by the program on the Initial Contact Form Form (ICF). The availability of this information will allow programs to report grouped data on the number of clients employed by various firms in order to provide better information for occupational program consultants.

- the client's town code is requested on the ICF in place of the county code to provide more detailed information on client residence.

- a question has been added to the ICF concerning prior admissions to Maine alcoholism treatment program in the past year.

- the ICF question on referrals was altered to allow for the reporting of a chain of referrals for each contact.

- specialized staff time data collection forms have been developed to meet the individualized needs of several programs. The forms allow for the collection of more detailed staff time data than required by NAPIS. The data may be handled internally for individual program management needs. Data on the detailed categories is combined during processing into the appropriate NAPIS categories.

- client ID numbers are assigned on a regional basis in two regions. At initial contact with a program clients are asked to sign a release form. If the client signs the form, a regional registry assigns a client number. One useful feature of this system is that it means that only one ICF and one IFF need to be completed for a client regardless of the number of program involvements.

Similarly, only one 180-day follow-up report needs to be completed for each client. Responsibility for completing the report is assigned to the program having the most recent contact with the client. Service reports credit the services provided to each client to the actual program providing those services in the same manner as the standard NAPIS system.

Most of the changes envisioned will modify output reports rather than changes in input. One contemplated change is the addition of an output report to show terminations and their causes.

The decision was made to limit the initial modifications to the system for two reasons. Such limitations would minimize the delay in system implementation, since extensive computer reprogramming would not be required. It was expected that state and program decision makers would be better able to specify changes which would tailor the system to their needs after a period of familiarity with existing system output.

System design and programming was only one phase of the changeover process. Program and central office staff had to be trained to use the system. Program staff were trained in forms-completion procedures. Program administrative staff were trained in data utilization and interpretation of NAPIS output. Selected OADAP staff were also trained in NAPIS data utilization.

At the time this is being written, data collection has been successfully implemented, but no output has yet been produced. Program personnel are thoroughly familiar with system procedures. Test runs, with dummy data, indicate that the programming conversion has been successful. However, actual data processing has been delayed because of a series of unforeseen personnel crises at the Human Services Keypunch Section. As soon as these are resolved and the backlog of punching reduced, output will become available.

The first output reports will be hand-delivered to program directors. This will allow the consultant and OADAP staff to go over the output with each director and his staff to point out pertinent findings from this first run. This will make the reports more meaningful to the programs and will reinforce their commitment to generating sound input.

It is far too early in system implementation to analyze its strengths and weaknesses on an informed basis. It is possible that problems will emerge in some areas, one being at the reporting program level. The relatively high level of personnel turnover within the programs means that a continuing effort will have to be maintained to ensure that data collection procedures are understood and adhered to. OADAP has developed three mechanisms for maintaining system quality. One is an intensive process of hand-editing forms before processing. The second is to keep the programs actively aware of our readiness to provide training and technical assistance in information management. The third is our policy of providing rapid feedback from the system.

The data from this system will be used by OADAP to generate reports for the state legislature, and to evaluate program performance. Local programs will also use the data for their own internal evaluation procedures. One specific example of the kinds of ways in which the data may be utilized occurred during the recently-completed grant review process. Data from the PMTES system, combined with the NAPIS reports and census data, were used to guide the decision to discontinue funding a residential treatment facility in order to provide sufficient funds to maintain an outpatient program in a different locale.

III. Drugs

The OADAP information system for drug abuse programs currently comprises: monthly Client Oriented Data Acquisition Process (CODAP) reports from publicly-funded drug treatment programs; an annual National Drug Abuse Treatment Utilization Survey (NDATUS) report from all drug treatment programs; and quarterly narrative and financial reports from all OADAP-funded drug programs. The system is used to evaluate program performance but is also used for planning purposes as one indicator of the nature and size of Maine's drug abuse problem.

Because of the small number of drug treatment programs in Maine and the relatively manageable size of the total client population for those programs, it has been possible to establish a manual card system for storage of CODAP information. This system permits retrieval of all but the most comprehensive information within an hour. CODAP data is most useful to OADAP for three specific evaluation purposes. The first is quarterly review of each program's performance. Items such as utilization rate, number of patients completing treatment and average length of treatment are compared for programs with the same modality and environment. Second is investigation and analysis of problems with individual programs. For example, observation of a low residential census at a particular program for one or two months would result in detailed analysis of the type of clients receiving and completing treatment. And finally, it is used for annual evaluation of existing programs in the grant-review process. The OADAP Research Analyst compiles CODAP data from the previous calendar year just prior to the beginning of the grant-review cycle in February. Statistics are displayed for each program and comparisons between similar programs are provided. This information is distributed to regional alcohol and drug abuse councils and to the State Advisory Council for use in their performance reviews of individual programs. OADAP has also used CODAP information for special purposes, such as profiling the residential client who has successfully completed treatment during the past two years.

NDATUS provides an annual summary of information on all treatment programs which is otherwise only available by collection from several information sources.

The quarterly narrative reports provide subjective information that supports or further explicates the objective data submitted on CODAP forms. The narrative reports in combination with quarterly financial reports are used to monitor programs' progress toward goals and objectives contained in their grant applications and their compliance with approved budgets and special conditions of grant awards.

Evaluation Efforts - Evaluation is conducted on a periodic basis in the following ways:

1. The OADAP Research Analyst, the Grants Manager and the Drug Program Specialist conduct a quarterly review of individual programs using objective data obtained from the information system as outlined above. The Drug Program Specialist also visits each drug treatment program at least once a quarter to discuss progress toward goals and objectives and problems which are being encountered and addressed.

2. On an annual basis, each existing drug program is evaluated as an integral part of the grant-review process. This evaluation uses cumulative data from the information system, data on referrals to and from the program, and evidence of accomplishments of the previous year's goals and objectives as measures of each program's success. Responsibility for conduct of this evaluation is shared by members of the regional alcohol and drug abuse councils, members of the State Advisory Council and OADAP staff people.

3. The one publicly-funded residential drug treatment center and the one private, proprietary center in Maine must, by law, be evaluated annually in accordance with the Regulations For the Licensing of Substance Abuse Treatment Facilities in the State of Maine. Those Regulations contain a provision for outpatient treatment programs to request such an evaluation on an optional basis.

During the process of conducting past evaluations detailed above, several criteria have been developed for measuring the success of drug abuse programs. These include:

1. Total number of clients served.
2. Rate of utilization of treatment slots.
3. Rate of successful completion of treatment.
4. Number of referrals from other agencies.
5. Number of staff hours spent in direct service to the client.
6. Amount of utilization of supportive services available in the community.
7. Rate of progress toward established measurable objectives.
8. Level of financial support from local sources.

OADAP itself establishes goals and objectives at the beginning of each state fiscal year. Those goals and objectives are formulated in consistence with broader goals set by the Bureau of Rehabilitation and are translated into objectives for each OADAP employee. Completion of individual and agency objectives is assessed on an annual basis.

Research efforts - At the present time, there are no scientific research efforts related to drug use being conducted in Maine. This fact reflects the scarcity of research institutes and institutions of higher education in this state. However, one community mental health center and a research center at the University of Maine have recently expressed interest in drug-related research.

OADAP has also been informed of possibilities for regional research through a committee, NEC-24, organized by the directors of experiment stations at New England land grant universities. OADAP will provide encouragement and technical assistance for each of these efforts in the coming year.

E. Budget Process

The State of Maine budgetary process is conducted biennially. On or before September 1st of even-numbered years, all departments and agencies of state government, corporations and associations desiring to receive state funds under provisions of the law prepare, in a manner prescribed and on forms supplied by the Bureau of the Budget, and submit to the Bureau estimates of their expenditure and appropriation requirements for each fiscal year of the ensuing biennium, contrasted with the corresponding figures of the last completed fiscal year and the estimated figures for the current fiscal year. Expenditure estimates are classified to set forth the data by funds, organization units, and character and objects of expenditure. Organization units are subclassified by functions and activities, or in any other manner, at the discretion of the Bureau.

Tentative revenue estimates are prepared by the State Budget Officer during the month of September of even-numbered years and are revised during the following November for inclusion in the budget. These revenue estimates are classified to show income by organization units, sources, and funds, or in any other manner, at the discretion of the State Budget Officer.

Upon receipt of the budget estimates submitted, the Bureau of the Budget, in conjunction with the Governor-elect or the Governor, reviews the budget estimates, altering, revising, increasing or decreasing items to meet the needs of various departments and agencies and the total anticipated income of state government during the next biennium. The State Budget Officer may require the heads of departments and agencies to appear before him and present additional data in support of their budget estimates. The Bureau of the Budget, at the direction of the Governor-elect or the Governor, then prepares a State Budget Document which must be transmitted to the Legislature no later than two weeks after the start of the regular legislative session, in the case of the Governor (no later than six weeks afterward, in the case of a Governor-elect).

The State Budget Document is a complete financial plan for the operation of state government for each year of the ensuing biennium, which sets forth all proposed expenditures of the departments and agencies of the state, all interest and debt redemption charges during each fiscal year, and all expenditures for capital projects to be undertaken and executed during each fiscal year of the biennium. The document is divided into three parts.

The first part is the budget message by the Governor-elect or the Governor, which outlines the financial policy of state government for the ensuing biennium, including a general budget summary supported by explanation schedules and statements.

The second part is a compilation of detailed budget estimates both of expenditures and revenues, including statements of the state's bonded indebtedness.

The third part consists of completed drafts or summaries of budget bills, financial plan when adopted by the legislature.

After legislative appropriation throughout the fiscal year, the Bureau of the Budget reviews requested allotments with respect to the work program of each department or agency of state government. Work programs for the ensuing fiscal year must be submitted to the Bureau no later than June first of each year and must show all appropriations, revenues, transfers and other funds made available to the department or agency for its operation and maintenance, and for the acquisition of property, in requested allotments by quarters for the entire fiscal year, classified to show allotments requested for specific amounts for personal services, capital expenditures and amounts for all other departmental expenses. The State Budget Officer, in conjunction with the Governor, reviews the requested allotments and, if they deem it necessary, revise, alter or change such allotments before approval and authorization for the State Controller to allow expenditures to be made from funds available.

Work programs may be revised at the beginning of any quarter during the fiscal year, subject to the approval of the State Budget Officer and the Governor. To meet any emergency situations arising during the year, special requests for allotment may be submitted to the Bureau by departments and agencies for approval by the Governor.

The Federal Office of Management and Budget (OMB) establishes uniform government-wide guidelines for identifying costs under grants and contracts to states. The Bureau of the Budget represents the state of Maine in preparing a Consolidated Cost Allocation Plan and in negotiating to complete the allocation of approximately four million dollars in identified state central service costs to state operating agencies. The allocation of approved central service costs is through the medium of an Indirect Cost Proposal prepared by state departments and submitted through the Bureau to the appropriate cognizant federal agency. The Bureau also establishes for each department an indirect cost rate to identify central service costs which benefit each agency.

The development of a budget request for the Office of Alcoholism and Drug Abuse Prevention (OADAP) is a two-part process. The first part concerns only the office operational requirements and is kept separate from the second part, which is the development of a budget for grants-in-aid. Coordination of activities for development of the operational requirements part of the budget is accomplished by the Bureau of Rehabilitation Business Office Manager.

A personal services budget line is prepared, which is based upon manning levels established by the Bureau of the Budget and approved by the Legislature. Merit increases, possible cost-of-living increases and the expected rise in fringe benefit costs are taken into consideration when this line is prepared. Once legislative approval for the budget is obtained, this line is not subject to revision. This has a limiting effect on unplanned expansion and a negative effect, should personnel costs be understated in the initial work plan.

Under all other categories the budget is broken out by line item based on projected expenditures, which are derived from a consideration of the previous year's expenses balanced against the probability of resource availability in the next fiscal year. Amounts remaining are allocated to the grants and contracts (6400) line which already was set at a minimum amount based on maintenance-of-effort requirements and prior-year program levels.

The second part of the budget request development entails analyzing grant-in-aid requirements for the next fiscal year. Federal resources are determined on the basis of restricted-fund categories (i.e. by grant program or contract purpose and limitation). State resources must be requested to provide for all match obligations for Title XX, NIDA Statewide Services Contract and maintenance of effort for NIAAA. Above that level funds are requested which are sufficient to provide alcoholism and drug abuse-related services at a level determined to be desirable through the state planning process. The costs and availability of these services are developed coincidentally with the OADAP grants-review process which is described in the grants-management system section of this part.

The budget request is then moved along through appropriate channels to the State Bureau of the Budget for inclusion in the State Budget Document. After the final form of the budget becomes law, the Bureau of Rehabilitation Business Office is given authority to expend funds on that basis, and the job of establishing quarterly work plans and managing the fiscal activities of OADAP begins.

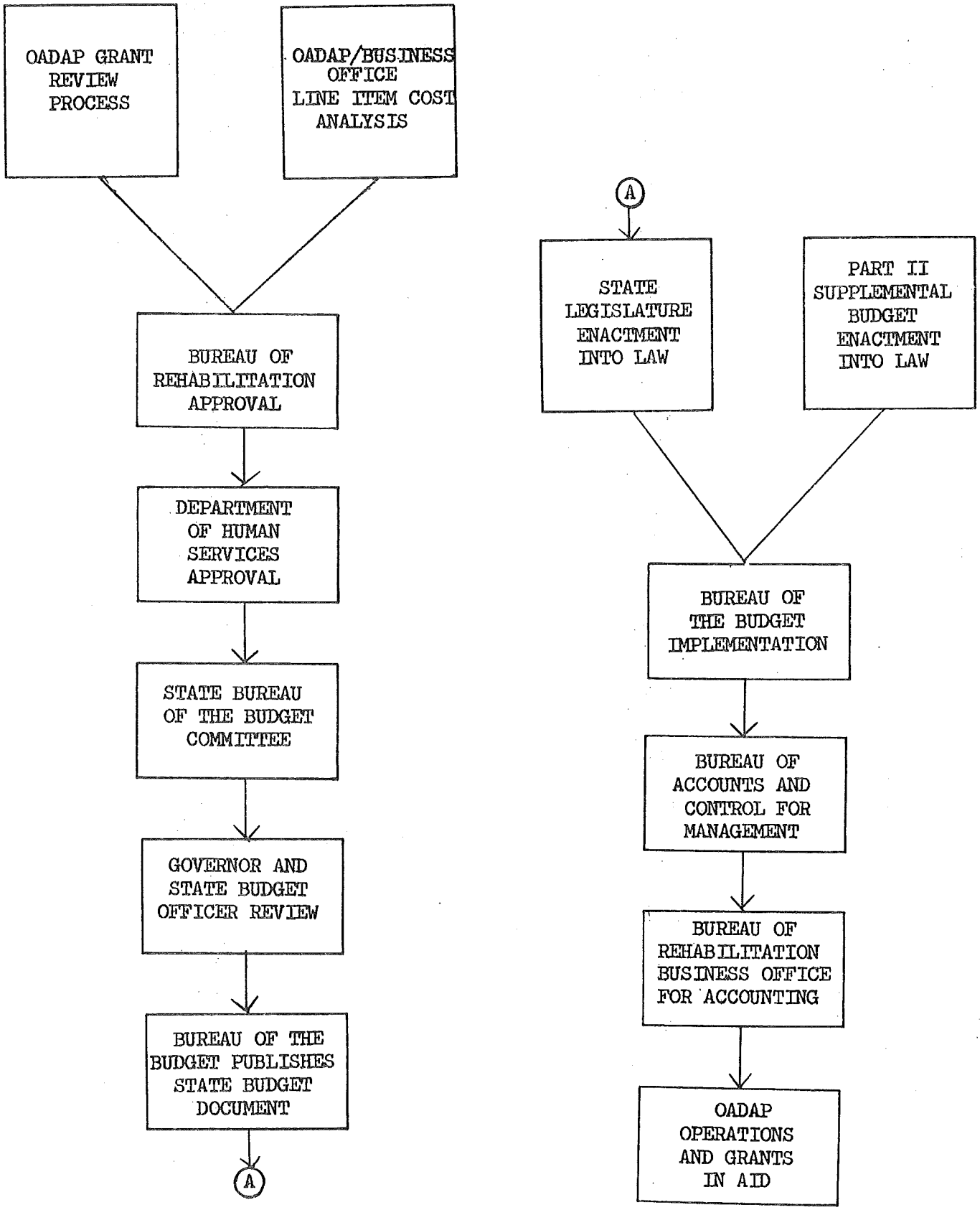
In each legislative session new programs may be generated through the passage of legislation. Funding for these programs, as well as the addition of funds to existing programs over and above funding in the State Budget Document, is considered by the appropriations committees of the legislature and a supplemental Part II budget is enacted into law. This helps to alleviate problems which may occur because of the long lead time tetween budget requests and budget approval (9 to 12 months in most cases).

Since each regular Part I budget is for a two-year period, unanticipated changes may be adjusted for by way of the Part II budget which receives consideration annually.

The following chart depicts the flow of budget development for this office. (Chart 4)

Chart 4

OADAP Budget Development Plan



F. Grants Management System

Alcoholism and drug abuse services are primarily delivered to the respective client groups by private non-profit agencies incorporated for such purposes in the state of Maine. Alcoholism services are supported in part by grants-in-aid from the single state agency (SSA) and by contracts for services under Title XX of the Social Security Act administered by the state's Bureau of Resource Development for the Department of Human Services. Drug abuse-related services are funded by SSA grants-in-aid and through the statewide services contract administered by the SSA which is obtained from the National Institute on Drug Abuse. Since both the alcoholism and drug abuse functions are assigned to this one office, it is a matter of good administrative practice to utilize one grants management system for the two functions. Separate accounts are maintained for each specific source of funds. This system conforms to the federal requirements for separation of funds.

State Agencies Awarding Funds

Two agencies in this state bear the major responsibility for awarding grants and contracts for alcoholism and drug abuse-related services. Both agencies are part of the Department of Human Services. One is a bureau-level agency (Bureau of Resource Development) and one is a division-level agency (Office of Alcoholism and Drug Abuse Prevention) located in the Bureau of Rehabilitation.

The Bureau of Resource Development, through its alcoholism contracts section, administers the Title XX funding for alcoholism services. The match rate is three federal dollars to one state or locally-generated dollar up to a maximum amount as published in the Statewide Title XX Services Plan ($1,400,000 for each of two years in the current period of which state government-supplied funds for match are $291,250). The mechanism for disbursement of these funds is a fee-for-service contract based on line-item reimbursement with each provider agency serving income- or group-eligible persons.

For the alcoholism services area, the Bureau of Resource Development relies heavily on the Office of Alcoholism and Drug Abuse Prevention recommendations concerning quality of service, need and contract amounts to be awarded. For this reason, many grant requests serve a dual purpose in that they represent application for direct grants-in-aid from this office and responses to the requests for proposals under the Title XX program. This greatly facilitates program fiscal planning statewide while eliminating the need for two distinct state agencies with alcoholism expertise.

The Office of Alcoholism and Drug Abuse Prevention serves as the other major in-state source of government funds for programs. This office has the lead position for all alcoholism and drug abuse-related planning and program support in the state. All of the direct grants-in-aid funds and more than 50% of the total state-administered alcoholism and drug-related funds pass through here.

These monies are primarily from state and federal government sources. The following breakdown is typical for any one fiscal year:

Primary Discipline	Funding Source	Agency Program	Mechanism	
			Obtained	Disbursed
Alcohol	NIAAA	State Formula Grants	Grant	Grants/Purchase Order
Alcohol	NIAAA	Uniform Act Incentive	Grant	Grants
Drug Abuse	NIDA	State Formula Grants	Grant	Grants/Purchase Order
Drug Abuse	NIDA	Statewide Service Contacts	Contract	Grants By Slot Cost
Drug Abuse	NIDA	State Training Support Program	Contract	Contract/Purchase
Consolidated Services		OADAP Appropriation	Legislative Appropriation	All Methods

When a contract is to be used for disbursement, the state's contract review mechanism is utilized. This provides a systematic process of contracting from a standardized request-for-proposal format and procedure to final performance review and sign-off. This method assures equal opportunity, lowest cost, good quality assurance and fiscal management controls. In the case of sub-contracting with federal contract funds, prior approval and other federally-required, contract-related events are observed in accordance with the appropriate contracting agency guidelines.

When a grant is appropriate for the disbursement of funds, the grant is developed and controlled in accordance with locally developed grant guidelines. The guidelines conform to specific federal requirements for use of federal funds and in part are taken directly from the Public Health Service grants policy statement. A complete version of the guidelines is provided in this plan as Appendix B (OADAP Grant Guidelines).

As a general rule, applicants for grants-in-aid from the state must be able to finance a minimum of 25% of their total project requirements with locally-generated dollars. This requirement is waived if program need is sufficient and the opportunity for such local match is demonstrated to be nonexistent. Funds are initially awarded for a maximum of 12 months, but extensions beyond that limit may be considered and granted on an individual program basis. This is primarily because of the state policy of returning unspent monies to the general fund at the close of each fiscal year. Thus, spending authority for this agency may not exist beyond any given fiscal year when state-appropriated funds from that year are involved.

Grant Reviews and Awards

In the fall of each year, notice is published to all state-funded projects and regional planning bodies concerning the grants-in-aid program for the coming fiscal year (state fiscal year runs July 1 to June 30). Applications are distributed as required (See Appendix C, OADAP Grant Application, for specimen) and a final submission date of February first is set for projects that begin on or after July first. The review process is conducted as outlined in the following flow chart. (Chart 5)

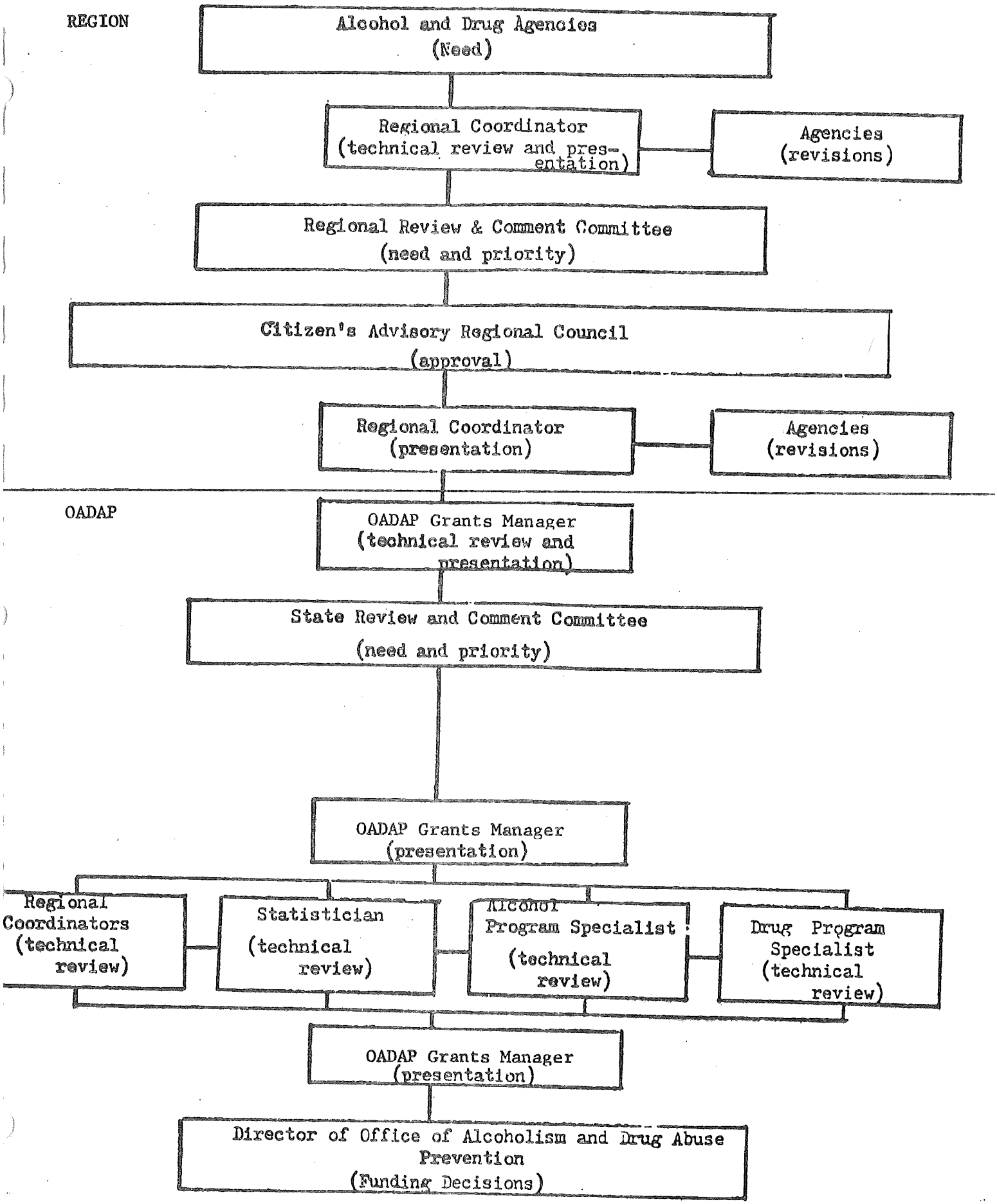
A file is established for each application received and a letter of receipt is sent to the applicant. Applications are then checked for completeness and assigned to a central office staff person for technical review. Discrepancies at the central office point are minimal since the application has already received a preliminary review at the regional level in addition to the assistance provided by the regional coordinator during the grant-development stage.

Staff comments are prepared in a standardized format and are sent to the applicant at the same time they are submitted to the OADAP Grants Manager. This allows time for applicant response to the staff comments, to be developed before presentation to the State Review and Comment Committee. Copies of both the staff comments and the application are sent to each Review and Comment Committee member before the Review Committee meeting. This helps to minimize meeting time to familiarize members with the application content. It also enables committee members to formulate specific questions or gather amplifying information for the application review.

Applicants and other interested parties are invited to be present to answer committee concerns about their respective applications. Also present during the application review are the regional coordinator, who speaks for the application with a local regional perspective, and the appropriate OADAP staff specialist (Alcoholism Program Specialist, Drug Abuse Program Specialist or Prevention Coordinator), who represent the state office viewpoint and provide technical assistance to the committee regarding program performance criteria and relevance of the proposed activity to the statewide planning effort. Review and Comment Committee members already possess a knowledge of statewide concerns by virtue of their membership on the State Advisory Council. (The committee is composed of the State Advisory Council Chairman and five other State Advisory Council members who act on behalf of the full council, but whose decision is not subject to review by the State Advisory Council.)

At the meeting, the committee discusses each application before interviewing the applicant. The interview process involves questions from both the committee members and the applicant. After the interview is completed, the committee again discusses the application as well as the findings of the interview. The committee then records its concerns and recommendation for presentation to the OADAP Director. This recommendation is not binding and the OADAP Director makes the final decision concerning each application. Any further appeal of the OADAP Director's decision may be made to him or his immediate superiors up to, and including, the Commissioner of Human Services.

CHART 5


REGION
Alcohol and Drug Agencies
(Need)
Regional Coordinator
(technical review and presentation)
Agencies
(revisions)
Regional Review & Comment Committee
(need and priority)
Citizen's Advisory Regional Council
(approval)
Regional Coordinator
(presentation)
Agencies
(revisions)
OADAP
OADAP Grants Manager
(technical review and presentation)
State Review and Comment Committee
(need and priority)
OADAP Grants Manager
(presentation)
Regional Coordinators
(technical review)
Statistician
(technical review)
Alcohol Program Specialist
(technical review)
Drug Program Specialist
(technical review)
OADAP Grants Manager
(presentation)
Director of Office of Alcoholism and Drug Abuse Prevention
(Funding Decisions)

All applicants are notified in writing of the committee's recommendation and the OADAP Director's subsequent decision. A grant-award letter is issued to each prospective grantee listing conditions for their particular award and informing them of the grant-period dates, amount of the award, reporting requirements and payment schedule.

The grant file maintained on each award includes the following as a minimum:

a. Complete original grant application (and any revisions).
b. Copy of the staff review comments.
c. Copy of review and comment findings (both regional and state).
d. All other documentation used in arriving at a final grant decision.
e. Copy of the grant-award letter (and any amendments).
f. Documentation relating to compliance with specific conditions of the grant award.
g. Payment authorizations.
h. Quarterly financial and program narrative reports (or other special reports as required).
i. Final financial report.
j. All associated correspondence, including but not limited to, letters of receipt and notification of noncompliance, notice of termination, request for refund, departmental audit report and copies of checks received as settlement for any exception or overpayment refund.

Grants Monitoring and Evaluating

Grants are monitored through periodic written reports, on-site visits, regional coordinator activities, statewide management information system data, general public comments, final program evaluation report (this is included in a subsequent year's application for funding and most often applies to continuation grants as a requirement for future project funding), and departmental audit findings.

Periodic written reports usually include quarterly or monthly submission of a grant-specific financial report signed by the grantee agency representative who is responsible for the total project accountability and a program narrative report of project activities. The latter report is supposed to include success or failure assessments based upon criteria established in the original grant application and an identification of problems with goal attainment during the reporting period. This provides the appropriate program specialist with information which may be used to form the basis for a technical assistance opportunity. In the case of grant awards predicated on units-of-service criteria, monthly reports include service-delivery information and a billing based on the quantity of service provided. Payment for these awards is usually a monthly fraction of the total award with the final payment being adjusted for any discrepancy created by unforeseen performance problems (i.e. a 12-month grant of this type would provide a payment for service each month equal to 1/12th of the total award for 11 months. A final payment would be based on actual service delivery for the full 12-month period). This method allows for more manageable cash-flow planning by the grantee agency.

On-site visits are usually accomplished by the appropriate program specialist and may involve the regional coordinator. Most of the agencies receiving OADAP grants also are licensed by this office. Thus, a site-visit and a licensing inspection may be combined, since they essentially examine the same program factors. Because many site visits are conducted informally, site visit reports are not usually written, except for licensing.

The management information system is described elsewhere in this plan. Its use by the various program specialists and the grants manager results in the major source of quantifiable information for objective observation of grant activity performance. All grantees providing treatment services are required to participate in this data collection system.

General public comments, although infrequent, provide a valuable tool for program monitoring. This office, in carrying out its responsibilities to the taxpayer and the public at large, must respond appropriately to all public comments. In the event of a complaint concerning any grantee, a formal investigation is conducted only if the complaint is received in writing, or if the situation is such that public knowledge or effect on a class of individuals is widespread and obvious to state agency personnel. However, even if a complaint is not written, time is taken to conduct an informal investigation to satisfy this agency as to the seriousness of the problem and the need and willingness to correct it.

Favorable public comment is introduced at grant reviews and other opportunities to provide support for program efforts. Such comment, when it is unsolicited and from persons having no direct interest in the specific proposal, is given substantial weight in determining community acceptance of project presence.

The final program evaluation report may be presented to OADAP in at least three different forms. The most common form is in the goals and objectives portion of the next grant application. This is because of the ongoing nature of most of OADAP's funding initiatives. Thus, a requirement for continuation becomes, by this fact, submission of an acceptable evaluation of prior performance. The staff comment format for grant review specifically directs the reviewer to an analysis of the information presented in that section.

Two other acceptable forms of the final program evaluation report are the formal evaluation plan results and documented evidence of compliance. The first of these is developed as an integral part of the project design and must be delivered prior to final payment of the award. The other may be an invoice or receipt identifying a specific expenditure, or it may include a fully executed affidavit affirming the expenditure, discharge or assumption of an obligation or completion of a prescribed activity on the part of the grantee. This second form is usually accepted for a single-purpose grant issued to purchase equipment, service or training from a vendor source.

Departmental audit is conducted by the Department of Human Services, Division of Audit, and is accomplished within six to nine months after the close of a fiscal year. Timing is greatly dependent on the auditors' workload. A formal audit report is usually available within six weeks of the on-site inspection. The report contains a complete analysis of transactions

occurring between the Department's various agencies and the grantee being audited. Findings are reported as exceptions and notices with the auditors' recommendation for a fair settlement. Upon receipt of the report, the agency may appeal any exceptions to the Commissioner of Human Services who makes a final decision concerning audit claims for the Department. If an appeal is not probable, requests for settlement are made in writing to the grantee agency which must make a reasonable effort to settle, or the case is turned over to the State Attorney General's office for possible legal action. No pressure for refund is exerted on any grantee while an appeal is in process.

The OADAP Grants Manager is responsible for taking notice of and coordinating the several types of grants monitoring for each award. He is responsible for taking action on exceptions and ensuring the appropriate program specialists are informed of reports and problem areas uncovered through the monitoring and evaluation process. Information generated through the life of the grants is utilized in the general planning process and for analysis of subsequent grant application submissions.

State Fiscal Year 1978 Grants Program

The following table illustrates the uses of funds available for the OADAP grants program during state fiscal year 1978:

GRANTS-IN-AID FY-78

SOURCE	KIND	NUMBER	DOLLAR AMOUNT
NIAAA Formula Grant	Reg. Planning Grant	3	$ 68,666
	Direct Services	2	36,520
NIAAA Uniform Act Incentive Grant	System Improvement	2	14,213
	Direct Services	10	194,289
State Alcoholism Grants	Direct Services	24	377,022
	Title XX Seed Donation	12	291,250
NIDA Formula Grant	Reg. Planning Grant	3	22,802
	Direct Services	8	120,432
NIDA Statewide Services Contract	Direct Services	6	67,250
NIDA Statewide Training Support Program	Training Grants	16	4,000
Tetracycline Settlement	Direct Services	1	28,628
State Drug Abuse Grants	Direct Services	9	133,611
	TOTAL	96	$1,358,683

The only major contract program for this fiscal year was the Title XX Alcoholism Services Program administered by the Bureau of Resource Development which supplied $1,050,000.00 in federal Title XX dollars which were matched with $291,250.00 of state seed dollars and $58,750.00 locally-generated seed dollars (other than state government).

Two awards for substance abuse services were made this year using federal funds from more than one discipline. When this combination effort occurs, funding is shared equally if the overlap of activity was such that no quantifiable apportionment of activity can be made, or if any specific activity can be defined, then dollar amounts from each discipline are prorated according to expected project time and/or resources to be expended in the pursuit of

that activity. Monitoring of the actual activity performance is conducted by way of site visits and periodic program narrative reports.

Health Systems Agency Involvement

The Maine Health Systems Agency has only recently been certified by the federal government as the planning and oversight body for local community projects utilizing federal funds. For this reason, they have not included themselves in our overall grants planning process. We have provided assistance with the State Health Systems Plan and expect to include them in the review of local projects which would receive federal monies cited in their enabling legislation for the next fiscal year. Eventually, they will be fully involved with all of our grants to local community health care projects. This will require more staff, both for them and for this office, in order to facilitate the close cooperation necessary to perform an adequate review in a timely manner. At the present time, no process for meeting the HSA review requirements has been developed. Such a process would not be developed earlier than fall of 1978 and must be available for use by February of 1979, if it is to be applied to the next program year.

G. Service Delivery System

The existing system for delivery of drug and alcohol treatment and prevention services in Maine comprises several community-based agencies and the Department of Education and Cultural Services. On the other hand, intervention services are delivered directly by OADAP and other state agencies. In order to provide an adequate description of the delivery system, information is provided here in three distinct formats.

First, two charts are presented. One summarizes modalities and volumes for treatment services. Modalities are defined as components of care which are contained in the OADAP Regulations for Licensing of Substance Abuse Treatment Facilities (Appendix D). The second chart categorizes prevention services as either information, education, intervention or alternative services. A brief description of each individual service is provided with an indication of the number of clients it serves.

Secondly, each community-based treatment or prevention program in our system has prepared a more detailed description of its services. These Facility Description and/or Program forms are presented in order by OADAP Planning Regions and are referenced by the type of treatment or prevention services offered. Anticipated changes in individual programs are briefly noted on the descriptive forms. Finally, since existing intervention services are highly specialized, a narrative description is presented for each of those services.

CHART 6

DRUG ABUSE, ALCOHOL ABUSE & ALCOHOLISM TREATMENT

*Modality (Component)	Number of Agencies containing Component	Capacity by Number of beds	Approximate usage of Component per year	Classification of components
Shelter	6	47	14,852 client nights	Alcoholism Agencies
Emergency Care	6**	57**	**2,356	Alcoholism
Inpatient Care	1	12 (others available on demand)	350 Admissions	Alcoholism
Intermediate Care (Social Setting Short Term Rehabilitation) (Up to 45 days)	6	49	1,050 Admissions	Alcoholism
Intermediate Care (Hospital Based) (up to 28 days)	2**	41**	**572 Admissions	Alcoholism
Intermediate Care (Halfway House) (90 day program)	2	46	144 Admissions	Alcoholism
Intermediate Care (180 day program) (NIDA Residential Treatment)	1	12	43 Admissions	Drug Abuse
Outpatient	13**	N/A	**3,831 Persons	Joint (2) Alcoholism (8) Drug Abuse (3)
Long Term Housing	0	0	0	(None available listed because of next year's objectives)

* Modality in Maine is referred to as component. This term is substituted throughout the plan for consistency with the State of Maine Licensing Regulations.

** These numbers do not include client caseload of:

(1) Togus Veterans Hospital, Togus, Maine, which is as follows -
Emergency Care - 10 beds with 1,377 admissions per year.
Intermediate Care (6 weeks program) - 40 beds serving 477 clients per year.
Outpatient Care - serving 1,500 clients per year.

(2) Elan, Poland Spring , Maine, which is as follows - Intermediate Care - 256 beds.

NOTE: 8 components of care stated above are within Community Mental Health Centers.

CHART 7

DRUG PREVENTION SERVICES

Agency/Program	Type of Service	Amount of Services Provided/ No. of Clients on an Annual Basis	Classification of Program
Office of Alcoholism and Drug Abuse Prevention	Information	300 film showings 8,000 pamphlets distributed 500 posters distributed	Integrated
Division of Alcohol & Drug Education, Department of Education & Cultural Services	Information	200 film showings 1,000 pamphlets distributed	Integrated
YWCA Drug Education Project	Information	2,100 parents, students, and community people	Integrated
Division of Alcohol & Drug Education, Department of Education & Cultural Services	Education	1,000 introductory presentations 350 teachers, 3,500 students	Integrated
Kennebunk-Kennebunkport Youth Services Project	Education	500 students, 1,000 parents and community people	Alcohol
'Pro-Act' Course, Crisis & Counseling	Education	50 students in-depth, 500 attend one-time presentations	Integrated
Tri-County Mental Health Prevention Project	Education	10 schools	Integrated
Youth Services Project, Aroostook	Alternatives	100 youth	Integrated
Waldo County Youth Alternatives Project	Alternatives	200 youth	Integrated
Kennebunk-Kennebunkport Youth Services Project	Alternatives	500 students	Alcohol

CHART 7

DRUG PREVENTION SERVICES
(Con't)

Agency/Program	Type of Service	Amount of Services Provided/ No. of Clients on an Annual Basis	Classification of Program
Channel One	Alternatives	20 students and adults	Integrated
Youth Services Project, Aroostook	Intervention	200 youth	Integrated
Waldo County Youth Alternatives Program	Intervention	40 youth	Integrated
YWCA Intervention Project	Intervention	60 students	Integrated
YWCA Drug Education Project	Intervention	120 students	Integrated
Youth Services Project, Mid-Coast	Intervention	330 students, 500 teachers, administrators, and parents	Integrated
Substance Abuse Prevention Component, Full Circle	Intervention	50 youth	Integrated
Prevention Component, Day One	Intervention	135 students on regular basis 800 students in one-time presentations	Integrated
The Community School	Intervention	12 youth	Integrated
Project Atrium	Intervention	12 youth	Integrated

CHART 8

OADAP Planning
Region Boundaries

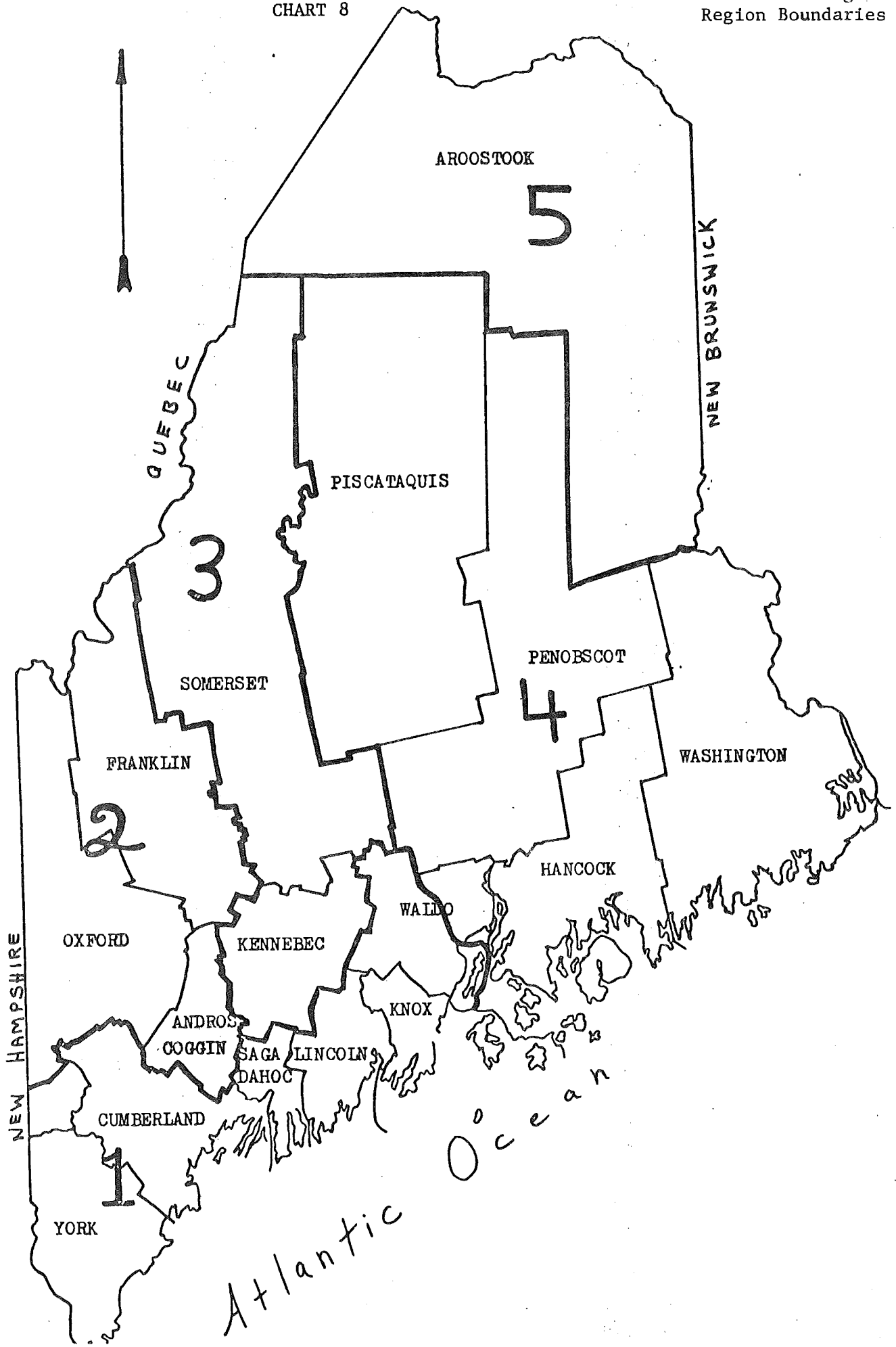
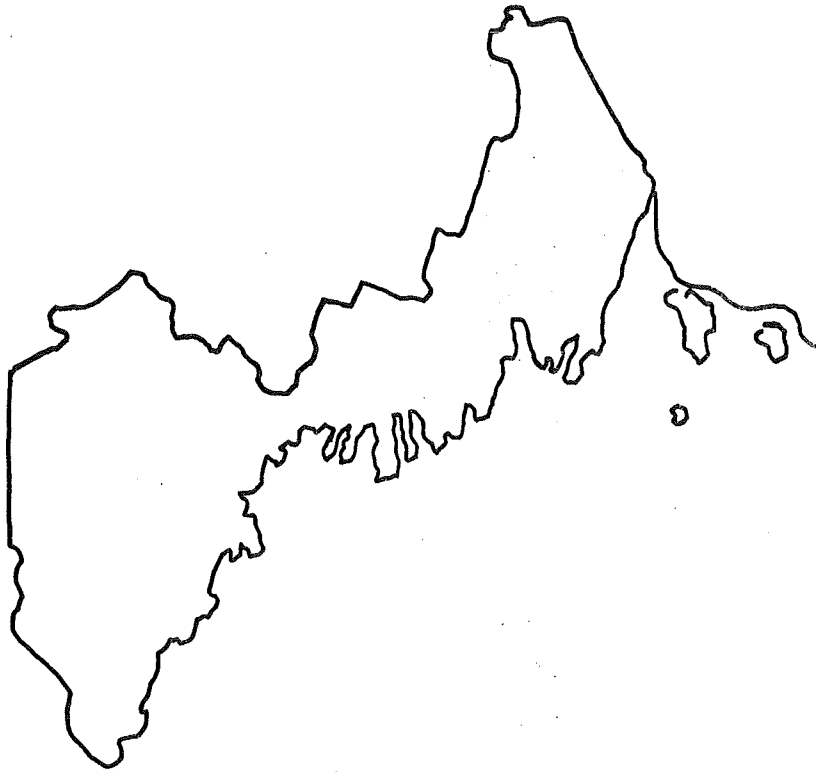


CHART 9

REGION I



FACILITY DESCRIPTION AND/OR PROGRAM

NAME: The Twenty-Four Hour Club, Inc.

ADDRESS: 65 India Street, Portland, Maine 04111

LOCATION: Portland Waterfront

TELEPHONE NO: 773-2335

NAME AND TITLE OF CONTACT PERSON Susan B. Palmer, Executive Director

HOURS 24 hours a day - 365 days a year

PURPOSE OF ORGANIZATION (one paragraph) The purpose of the Twenty-Four Hour Club is twofold. The first is the provision of emergency shelter services (bed, food and an opportunity for personal hygiene). The shelter also works with clients to promote self-sufficiency by encouraging treatment and self initiative and responsibility for the clients' lives. The second purpose is detoxification from alcohol. This includes medical detoxification, an introduction to A.A. and a referral to either outpatient counseling or residential treatment.

QUALIFICATIONS/TYPE OF CLIENT: Any alcoholic with a sincere desire to stop drinking.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) During the past year the Club has earned credibility as a viable treatment facility through changes in the administrative structure and basic program. This has included an individual counselor program and a solid referral structure.

TREATMENT: 10 days detoxification.

FUNDED BY: Title XX, OADAP, City of Portland

PUBLICATIONS:

TREATMENT SERVICES: Shelter - Emergency Care - Intermediate Care
(Short Term Rehabilitation Social Setting)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Milestone Foundation, Inc.

ADDRESS: 88 Union Avenue

LOCATION: Old Orchard Beach, Maine 04064

TELEPHONE NO.: 883-2815

NAME & TITLE OF CONTACT PERSON: Paul A. McDonnell, Administrative Director

HOURS: 24 Hours a Day

PURPOSE OF ORGANIZATION (one paragraph) To provide detoxification/ rehabilitation services to alcoholics requesting such. Services include room, board, medical and psychological assistance in the control of alcoholism. Method of delivery includes 24-hour nursing care, physical exam by a licensed physician, chemotherapy, group, individual, family counseling and intorduction to Alcoholics Anonymous.

QUALIFICATIONS/TYPE OF CLIENT: Alcoholics desiring such assistance

FEES: Title XX, Fee-for-service

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Provision of services in 609 admissions for FY77 including 2,174 days of detoxification, 3,201 days of rehabilitation services in which 5,239 hours of individual counseling and 9,855 hours of group counseling were delivered producing a 21.6 improvement (5 point scale) in medical/clinical problems of the client.

TREATMENT: Detoxification - medical model, inpatient rehab.- short-term(9 day

FUNDED BY: OADAP, Title XX, Fee-for-Service, donations

PUBLICATIONS: Brochure

TREATMENT SERVICES: Emergency Care - Intermediate Care - Aftercare
(Short and long term rehabilitation Social Setting)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Crossroads

ADDRESS: 1040 Main Street

LOCATION: South Windham, Maine 04082

TELEPHONE NO.: 892-2192 or 892-2146

NAME & TITLE OF CONTACT PERSON: Nurse on Duty

HOURS: Twenty-Four Hours a Day

PURPOSE OF ORGANIZATION (one paragraph) To provide an alcoholism treatment program with home-like atmosphere for the scientific evaluation, treatment, counseling, and recovery guidance of the alcoholic woman. To attempt to arrest the disease of alcoholism by instituting a multi-faceted treatment approach which includes family members and loved ones.

QUALIFICATIONS/TYPE OF CLIENT: Female - primary diagnosis of alcohol abuse.

FEES: Sliding fee schedule based upon ability to pay

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Occupancy rate doubled; alteration of physical plant completed, restaffing of counseling department, addition of consultants who continuously provide assessment of program needs and upgrade staff training, development of better cooperative relationships with other agencies and facilities.

TREATMENT: Detoxification, Intermediate Care, Aftercare

FUNDED BY: National Institute on Alcohol Abuse and Alcoholism

PUBLICATIONS:

TREATMENT SERVICES: Emergency Care - Intermediate Care
(Short Term Rehabilitation Social Setting)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Merrymeeting House

ADDRESS: RFD Bowdoinham, Maine 04008

LOCATION: Rural setting on 5 acres off Rte. 138

TELEPHONE NO.: 666 - 5583

NAME & TITLE OF CONTACT PERSON: Rob Gordon, Program Director

HOURS: 24 hours a day, 365 days a year

PURPOSE OF ORGANIZATION (one paragraph) Merrymeeting House strives to help people afflicted with the disease of alcoholism achieve and maintain sobriety in order that they may live happier, more productive and self-sufficient lives. Through detoxification, intermediate care, and aftercare services, the program seeks to develop and support the client's motivation for sobriety.

QUALIFICATIONS/TYPE OF CLIENT: Admission is voluntary for men and women of all ages who are experiencing problems related to alcohol abuse.

FEES: Title XX Funds for those income eligible, sliding fee scale for others.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Purchase of facility through a holding company; expanded nursing coverage; initiated OT program; instituted problem-oriented record; formalized structure of aftercare services; operated at 109% of projected capacity; implemented NAPIS and MIS systems.

TREATMENT: Detoxification, Rehabilitation, Aftercare

FUNDED BY: OADAP, TITLE XX, NIMH, BBMHC, FEES, Local Contributions

PUBLICATIONS:

TREATMENT SERVICE: Intermediate Care
(Short Term Rehabilitation Social Setting)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Mid-Coast Rehabilitation Center [1]

ADDRESS: Star Route 32, Box 180, Rockland, Maine 04841

LOCATION: Owl's Head, Maine

TELEPHONE NO: 207-594-2561

NAME AND TITLE OF CONTACT PERSON Terry Coyne, Executive Director

HOURS 24 hours

PURPOSE OF ORGANIZATION (one paragraph)

Residential alcoholism rehabilitation, 30-day Program.
(Psycho-Social Model of Alcoholism Recovery)

QUALIFICATIONS/TYPE OF CLIENT: Alcohol/Drug free, past 48 hours, Co-ed
30% Episodic/70% Chronic

FEES: $25.00 per day, based on ability to pay/sliding fee scale

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Served approximately 170 recovering episodic/chronic alcoholics. Developing comprehensive mid-coast treatment program in keeping with our COMMUNITY MODEL of alcoholism treatment. Handled approximately 800 crisis intervention phone calls (24 hr. service) plus 400 hours of emergency outpatient services including detox. arrangements.

TREATMENT: Psycho-Social

FUNDED BY: OADAP administered, Title XX funds/some OADAP direct funds.

PUBLICATIONS: None

[1] Special circumstances explained following this section.

TREATMENT SERVICE: Intermediate Care
(Long Term Rehabilitation)
(Halfway House)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Community Alcoholism Orientation House, Inc. (SERENITY HOUSE)

ADDRESS: 30 Mellen Street Portland, Maine

LOCATION: Intown Portland-- 1 block from State Street and 1/2 block off Congress

TELEPHONE NO.: 774 2722

NAME & TITLE OF CONTACT PERSON: David C. Finn

HOURS: Office Hours 9AM to 5PM Counselor on duty 24hrs.

PURPOSE OF ORGANIZATION (one paragraph)

We are a Halfway House with a 3 to 6 month residency and provide group and individual counseling to assist recovering alcoholics in maintaining sobriety and readjusting to work and reentering community life.

QUALIFICATIONS/TYPE OF CLIENT: Male, ages 18 to 65, desire to change lifestyle, employable or able to maintain self economically.

FEES: based on ability to pay

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

We have had a significant impact on approximately 50% of our former residents in the past year. We have stabilized them within a set of detailed criteria as outlined in our grant application. It would be impossible to relate this in one paragraph.

TREATMENT: intermediate long term care

FUNDED BY: Vocational Rehabilitation, Title XX, and O.D.A.P.

PUBLICATIONS: ??

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Office of Alcoholism and Drug Abuse Prevention

ADDRESS: 509 Forest Avenue, Portland, Maine 04101

LOCATION: Portland, Maine 04101

TELEPHONE NO: 207-775-6507

NAME AND TITLE OF CONTACT PERSON Charles Meserve, Alcohol Counselor II

HOURS 8:00 to 5:00 Monday - Friday Evenings by appointment

PURPOSE OF ORGANIZATION (one paragraph)

Information, referral and outpatient counseling for the alcoholic and/or family members.

QUALIFICATIONS/TYPE OF CLIENT: Anyone experiencing an alcohol problem or family members effected by an alcohol problem.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) The approximate number of clients and families, through information referral and outpatient counseling in one year is 800. The office provides literature on request. Consultant services are provided to workers within the Department of Human Services and treatment facilities in the area. Consultant to the Bureau of Rehabilitation, Vocational Rehabilitation.

TREATMENT: Outpatient counseling

FUNDED BY: OADAP - Direct Services

PUBLICATIONS: None

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Community Alcoholism Services

ADDRESS: 317 Congress Street

LOCATION: Portland, Maine 04111

TELEPHONE NO: 207-775-5671

NAME AND TITLE OF CONTACT PERSON Paul A. McDonnell, Director

HOURS 9:00 to 5:00 Monday - Friday - Evening hours by appointment

PURPOSE OF ORGANIZATION (one paragraph) The provision of outpatient/outreach/ alcoholism counseling services to residents of Cumberland County. Services include aftercare for clients completing a Residential Alcoholism treatment program, community consultation/education, individual, group and family counseling to referrals from community agencies (Cumberland County Jail, D.E.E.P. Maine Youth Center, Portland Police Dept., Parole and Probation, etc.) and self-referrals.

QUALIFICATIONS/TYPE OF CLIENT: Alcoholics/alcohol abusers, family members and employers of alcoholics.

FEES: Title XX and sliding fee schedule

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) 952 clients seen for 10,676 hours of direct service, 704 request for information filled, 140 referrals for additional services, 148 groups completed at Community agencies, 24 in-service training programs conducted at other agencies. Sample survey in FY/76 showed 67% of client population employed or not employable, and 81% not drinking.

TREATMENT: Individual, group and family counseling.

FUNDED BY: OADAP, Title XX, City of Westbrook, United Way, Catholic Church fee for service.

PUBLICATIONS: None

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Community Alcohol Services
50 Court Street; Belfast, Maine 04915
ADDRESS: 385 Main Street; Rockland, Maine 04841

LOCATION: Waldo, Knox and Northeastern Lincoln Counties

TELEPHONE NO: Belfast: 338-1629; Rockland: 594-2176

NAME AND TITLE OF CONTACT PERSON Judith Pinkham - Program Director
HOURS 8 A.M. to 5 P.M. weekdays; emergency and weekends by appointment; 24 hour emergency service as needed.

PURPOSE OF ORGANIZATION (one paragraph) To identify, evaluate and treat persons who experience problems related to alcohol use; ensuring continuity of care habilitation and motivation to change life styles centering around alcohol abuse, alcoholism and revolving crisis situations for the affected families. This will be accomplished through the following activities: Outreach, Outpatient, (including: Intake/evaluation/screening, individual, group, and family counseling, employee assistance, crisis intervention, follow-up/aftercare, case consultation and assistance services) Prevention and Education and community development.

QUALIFICATIONS/TYPE OF CLIENT: All persons residing in Knox, Waldo, and Northeastern Lincoln Counties.

FEES: Sliding scale - no one refused service because of lack of ability to pay.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) 569 clients served 2) DEEP 3) in-school Education and Prevention Program reaching 1102 persons in the last quarter along. 4) Maine State Prison Maximum and Minimum Security Programs. 5) increase in referrals due to outreach contacts, new client groups and a new emphasis on womens' programs and special needs. 6) Waldo County Jail Program 7) CAS passed the State of Maine Approval Inspection and is now a State Certified Outpatient Counseling Program.

TREATMENT: Outpatient

FUNDED BY: NIAAA, OADAP, MCJPAA, CETA, Title XX (Tentative), Towns, Fees.

PUBLICATIONS:

PREVENTION SERVICE: Intervention

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Waldo County Youth Alternatives Program [2]

ADDRESS: 100 Main Street, Searsport, Maine 04974

LOCATION: Sponsored by: Waldo County Committee for Social Action

TELEPHONE NO: 207-548-2213

NAME AND TITLE OF CONTACT PERSON Bill McDonnell

HOURS 9:00 to 5:00

PURPOSE OF ORGANIZATION (one paragraph) The Program provides counseling, remedial education and vocational assistance to youth. Its staff also work as advocates to develop other services for youth in the County, e.g. recreational opportunities.

QUALIFICATIONS/TYPE OF CLIENT: High-risk youth between ages 12-20 in Waldo County.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

TREATMENT:

FUNDED BY: OADAP, CETA, MCJPAA, Local funds

PUBLICATIONS: None

* Completed by OADAP Staff

[2] Special circumstance explained following this section.

TREATMENT SERVICE: Outpatient

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Substance Abuse Component - York County Counseling Services, Inc.

ADDRESS: 31 Beach Street, Saco, Maine 04072

LOCATION: Saco, Sanford

TELEPHONE NO: 207-282-4151

NAME AND TITLE OF CONTACT PERSON Griff Matthews

HOURS 9:00 to 5:00

PURPOSE OF ORGANIZATION (one paragraph) The component delivers outpatient services to clients in the form of individual, group and family therapy. Crisis intervention services, consultation and education are also provided to clients and to community agencies.

QUALIFICATIONS/TYPE OF CLIENT: York County Residents

FEES: Sliding fee scale - minimum $5.00 fee.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

TREATMENT: Outpatient

FUNDED BY: OADAP - NIAAA - Title XX

PUBLICATIONS: None

* Completed by OADAP

TREATMENT SERVICES: Intermediate Care - Outpatient
PREVENTION SERVICES: Intervention

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Day One

ADDRESS: 158 Danforth Street

LOCATION: Portland, Maine 04102

TELEPHONE NO: 207-774-6373

NAME AND TITLE OF CONTACT PERSON Bruce L. Levine, Director

HOURS 24 hours

PURPOSE OF ORGANIZATION (one paragraph)

1. Drug & Alcohol Abuse Services - Rehabilitation, Counseling Referral.

2. School-based Prevention & Intervention.

3. Community Education, Training, Consultation.

QUALIFICATIONS/TYPE OF CLIENT: Substance abuser (drug or alcohol), or family member, who recognizes problem and is motivated to change; usually 15-35; no current, undetoxified addiction, no psychosis, able to control aggressive-assaultive behavior.

FEES: Sliding Scale

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

a) Treated 41 residents and 51 outpatients.

b) Classroom or individual contact with more than 500 High School students.

c) Upgrading of program services.

d) Improved referral, recordkeeping, service provision, and aftercare systems.

TREATMENT: a) Residential therapeutic community; b) Outpatient substance abuse counseling; c) School-based presention & consultation training & education in the community.

FUNDED BY: OADAP/NIDA, Portland (HUD/CDA), fees, etc.

PUBLICATIONS:

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Community School

ADDRESS: Box 429, Camden, Maine 04843

LOCATION: 79 Washington Street, Camden, Maine 04843

TELEPHONE NO: 236-3000

NAME AND TITLE OF CONTACT PERSON Dick Watson

HOURS 9:00 to 5:00

PURPOSE OF ORGANIZATION (one paragraph) To provide a residential Group Home/School where students receive a full-time 40 hour/week job experience, structured classes in the evening leading to a High School Diploma, close living relationships with other students and staff, which includes constant informal counseling, as well as a structured weekly Group Rap where abuse problems, emotional issues and self-discipline are handled.

QUALIFICATIONS/TYPE OF CLIENT: 16 - 20 year old high school drop-out with substance abuse and/or legal,and/or social problems.

FEES: $940/month

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Four students were enrolled at the school the Spring/Summer 1977 Term - Three were granted diplomas September 17th. Camping trips included a 2-day canoe expedition on the St. George River and a trip to Cape Cod. Six students were enrolled the Fall/Winter 1978 Term - Four received diplomas March 19th. Two former students became Board Members. An Operations Manual was completed.

TREATMENTXX

FUNDED BY: (OADAP, Title XX, LEAA, School Districts, Mental Health Corrections, Probation & Parole, Parents and Students.

PUBLICATIONS: Brochure, Newsletter

TREATMENT SERVICE: Outpatient
PREVENTION SERVICE: Intervention

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Full Circle

ADDRESS: 24 Jordan Avenue

LOCATION: Brunswick, Maine 04011

TELEPHONE NO: 207-729-8706

NAME AND TITLE OF CONTACT PERSON Herman J. Stegeman, RSW

HOURS 8:00 to 5:00 Monday - Friday, After hours by appointment

PURPOSE OF ORGANIZATION (one paragraph) Reduction of substance abuse by youthful residents of the area.

A. Provision of clinical services for individuals, families, groups who are experiencing abuse or who are at-risk.

B. Provision of education/consultation on community substance abuse issues.

QUALIFICATIONS/TYPE OF CLIENT: Residents of Sagadahoc County and parts of Lincoln and Cumberland Counties.

FEES: Sliding

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Effective clinical services and ancillary activities plus educational activities provided throughout the area on a community-based model.

TREATMENT: Group, family, individual outpatient counseling.

FUNDED BY: Local, State, Federal.

PUBLICATIONS: "Close to the Ground" (Resource Guide)

PREVENTION SERVICE: Intervention

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Youth Services Project, Mid-Coast Mental Health

ADDRESS: 385 Main Street

LOCATION: Rockland, Maine 04841

TELEPHONE NO: 207-594-2541

NAME AND TITLE OF CONTACT PERSON Stephen Fein

HOURS 9:00 to 5:30

PURPOSE OF ORGANIZATION (one paragraph) The Project provides individual, group and family counseling to high-risk adolescents in selected school districts. It also provides consultation/education and training opportunities to teachers, administrators and parents who live and work with those adolescents.

QUALIFICATIONS/TYPE OF CLIENT: Youth ages 15 - 19

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

TREATMENT:

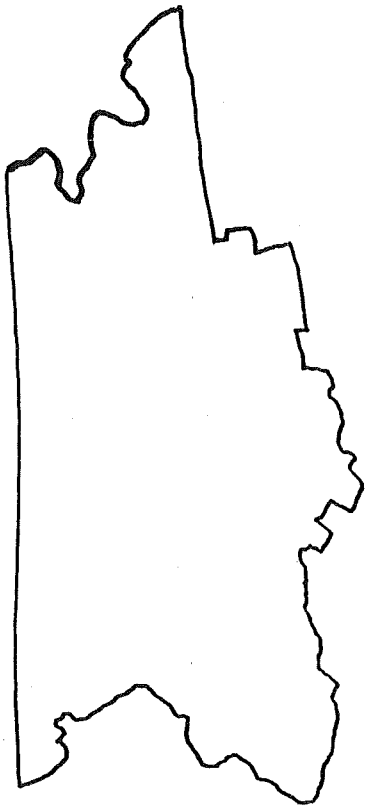
FUNDED BY: OADAP - Mid-Coast Mental Health

PUBLICATIONS: None

* Completed by OADAP Staff

CHART 10

REGION II



FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Fellowship House [3]

ADDRESS: 95 Blake Street

LOCATION: Lewiston, Maine 04240

TELEPHONE NO: 207-784-2901

NAME AND TITLE OF CONTACT PERSON Edward E. Dennison, Director

HOURS 24 Hours

PURPOSE OF ORGANIZATION (one paragraph)

To shelter and detoxify alcoholics - To provide treatment for 10 days in detoxification and no more than 24 hours in shelter, and to provide arrangements for aftercare.

QUALIFICATIONS/TYPE OF CLIENT: Title XX Low income eligibility.

FEES: Arrangements on case, by case arrangements.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) We served 290 clients in detoxification - 361 clients shelter. 74.7% of clients completed treatment - 62.6% of all clients were referred to an aftercare, based on individual needs.

TREATMENT: Shelter and Detoxification

FUNDED BY: OADAP - Title XX

PUBLICATIONS: None

[3] Special circumstances explained following this section.

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Tri-County Mental Health - Alcoholism Services [4]

ADDRESS: 106 Campus Avenue

LOCATION: Lewiston, Maine 04240

TELEPHONE NO: 207-783-9141

NAME AND TITLE OF CONTACT PERSON Ray Guest, Supervisor

HOURS 9:00 to 5:00 Monday - Friday

PURPOSE OF ORGANIZATION (one paragraph) Alcoholism services consisting of group and individual counseling, referral, aftercare for alcoholics and/or family members - special education programs.

QUALIFICATIONS/TYPE OF CLIENT: Alcoholics or family members

FEES: None or Sliding Scale - No one refused services

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

Direct service is provided to 600 clients - Group services provided to 150 clients.

TREATMENT: Individual and group counseling

FUNDED BY: Title XX - OADAP - Client fees

PUBLICATIONS: None

[4] Special circumstances explained following this section.

TREATMENT SERVICE: Intermediate Care

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Elan One

ADDRESS: RFD Box 33

LOCATION: Poland Spring, Maine 04274

TELEPHONE NO: 207-998-4666

NAME AND TITLE OF CONTACT PERSON Arlene Best, Executive Secretary

HOURS 24 Hours a day - Office business hours 9:00 to 5:00 Monday - Friday

PURPOSE OF ORGANIZATION (one paragraph) Elan One is a residential treatment facility for behaviorally disturbed and impulsive adolescents: drug and alcohol abuse, delinquency, violence, etc.

QUALIFICATIONS/TYPE OF CLIENT:

FEES: $1200/month - $3000/year education

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

TREATMENT:

FUNDED BY:

PUBLICATIONS:

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Tri-County Mental Health Prevention Project

ADDRESS: 106 Campus Avenue

LOCATION: Lewiston, Maine 04240

TELEPHONE NO: 207-783-9141

NAME AND TITLE OF CONTACT PERSON Madonna Clifford

HOURS 8:00 to 5:00

PURPOSE OF ORGANIZATION (one paragraph) Develop needs assessment and appropriate material and training for dealing with drug abuse in schools.

QUALIFICATIONS/TYPE OF CLIENT: Schools in Androscoggin, Oxford and Franklin Counties.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) New - Survey tool developed, and survey begun.

TREATMENT: Prevention Education

FUNDED BY: NIMH

PUBLICATIONS: None

* Completed by OADAP Staff

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Y.W.C.A. Drug Education Program

ADDRESS: 248 Turner Street

LOCATION: Auburn, Maine 04210

TELEPHONE NO: 207-783-8317

NAME AND TITLE OF CONTACT PERSON Mary E. Fuller, Counselor

HOURS 9:00 to 5:00

PURPOSE OF ORGANIZATION (one paragraph) The Drug Education Program is a preventive approach to substance abuse aimed toward responsible decision making about drug use. The program is designed for 6th, 7th and 8th grade students at 3 local Junior High Schools on a voluntary participation basis, with referrals to appropriate agencies for follow-up.

QUALIFICATIONS/TYPE OF CLIENT: Interested students and potentially abusing students.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Over the past year, I have conducted on-going in-school groups for 100 students. I have also offered several educational presentations (approximately 50) to schools, Church and parent groups.

TREATMENT: Prevention

FUNDED BY: OADAP

PUBLICATIONS: None

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Y.W.C.A. Intervention Program

ADDRESS: 248 Turner Street

LOCATION: Auburn, Maine 04210

TELEPHONE NO: 207-782-2441

NAME AND TITLE OF CONTACT PERSON Susan Gang, Director

HOURS 9:00 to 5:00 - Evenings by appointment or emergency

PURPOSE OF ORGANIZATION (one paragraph) Full scale adolescent counseling program - 11 - 20 - Individual counseling - in-school drug and alcohol Group Counseling, family counseling and in-school prevention groups.

QUALIFICATIONS/TYPE OF CLIENT: Any adolescent 11-20

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Created a network of adolescents, provided services to 150 adolescents, established many groups in schools and worked in placing adolescents in emergency homes.

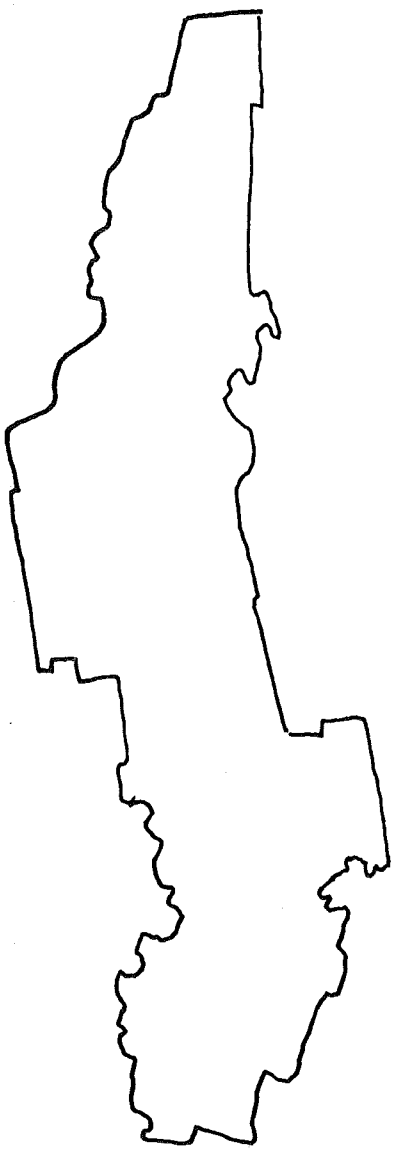
TREATMENT:

FUNDED BY: LEAA, Title XX, OADAP, City of Auburn, United Way.

PUBLICATIONS: None

CHART 11

REGION III



TREATMENT SERVICES: Intermediate Care - Outpatient - Outreach
(Short Term Rehabilitation Social Setting)

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Mt. Zion Christian Fellowship Home

ADDRESS: 53 Second Street

LOCATION: Hallowell, Maine 04347

TELEPHONE NO: 207-622-6434

NAME AND TITLE OF CONTACT PERSON Father Louis Verini, Executive Director

HOURS 24 Hours

PURPOSE OF ORGANIZATION (one paragraph) Mt. Zion provides outreach, outpatient counseling, shelter and short term rehabilitation to the alcoholic. Referral for additional supportative services as needed.

QUALIFICATIONS/TYPE OF CLIENT: Alcoholic persons in need and seeking assistance.

FEES: $7.00 per day - No one refused for inability to pay.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Mt. Zion was licensed by the State of Maine to operate on February 1, 1978. Approximately 75 clients will be served per year.

TREATMENT: Individual/group counseling, educational sessions on diet and effects of alcohol in the body, spiritual counseling, Alcoholics Victorious.
FUNDED BY: Client fees, private donations

PUBLICATIONS: None

* Completed by OADAP Staff

TREATMENT SERVICES:=Outreach - Outpatient - Aftercare - Intermediate Care (Short Term Rehabilitation)
(Hospital Based)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Kennebec Valley Comprehensive Alcoholism Treatment Program (KVCATP)

ADDRESS: Mid-Maine Medical Center - Seton Unit

LOCATION: Waterville, Maine 04901

TELEPHONE NO: 207-873-2171, Ext. 254

NAME AND TITLE OF CONTACT PERSON Counselor on duty

HOURS Twenty-Four

PURPOSE OF ORGANIZATION (one paragraph) To rehabilitate alcoholics and their families so that they may become aware of their intrinsic value of self-worth and return to the community as productive citizens.

QUALIFICATIONS/TYPE OF CLIENT: Resident of Kennebec, Somerset Counties and the State of Maine.

FEES: Title XX, Insurance, Self-pay.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Treated 250 persons in rehabilitation - 100 in shelter - 320 in aftercare - 116 in outpatient and 500 hours in prevention and education.

TREATMENT: Prevention, Education, Intermediate Care and Outpatient

FUNDED BY: OADAP, Title XX, MMMC (Insured Patients)

PUBLICATIONS: None

TREATMENT SERVICE - Outpatient
PREVENTION SERVICE - Education

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Crisis and Counseling Center

ADDRESS: 79 Sewall Street, Augusta, Maine 04330

LOCATION: Augusta, Waterville, Skowhegan

TELEPHONE NO: 623-4511

NAME AND TITLE OF CONTACT PERSON Chris York, Director

HOURS 8:30 to 5:00 - Monday - Friday

PURPOSE OF ORGANIZATION (one paragraph) The Crisis and Counseling Center is an outpatient drug counseling center, with services for adolescent alcohol abusers. We provide: Personal and Group Counseling to clients, prevention and drug information classes to schools and drug identification and information to the general public.

QUALIFICATIONS/TYPE OF CLIENT: Any person with substance abuse problems.

FEES: Sliding Fee Scale

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) We have provided substance abuse counseling to a total of 204 people. Also during the past year, we provided drug abuse prevention/information to eight area school systems and various community organizations.

TREATMENT: Counseling

FUNDED BY: National Institute of Drug Abuse and OADAP

PUBLICATIONS: ----------

PREVENTION SERVICE: Information, Education

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Human Development and Guidance Resources Unit, Department of Education and Cultural Services. [5]

ADDRESS: Education Building

LOCATION: Augusta, Maine 04330

TELEPHONE NO: 289-2306

NAME AND TITLE OF CONTACT PERSON Carl Mowatt

HOURS 8:00 to 5:00

PURPOSE OF ORGANIZATION (one paragraph) Develop school projects to assist schools better relate to students and their problems with drugs, in order that these problems will be either reduced or eliminated.

QUALIFICATIONS/TYPE OF CLIENT: School Systems

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Presented student/teacher/parent workshops; Human Development Program Workshops; and Drug, Alcohol, Tobacco and Human Behavior Workshops in public schools - statewide.

TREATMENT:

FUNDED BY: Department of Education and OADAP

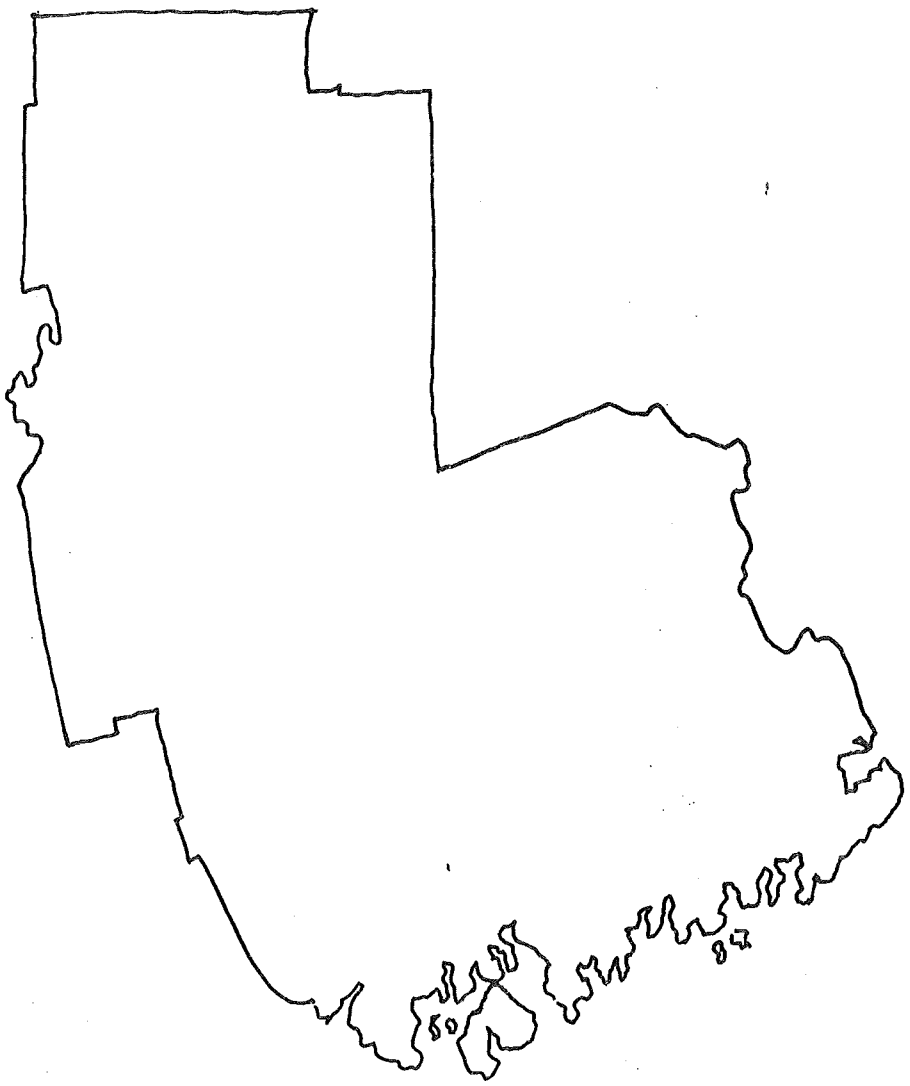
PUBLICATIONS: None

* Completed by OADAP Staff

[5] Special circumstances explained following this section.

CHART 12

REGION IV



FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Hope House, Inc.

ADDRESS: 43 Illinois Avenue

LOCATION: Bangor, Maine 04401

TELEPHONE NO: 207-942-1808

NAME AND TITLE OF CONTACT PERSON Richard Nason, Director

HOURS Shelter: 5:00 P.M. to 6:00 A.M. Detox, anytime

PURPOSE OF ORGANIZATION (one paragraph) Hope House is a facility whose philosophy is of AA and it is our goal to provide shelter, service and detoxification to every alcoholic that is in need of a place to sleep or to begin a program of recovery.

QUALIFICATIONS/TYPE OF CLIENT: Any alcoholic who is in need of a place to sleep or wants to begin a program of recovery. At present, Hope House is unable to accept clients who are not ambulatory due to the construction of the house.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) In 1977, Hope House provided 5,675 units of shelter to clients who were intoxicated. It is estimated that we have served 180 different individuals during this period or approximately 10% of the chronic alcoholic population of the region. Secondary detoxification in 1977, provided 2,913 units of detoxification.

TREATMENT: Shelter, Detox, group therapy, counseling, AA meetings

FUNDED BY: OADAP, Title XX, City of Bangor

PUBLICATIONS: None

TREATMENT SERVICES: Inpatient Care - Intermediate Care
(Short Term Rehabilitation)
(Hospital Based)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Alcohol Institute - Eastern Maine Medical Center [6]

ADDRESS: 489 State Street, Bangor, Maine 04401

LOCATION:

TELEPHONE NO: 207-947-3711

NAME AND TITLE OF CONTACT PERSON Lawrence Pixley, Administrator or any counselor

HOURS For referrals - any day 8:30 a.m. - 9:30 p.m.

PURPOSE OF ORGANIZATION (one paragraph) The Alcohol Rehabilitation Unit of the Eastern Maine Medical Center offers an intensive short-term treatment program for those who have lost control of their use of alcohol and seek a way to live free of alcohol-dependence. It is a program for those who want help and are willing to share in responsibility for their own recovery.

QUALIFICATIONS/TYPE OF CLIENT: Participants come from all walks of life, economic levels, and age groups. Both men and women. The primary qualification for admission is a demonstrated capacity for recovery. Must be over 18 years of age.

FEES: $116 per day - most insurance companies cover inpatient treatment for alcoholism No one is turned away for lack of funds.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) We detoxified over 350 patients and treated 250 people in our rehab program. We offered family education sessions to over 750 people during 1977. Because of growing acceptance and recognition, our patient census has increased 23% each year since we opened. The highlight of 1977 was when 450 sober former graduates and their families attended our anniversary party at Brewer auditorium.

TREATMENT: Individual, group and family therapy. Education sessions for family and patients. Heavy emphasis on AA and Al-Anon philosophy.

FUNDED BY: Insurance reimbursement, OADAP, NIAAA

PUBLICATIONS: None

[6] Special circumstances explained following this section.

TREATMENT SERVICE: Intermediate Care
(Long Term Rehabilitation)
(Halfway House)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Bangor Halfway House, Inc.

ADDRESS: 98 Cumberland Street

LOCATION: Bangor, Maine 04401

TELEPHONE NO: 945-3163

NAME AND TITLE OF CONTACT PERSON Kenneth Schmidt, Executive Director

HOURS 8 to 5

PURPOSE OF ORGANIZATION (one paragraph) The Halfway House provides long term rehabilitation treatment for male alcoholics. The program seeks to help men who have had difficulty with maintaining families and employment due to their alcoholism. Men live in the program for three to six months or longer as necessary. Services provided: Referral to Alcoholics Anonymous, one-to-one and group counseling, vocational counseling and retraining as necessary, peer group support, psychological assessment, evaluation and therapy, recreation, Aftercare.

QUALIFICATIONS/TYPE OF CLIENT: Clients must be 18 years old or older, have been sober for 10 days and demonstrate a reasonable motivation for sobriety and employment.

FEES On the ability to pay. No payment necessary for those without Income.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) During Calendar 1976, 35 men participated in the program. Ten of these men have been sober and employed for over two years and eight men have shown significant improvement over their past lives. It is too early to make a clear statement concerning the clients using the program in 1977.

TREATMENT:

FUNDED BY: Bureau of Rehabilitation, OADAP, United Way and other sources.

PUBLICATIONS:

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: The Counseling Center - Alcohol Services [7]

ADDRESS: 43 Illinois Avenue, Bangor, Maine 04401

LOCATION: Bangor, Ellsworth, Bar Harbor, Dover-Foxcroft, Millinocket

TELEPHONE NO: 207-947-0366

NAME AND TITLE OF CONTACT PERSON Karen Hartnagle

HOURS Flexible - according to client-counselor schedules.

PURPOSE OF ORGANIZATION (one paragraph)

Alcohol services is providing outpatient services and emergency services through the Counseling Center's Dial Help system. We are also providing consultation to industries for industrial employee assistance programs.

QUALIFICATIONS/TYPE OF CLIENT: Anyone who feels he has an alcohol problem or is concerned about an alcohol problem; i.e. a family member's problem, etc.

FEES: Sliding scale according to income and family size

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

Served 737 persons, provided emergency telephone counseling to approximately 1,200 persons and have consulted with several industries.

TREATMENT:

FUNDED BY: OADAP - April, May & June

PUBLICATIONS: None

[7] Special circumstances explained following this section.

TREATMENT SERVICE: Outpatient
Native American

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Wabanaki Corporation, Inc.; Maine Indian Alcoholism Services Program

ADDRESS: 93 Maine Street

LOCATION: Orono, Maine 04473

TELEPHONE NO: (207) 866-5577/78

NAME AND TITLE OF CONTACT PERSON George M. Mitchell, Executive Director

HOURS 8:00 A.M. - 5:00 P.M.

PURPOSE OF ORGANIZATION (one paragraph) To combat and prevent the disease of alcoholism and alcohol abuse amongst Maine Indians.

QUALIFICATIONS/TYPE OF CLIENT: Indian alcoholics and their families

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Primary accomplishment was the development of the Wabanaki Wilderness Pursuits Program. This unique program is geared towards the Indian youth and utilizes a wilderness, controlled stress situation to enable the Indian youth to deal more effectively with family, alcohol, drug etc. problems.

TREATMENT: Individual, family, group counseling

FUNDED BY: National Institute on Alcoholism and Alcohol Abuse, OADAP, Title XX

PUBLICATIONS: N/A

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Project Atrium, Inc., also called Atrium House

ADDRESS: 265 Hammond Street, Bangor, Maine 04401

LOCATION: Urban setting

TELEPHONE NO: 207-942-5686

NAME AND TITLE OF CONTACT PERSON Jean L. Higgins

HOURS Office: 8:30 to 4:30; Residence: 24 hours

PURPOSE OF ORGANIZATION (one paragraph) Atrium House offers an alternative living arrangement for high-risk youth. Individual and group counseling, tutoring and development of basic living skills are the primary services provided.

QUALIFICATIONS/TYPE OF CLIENT: Youth ages 14-18 judged incorrigible, adjudicated or on probation for minor offenses.

FEES: Sliding scale; some grant monies pay for clients in full.

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) In the first year of operation, we served fifteen adolescents on a long-term basis and another fifteen in emergency situations. We have set up a viable program which is based on a system of Contracts to work on individual goals. Our success/non-success depends greatly on the commitment of the client.

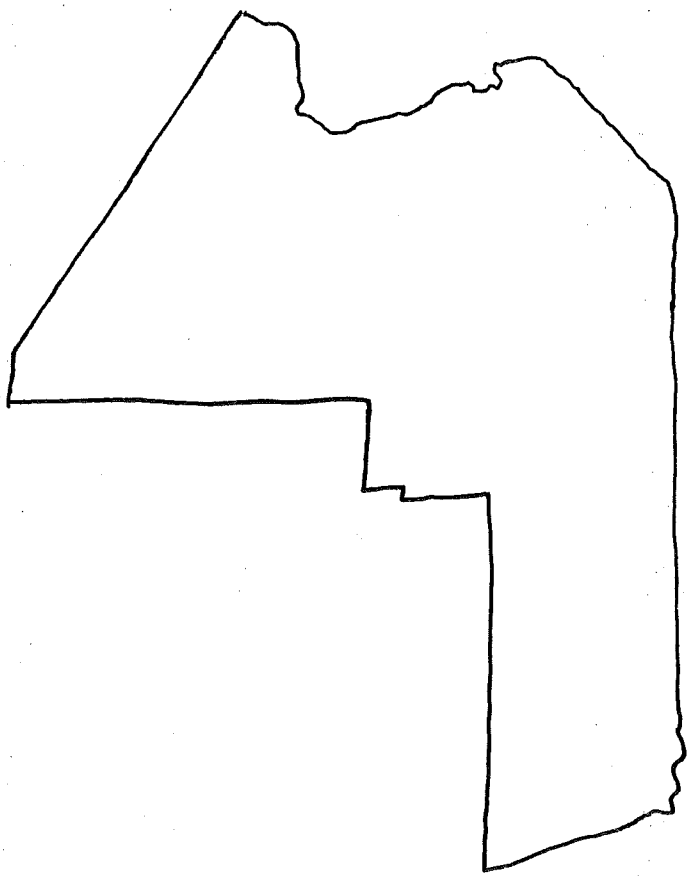
TREATMENT:

FUNDED BY: Law Enforcement Assistance Agency, OADAP, Dept. of Human Service

PUBLICATIONS: None

CHART 13

REGION V



TREATMENT SERVICES: Outreach - Outpatient - Intermediate Care
(Short Term Rehabilitation Social Setting)
(Substance Abuse)

FACILITY DESCRIPTION AND/OR PROGRAM*

NAME: Aroostook Mental Health Center

ADDRESS: 7 Green Street, Fort Fairfield, Maine 04742

LOCATION: Satellite offices throughout Aroostook County

TELEPHONE NO: 207-472-3511

NAME AND TITLE OF CONTACT PERSON Wes Davidson, Director
(24 hour emergency line available)

HOURS 8:30 to 5:00 Evening hours offered in selective locations.

PURPOSE OF ORGANIZATION (one paragraph) To provide alcoholism services to alcoholics, their family members/associates, and the community at large. Serves four to five hundred clients per year.

QUALIFICATIONS/TYPE OF CLIENT: Persons with clear indication of the presence of an alcohol abuse or alcoholism problem or immediate family members of persons experiencing alcohol problems.

FEES: Sliding scale fee (No one refused services because of inability to pay)

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Integration of Mental Health and Alcoholism - 24 hour HELP-LINE - Designation of the Residential Treatment Farm as a Substance Abuse Facility - Integration of Mental Health and Alcoholism Community Education Program.

TREATMENT: 24 hour telephone, outpatient and residential; psychiatric; social evaluations; individual, marital family group therapy; educational, education

FUNDED BY: NIAAA - OADAP (directed at community awareness.

PUBLICATIONS: Newspaper articles - Brochure Alcoholism - The Aroostook View-
(Video Tape)

* Prepared by OADAP Staff - Information from AMHC

TREATMENT SERVICE: Information & Referral

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Aroostook Community Action Program - Alcohol Information & Referral Program

ADDRESS: 17 Church Street

LOCATION: Presque Isle, Maine 04769

TELEPHONE NO: 207-769-7811

NAME AND TITLE OF CONTACT PERSON Don Thibodeau - Program Director
Candice DuPerry - Alcoholism Specialist

HOURS 8:30 to 5:00 Monday - Friday (Answering service available 24 hours & weekends.

PURPOSE OF ORGANIZATION (one paragraph) Information and Referral for Alcoholics. Education - Informational Program available for all schools in Aroostook County - Workshops for Teachers. Information programs for school, churches, and community social groups.

QUALIFICATIONS/TYPE OF CLIENT: Low income in Aroostook - No one turned away.

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

Serves 125 clients per year. Provides information to 200 clients through telephone contact.

TREATMENT:

FUNDED BY: National Institute of Alcohol Abuse & Alcoholism.

PUBLICATIONS: None

TREATMENT SERVICES: Information - Referral - Outpatient Counseling (Native American Program)

FACILITY DESCRIPTION AND/OR PROGRAM

NAME: Association of Aroostook Indians

ADDRESS: 1 Bowdoin

LOCATION: Houlton, Maine 04730

TELEPHONE NO: 207-532-6452

NAME AND TITLE OF CONTACT PERSON Maynard Polchies (Alcohol Counselor Position Vacant)

HOURS 24 hours a day

PURPOSE OF ORGANIZATION (one paragraph) Referral and outpatient counseling

QUALIFICATIONS/TYPE OF CLIENT: Native American

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph) Estimated 70 to 80% of Native American population is in need of service - No estimate of yearly caseload until counselor is hired.

TREATMENT:

FUNDED BY: NIAAA

PUBLICATIONS: None

FACILITY DESCRIPTION AND/OR PROGRAM *

NAME: Youth Services Program, Aroostook County Action Program

ADDRESS: Box 1116, Presque Isle, Maine 04769

LOCATION: Various sites in Aroostook County

TELEPHONE NO: 207-764-3721

NAME AND TITLE OF CONTACT PERSON Sonja Fongemie

HOURS 8:00 to 4:30

PURPOSE OF ORGANIZATION (one paragraph) The program provides individual counseling and referral services for youth with alcohol, drug, family or legal problems. In addition, educational workshops are organized to increase school and community awareness of drug and alcohol problems. Finally, employment and job training opportunities for youth are coordinated through this program.

QUALIFICATIONS/TYPE OF CLIENT: Youth ages 11-17

FEES: None

ACCOMPLISHMENTS OF PAST YEAR: (one paragraph)

TREATMENT:

FUNDED BY: OADAP - CETA Funds

PUBLICATIONS: None

* Completed by OADAP Staff

Description of Special Circumstances

[1] Mid-Coast Rehabilitation Center, Owl's Head, will be defunded by the OADAP on June 30, 1978, to provide funds for outpatient and aftercare services in Region IV.

[2] Project is not proposed for OADAP funding in the coming year because of a shortage of available funds.

[3] Fellowship House - program may change beginning October 1, 1978, because of St. Mary's Hospital project which is in planning stage.

[4] Tri-County Mental Health - program may change beginning October 1, 1978, because of St. Mary's Hospital project which is in planning stage.

[5] Project is not proposed for OADAP funding in the coming year because of a shortage of available funds and a shift in prevention priorities to local community-based efforts.

[6] The Alcohol Institute - Bangor has been requested to provide outpatient and aftercare services in Region IV beginning July 1, 1978, using funds provided by the OADAP.

[7] The Counseling Center - Bangor will discontinue services June 30, 1978, because year 08 of this NIAAA Grant was not funded.

Criminal Justice System Treatment Project

On October 1, 1976, a grant was obtained from the Maine Criminal Justice Planning and Assistance Agency which funded substance abuse counseling services in criminal justice facilities statewide. The project operated for eighteen months during which OADAP contracted with several service provider agencies for the provision of counselor availability. The location of the agencies selected was convenient to correctional institutions or county jails. A summary of the provider agencies and the institutions in which the services were offered is included in Chart 14.

After April 1, 1978, no further funding was available from the Maine Criminal Justice Planning and Assistance Agency for this purpose. However, many programs continued utilizing other resources. The following table shows the status of substance abuse counseling within the Maine Criminal Justice System after April 1, 1978. The following programs will continue operation in spite of the grant termination on April 1, 1978:

a. Community Alcohol Services, Belfast - Maine State Prison
b. Community Alcohol Services, Belfast - Waldo County Jail
c. Aroostook Mental Health Center - Aroostook County Jail
d. Kennebec Valley Regional Health Agency - Somerset County Jail
e. Community Alcoholism Services, Portland - Cumberland County Jail

Programs which terminated operations on April 1, 1978 were:

a. Tri-County Mental Health Services - Androscoggin County Jail
b. Crisis & Counseling - Maine Correctional Center

Programs which were not funded under this grant but continue to exist are:

a. York County Counseling Services - York County Inmates of Cumberland County Jail.
b. Day One - Maine Youth Center
c. Crisis & Counseling - Kennebec County Jail

CHART 14

Availability of Criminal Justice Project Counselors

AGENCY	FACILITY	AVAILABILITY	CONTRACT PERIOD	CONTRACT AMOUNT
Aroostook Mental Health Center	Aroostook County Jail	½ Day/Week	11/1/76-3/31/78	$3,400
Community Alcohol Services, Belfast	Maine State Prison	2 to 5 Days/Week	10/1/76-3/31/78	15,169
Community Alcohol Services, Belfast	Waldo County Jail	½ Day/Week	10/1/76-3/31/78	3,400
Community Alcoholism Services, Portland	Cumberland County Jail	½ Day/Week	11/1/76-3/31/78	3,400
The Counseling Center, Bangor	Penobscot County Jail	½ Day/Week	11/1/76-3/31/77	1,000
The Counseling Center, Bangor	Piscataquis County Jail	½ Day/Week	11/1/76-3/31/77	1,000
The Counseling Center, Bangor	Washington County Jail	½ Day/Week	11/1/76-3/31/77	1,000
Crisis and Counseling, Augusta	Maine Corrections Center	1 Day/Week	11/1/76-3/31/78	6,000
Day One, Portland	Androscoggin County Jail	½ Day/Week	11/1/76-3/31/77	1,000
Day One, Portland	Oxford County Jail	½ Day/Week	11/1/76-3/31/77	1,000
Kennebec Valley Regional Health Agency	Somerset County Jail	½ Day/Week	11/1/76-3/31/78	3,400
Mid-Coast Rehabilitation Center, Rockland	Knox County Jail	½ Day/Week	11/1/76-12/31/77	2,200
Tri-County Mental Health Services, Lewiston	Androscoggin County Jail	½ Day/Week	4/1/77 -3/31/78	2,400
Tri-County Mental Health Services, Lewiston	Franklin County Jail	½ Day/Week	11/1/76-3/31/77	1,000
TOTAL				$45,369

Intervention Services

Court Intervention

OADAP has one Alcohol Counselor II who works with the various courts in Region I to provide information, referral and outpatient counseling to those individuals who appear within the court system as a result of alcohol-related offenses.

The Court Counselor provides information and referral services to approximately 602 individuals per year. Outpatient counseling is provided for approximately 130 clients.

Driver's Education and Evaluation Program (DEEP)

The DEEP Program was established in October, 1977, by the Department of Human Services, Office of Alcoholism and Drug Abuse Prevention to help reduce the number of traffic accidents involving alcohol. It is designed for individuals convicted of operating under the influence (OUI).

DEEP conducts, through direct services or by contractual agreement, a 5-day educational program of 10 hours designed to: a) acquaint the OUI offender with the effects of alcohol on the human body and driving performance, and; b) to explore personal drinking habits and to consider changing those habits, if necessary. The education program also includes an evaluation of each participant to determine if he is a problem drinker. Individuals found to have a drinking problem are referred to treatment programs. Those individuals involved in treatment are included in the treatment chart (see Chart 6). It is anticipated that approximately 4,000 individuals per year will enter DEEP with approximately 40% referred for further treatment.

Occupational Programming

OADAP has one Occupational Program Consultant on its staff. He provides technical assistance and coordination services to Regional Councils and local program OPCs. He also works directly with industries assisting them in developing employee-assistance policies and in training supervisory personnel.

Fourteen companies have employee-assistance policies. About half of these actively follow the policies. A major thrust for the Occupational Program Consultant (OPC) is to motivate the remaining companies to implement the policies.

By Region:

V. Aroostook area is interested in developing programs, but has no personnel or industrial committee to work with.

IV. The Regional Council has an industrial committee and an active OPC who has developed a few good programs to date. The OPC is being phased out by recent action surrounding the Counseling Center.

III. In the absence of a Regional Coordinator, the OADAP OPC has developed a program with one of the large companies in the area. The OADAP OPC has also worked with state officials to develop and finally implement a State Employee Assistance Program. A counselor has been assigned to the program. The Personnel Department has assisted in the training of 2,700 supervisors.

II. The action in this area is at a stage of wait and see. Local groups are awaiting the outcome of a proposed consolidated program based on the Johnson model in Lewiston. Orientation to 100 Industrial Management Club members has taken place. The Tri-County Mental Health Center staff includes an active OPC.

I. This region seems to have placed the priorities in other areas, probably to resolve immediate crises. The Regional Coordinator is developing a few programs on his own. No industrial committee has been established.

The Occupational Program Consultants Association of Maine (OPCAM) is now incorporated and has the potential of being able to receive monies as a non-profit organization, and also of charging fees for service. At present there are five active members. Another five members show varying levels of commitment.

Consideration is being given by members to submit a grant to NIAAA to cover a unique area (population) that would attract funding without much difficulty, specifically - top and middle management.

Because of budget and previous commitments, it has been difficult to develop many programs while working alone. The fact that OPCAM members are also employees of various treatment facilities and are restricted to their agency policies, creates some dilemma.

It is my belief that future support for agencies interested in rehabilitation will eventually come from business and industry. Private organizations are reluctant to become involved; however, there should be constant thrusts to motivate them in this direction. The day may come when labor/management insist on policies and programs to save lives and money, if we can continue to develop programs at the present rate.

Top management is generally hesitant to develop programs for fear of backlash. This is a valid feeling on their part, as the problem is rampant at that level also!

State of Maine Employees Assistance Program

The State of Maine Employees Assistance Program has been developed through a task force of individuals representing state government, private providers, and consumers, and the OADAP Occupational Program Consultant. The task force was appointed by Governor James Longley.

The State of Maine EAP is administered by the Department of Personnel and is staffed by a counselor assigned to the Bureau of Rehabilitation. The counselor sees individuals through supervisory referrals and self-referrals as well. When job performance points to substandard work, a supervisor can ask the worker if he wants to use the counseling services.

The counselor discusses the situation with the employee and refers him to appropriate resources as necessary.

The Employees Assistance Program is expected to reach 125 persons per year.

Licensure and Accreditation Standards

Licensing or Certificate of Approval

The licensing of alcohol and drug residential treatment facilities was established in 1975 through legislation (MRSA - Title 22 § 5A).

In October, 1976, the alcohol residential facility regulations and drug abuse residential facility regulations were combined into Regulations for the Residential Licensing of Substance Abuse Treatment Facilities in the State of Maine (Appendix D, licensing regulations).

In addition, provision is made within the regulations for approval of non-residential treatment programs, alcohol, drug abuse or substance abuse.

Even through the regulations are combined under substance abuse, the residential or non-residential drug abuse and alcoholism programs are differentiated on the license or certificate.

Approval for Driver's Education Evaluation Program Treatment

During 1977. the State of Maine Legislature, through Chapter 626 - P.L. 1978 (Appendix E, DEEP legislation) transferred the Driver's Rehabilitation Course, which was under the Division of Motor Vehicles, to the Office of Alcoholism and Drug Abuse Prevention (OADAP). The law has also changed the program considerably from education for first offenders to education and evaluation for all offenders with provision for mandatory referral for treatment, where deemed necessary, through evaluation.

Regulations for the approval of agencies to provide treatment for referrals from the Driver's Education Evaluation Program (DEEP) (the name was changed to better reflect the contents of the program) are provided through the existing requirements for a Certificate of Approval for non-residential substance abuse treatment programs outpatient component.

Regulations providing approval for individual professionals and others to treat DEEP referrals have been developed through the Regulations for the Approval and Operation of the OUI (Operating under the Influence) Treatment Programs (Appendix F, DEEP regulations) (Appendix G, letter of agreement).

Registered Substance Abuse Counselors are authorized to provide services for OUI offenders. However, the mechanism for registering substance abuse counselors has not yet been implemented. Until the process for registration is operational, individual substance abuse counselors who meet the regulation requirements will be certified by OADAP through the letter of agreement (Appendix G).

Procedure for Licensure and/or Certificate of Approval

1. An agency must request application (Appendix H, licensing application) for new license or certificate. Renewal applications are sent from the Office of Alcoholism and Drug Abuse Prevention to the agency 105 days before license expiration. Applications are to be returned within 15 days.

   If the application is not received within 15 days, a letter is sent to the agency requesting immediate return. A licensing log with date of issuance, expiration, date application was sent and due date of application return is maintained by OADAP.

2. When the application and fee ($50) are received at OADAP, a photostat of the check is given to the business office and a file is set up for each agency.

3. The head of the licensing team (the Alcohol Program Specialist) determines if the application is complete and documentation is attached. If incomplete, the application is returned to the agency with instructions.

4. If the application is complete, OADAP requests the Department of Health Engineering and the Office of the Fire Marshal to inspect the facility. Nonresidential programs applying for a certificate of approval must arrange for local inspections and assure compliance through documentation during the on-site inspection.

5. The licensing team is composed of the Alcohol Program Specialist, Drug Program Specialist (for drug facilities inspections), Grants Manager, Associate Planner and the nurse consultant, who are responsible for different sections of the licensing regulations. A mutually convenient date is established for the inspection, usually 30 days before expiration of the present license. A letter of confirmation is sent to the agency accompanied by a schedule of inspection (Appendix I, inspection schedule). The regional coordinator is notified of the inspection date.

6. The on-site inspection begins with a thorough review of the application with the agency director to record any changes that might have occurred since OADAP received the application. The group meeting with staff serves to gain additional documentation of the program as explained in the policy manual. In addition, each staff member is asked to explain his responsibilities and feelings about the program and clients.

   The group meeting with clients (on a voluntary basis) serves to relieve the anxiety and mystery usually surrounding a licensing inspection. The meeting includes discussion on the quality and appropriateness of client services. In meeting with the board of directors or advisory committee members, community participation, present programming and future plans of the agency are discussed.

7. The team leader collects the rating sheets from team members, the results and recommendations from the Department of Health Engineering (if a follow-up inspection is necessary, it is arranged) and the results and recommendations from the Office of the Fire Marshal (the fire marshal requires a correction plan with dates for compliance).

8. The percentage of compliance is determined by dividing achieved score by possible score. Consideration is given to health and fire inspection recommendations before the final decision is made on the type of license issued. If denial or conditional license is recommended by the health or fire inspectors, that recommendation takes precedence in issuing the license.

9. After determining the type of license to be issued, the agency is sent a photostatic copy of the rating sheets along with correspondence acknowledging the type of license and, if necessary, the conditions of a conditional license.

   Three types of licenses can be issued as stated in the regulations. A conditional license is accompanied by correspondence, outlining conditions and dates for compliance. Reinspections to check noncompliance sections are carried out by the appropriate licensing team member on a pre-scheduled basis.

   The term of a temporary license shall not exceed 90 days. Reinspection must occur prior to license expiration.

   Particular attention is given to areas of noncompliance that might endanger clients. Compliance in these areas is demanded as soon as possible.

JCAH Accreditation

Two Maine agencies, both in Region I, have received JCAH Accreditation: Crossroads, the women's detoxification and residential rehabilitation program (short- and long-term rehabilitation) located in South Windham; and York County Counseling Center, outpatient services located in Saco and Sanford.

The Eastern Maine Medical Center Alcohol Institute detoxification and short-term rehabilitation program will be applying for accreditation of its alcohol units in the near future.

The following pages indicate programs and facilities holding Maine licenses or Certificates of Approval.

CHART 15

LICENSED ALCOHOLISM FACILITIES

Region	Facility	Number of Beds	Component	Type of License	Date of Expiration	Percentage Rate	License Number
I	* Crossroads	3 10 3	Emergency Care Intermediate Care Aftercare	Full	11/18/78	96%	LA7738
	Merrymeeting House	9 6	Emergency Care Intermediate Care	Conditional (Water Temperature)	12/23/78	98%	LA7733
	Mid-Coast Rehabilitation Center	18	Intermediate Care	Full	12/22/78	90%	LA7735
	Milestone Foundation	8 12 3 **	Emergency Care Intermediate Care Shelter	Full	12/18/78	91%	LA7734
	Community Alcoholism Orientation House (Serenity House) (Halfway House)	31	Intermediate Care	Full	11/18/78	85%	LA7736
	Twenty Four Hour Club	11 18 **	Emergency Care Shelter	Full	4/7/79	84%	LA7845
II	Fellowship House	15 (3) **	Emergency Care Shelter (3 emergency care beds used for shelter if necessary)	Full	12/19/78	87%	LA7731
III	Kennebec Valley Comprehensive Alcoholism Treatment Program (Seton Unit)	26 2 **	Intermediate Care Shelter (Hospital based)	Full	11/18/78	96%	LA7846X
	(Mt. Zion Christian Fellowship Home) Private Facility	7 1 **	Intermediate Care Shelter	Conditional	2/1/79	79%	LA7840

CHART 15 (continued)

LICENSED ALCOHOLISM FACILITIES

Region	Facility	Number of Beds	Component	Type of License	Date of Expiration	Percentage Rate	License Number
IV	Alcohol Institute Alcohol Rehabilitation Unit	15	Intermediate Care (Hospital based)	Full	1/18/79	94%	LA7841
	Bangor Halfway House, Inc.	15	Intermediate Care	Full	12/24/78	90%	LA7730
	Hope House	11 19 **	Emergency Care Shelter	Conditional	9/1/78	80%	LA7844
V	Aroostook Mental Health Center Residential Treatment Farm	13	Intermediate Care	Conditional (Water)	12/16/78	97%	LSA7729 (Substance Abuse)

* Program for the woman alcoholic (JCAH Accredited)

** Shelter is inspected if it is connected with another component to be licensed.

LICENSED DRUG ABUSE FACILITIES

CHART 16

Region	Facility	Number of Beds	Component	Type of License	Date of Expiration	Percentage Rate	License Number
I	Drug Rehabilitation, Inc. (Day One)	12	Intermediate Care	Full	2/13/79	86%	LD7813
	PRIVATE FACILITY						
II	Elan One	Governing Authority		Full	7/1/78	83%	LD7705
	Elan Two	30	Intermediate Care	Full	6/25/78	86%	LD7706
	Elan Three	86	Intermediate Care	Full	7/1/78	86%	LD7707
	Elan Five	35	Intermediate Care	Full	7/1/78	86%	LD7709
	Elan Six	40	Intermediate Care	Full	6/25/78	86%	LD7710
I	Elan Four	65	Intermediate Care	Full	7/1/78	86%	LD7708

PROGRAM — Certificate of Approval — Substance Abuse

Region	Agency	Component	Date of Expiration	Percentage Rate	Certificate Number
I	Community Alcohol Services - Belfast - Rockland	Outpatient Outreach	4/21/79	90%	CA7806
	Community Alcohol Services - Portland	Outpatient Outreach	10/1/78	93%	CA7701
*	York County Counseling Services - Saco - Sanford*	Outpatient	4/1/79	92%	CA7805
III	Kennebec Valley Comprehensive Alcoholism Treatment Program (Seton Unit) Waterville - Bingham Augusta - Skowhegan	Outpatient	11/18/78	96%	CA7702
	Mt. Zion Christian Fellowship Home - Hallowell	Outpatient Outreach	2/1/79	79%	CA7804
V	Aroostook Mental Health Center - Fort Fairfield Fort Kent - Presque Isle Madawaska - Houlton Van Buren - Caribou	Outpatient Outreach	12/16/78	97%	CA7703

*JCAH Accredited Program

PART II

PERFORMANCE REPORT

PART II. PERFORMANCE REPORT

Introduction

This part of the Plan describes the actions taken by OADAP in pursuit of the goals and objectives proposed in last year's separate alcohol and drug abuse state plans. These plans were titled respectively, Update to the Maine State Plan on Alcohol Abuse and Alcoholism (ASP) and the 1977-78 State of Maine Drug Abuse Prevention Plan (DSP).

Consistent with Federal guidelines for this part, OADAP's activities have been organized into five functional areas. These areas are: Administrative Services, Treatment, Rehabilitation and Diversion, Quality Assurance and Evaluation, Prevention and Education, and Manpower and Training. Administrative Services has been divided into the areas of planning and coordination and management information systems.

The discussion of activities within each area is structured so that any objectives which were identical in each plan are described first. Common objectives are followed by alcoholism objectives. These in turn are followed by drug abuse objectives.

1. Administrative Services

A. Planning and Coordination

1) Common Objectives

Planning and coordination is accomplished on three levels. The Maine Council on Alcohol and Drug Abuse Prevention and Treatment (State Advisory Council) serves in an advisory capacity to the Governor and the Director of OADAP, and functions on the policy development and state-wide planning level. The Office of Alcoholism and Drug Abuse Prevention (OADAP), which seeks and receives advice from the State Council, functions as the single state agency for planning and coordination. The Regional Councils function on the local level providing information directly to OADAP and developing substate planning initiatives, while accomplishing the coordination of all services in their area.

The State Advisory Council consists of 17 members. The chart on the following page contains the names of the current council members.

No changes have occurred in the council's structure or duties during the last year. The by-laws were changed to allow fewer members to constitute a quorum. (Six members are needed for a quorum. In the past, a majority of members present was needed, which meant as many as 9 members out of 17 would have to be in attendance. See minutes of October 12, 1977 meeting, Appendix J, Advisory Council Minutes.) This change was made necessary because of the long distances which members must travel to meetings during uncertain and harsh winter weather conditions. In spite of such weather this year, meetings have been well-attended which speaks well for the high level of interest that this council has shown over the past twelve months.

STATE ADVISORY COUNCIL CHART 17

MEMBER'S NAME	TERM EXPIRES	REPRESENTING	COMMITTEES
A. Russell Didsbury - Chairman Rockland	1980	Service Provider	Review and Comment
Frederick Wendelken, Jr. Brunswick	1980	Private Citizen	Review and Comment Counselor Registrati n
Robert Ohler, M. D. Winthrop	1978	Physician	Review and Comment
Paul L. Adams Portland	1978	Mental Health Planning	Review and Comment
Eaton W. Tarbell Bangor	1979	Private Citizen	None
John Blatchford Bangor	1980	Private Citizen	Review and Comment
Rev. James H. Word Bath	1979	Clergyman	Review and Comment Counselor Registration
Alberta R. Nicola, R. N. Old Town	1978	Native American	None
Nancy Anne Bellhouse Friendship	1980	Youth	None
Charles C. Aleck, Jr. Mexico	1979	Private Citizen	None
D. Dwight Dogherty, Jr. Auburn	1979	Private Citizen	None
Deborah Anne Buccina Rumford	1980	Youth	None
Grace E. Ridlon Hallowell	1978	Private Citizen	Counselor Registration
Clement E. Pooler Fairfield	1979	Private Citizen	None
Senator Minnette Cummings Newport	**	Legislator	None
Rep. Stephen T. Hughes Auburn	**	Legislator	None
Edward Henry Jones Waldoboro	1980	Senior Citizen	Counselor Registrati n

** Term not specified. Member serves at the pleasure of the President of the Senate or Speaker of the House.

CHART 18

The following list is a record of the council's meetings for the past year and a projected schedule of meetings still to be held. Ordinarily, meetings are held in the morning of the third Wednesday of each month.

LIST OF STATE ADVISORY COUNCIL MEETINGS

DATE	TIME	PLACE	ATTENDANCE (Members)
8/17/77	9:45 a.m.	Central Office, Augusta	11
9/14/77	1:18 p.m.	Central Office, Augusta	9
10/12/77	9:18 a.m.	Central Office, Augusta, Conference Room	8
11/10/77	9:27 a.m.	Central Office, Augusta, Conference Room	7
11/30/77	9:35 a.m.	Capitol Bldg., Room 134, Augusta	10
12/20/77	9:44 a.m.	Central Office, Augusta	13
1/20/78	9:58 a.m.	Central Office, Augusta	5
2/15/78	9:43 a.m.	Central Office, Augusta	6
3/15/78	9:39 a.m.	Central Office, Augusta	7
4/19/78	9:50 a.m.	Central Office, Augusta	7
5/17/78	---	CANCELLED	--
6/21/78	9:30	(scheduled)	--
7/19/78	9:30	(scheduled)	--

Significant projects undertaken by the State Advisory Council consisted of:

1. Assembling nominations for the Substance Abuse Counselor Registration Board and submitting them to the Governor for appointment.

2. Screening of candidates for the permanent position of OADAP Director, the results of which was the selection of the current OADAP Acting Director over a field of five other applicants. This selection is still awaiting confirmation by the Commissioner of Human Services.

3. Study of the current prevention and treatment system to help in establishing criteria for system change. This activity also included developing a model for a client-oriented hospital core comprehensive treatment system. The original date for completion of the project was optimistically set for July 1, 1978. Now it appears that at least another year will be needed.

4. Review and comment for the fiscal year 1979 OADAP grants in aid program. The committee responsible for this activity has functioned superbly throughout the process. Meetings were attended by all members and the final recommendations to the OADAP Director were strongly supported.

Minutes for all council meetings are included in Appendix J (State Advisory Council Minutes).

Following is a list of the committees which were operational during the previous year.

CHART 19

Committee	Members	Purpose
Review and Comment Committee	A. R. Didsbury * J. H. Word F. Wendelken, Jr. R. Ohler, M.D. P. L. Adams J. Blatchford	Meets to Review OADAP Grant Applications received from local programs.
Counselor Registration Committee	F. Wendelken, Jr. E. H. Jones G. E. Ridlon J. H. Word	Met to screen Counselor Registration Board nominees for recommendation to the Governor. Committee also was tasked with conducting screening interviews for permanent OADAP Director job.

2) Alcoholism Objectives

No objectives were specifically directed toward the area of planning and coordination during the past year. Due to new legislation and regulation changes, some activities which sought to improve planning and coordination did occur.

Legislation, which has had a significant effect on this area, centers around the establishment of a State Health Planning and Development Agency (SHPDA) known as the Bureau of Health Planning and Development in Maine, and the activation of a State Health Systems Agency (HSA). The latter organization is normally a substate body in other states. However, in Maine it encompasses the whole state. This serves to add two more layers of review onto the already existing review authorities which are A-95 and the Governor's grants coordinator.

In order to minimize problems which might result from the additional review requirements, OADAP staff have been meeting regularly with staff of both the SHPDA and the HSA. The meetings have resolved possible conflicts in format of plan documents, lead times needed for review and sign-off and unnecessary duplication of effort. The large workload demands and inadequate staffing allowances have been a noticeable block to complete cooperative efforts in all three agencies. Given the expected levels of future funding, it is possible that this problem will never be resolved. At this point in time, the cost of coordination with the various review mechanisms far exceeds any benefits that have been realized. We find ourselves spending ever increasing amounts of time and effort coordinating at the state bureaucracy level, while the real need for coordination is at the community level where clients must be joined with services if our primary purpose is to be accomplished.

3) Drug Abuse Objectives

(From Administration, Planning & Coordination (DSP))

Objective (1): Review and approve/deny new and old continuation applications for OADAP funding annually.

(a) Assign OADAP staff to complete technical review of all proposals.

After submission of grant proposals in February, 1978, each OADAP staff person was assigned to perform a technical review on each of five separate proposals. The review was structured by a standard outline. The resulting "OADAP Staff Comments" for each proposal were forwarded to the submitting agency and to members of the state-wide Review and Comment Committee of the OADAP Advisory Council.

(b) Insure that each grant is reviewed by the appropriate regional alcohol and drug abuse council and forwarded with recommendations to the State Advisory Council.

(c) Present results of the OADAP review and the five regional reviews to the State Advisory Council for recommendations.

The Regional Coordinators assumed responsibility for insuring completion of regional council review of grant applications prior to the review of the state-wide Review and Comment Committee. Each coordinator then attended the state-wide review of grants from his particular region and conveyed regional recommendations at that meeting, reflecting the written documentation of those recommendations which had already been provided. The OADAP Grants Manager staffed the meetings of the state-wide Review and Comment Committee of the Advisory Council. He insured that the contents of regional and OADAP Central Office reviews were available to Committee members. Representatives from each agency which submitted a grant were invited to appear before the Committee to discuss their proposed programs and to answer questions raised by their applications.

(d) Present results of all previous reviews to the SSA Director for final decisions.

The recommendations developed by the Review and Comment Committee were presented by the OADAP Grants Manager to the SSA Director for action. The full Advisory Council to OADAP was subsequently advised of the Director's decision, and letters indicating the amount and conditions of grant award were sent to each submitting agency.

Objective (2): Assist drug abuse treatment programs in their efforts to generate additional reimbursement from third-party payers so that a 30% increase is reflected in the total amount of reimbursement received from those sources during 1976-77.

(a) Assist the one publicly-funded residential treatment center to increase the current rate of reimbursement from Vocational Rehabilitation so that it reflects a greater percentage of the actual cost for reimbursable services to VR-eligible clients.

The current rate of reimbursement for VR clients at Day One remains at last year's level. However, the new Director of that agency has recently begun negotiations with the regional VR office in that area to recover a greater share of the cost of treatment for those clients. The OADAP Drug Specialist is providing assistance in this effort. The number of clients at Day One who are approved as VR-eligible is increasing, so that additional funds are being generated from that source.

(b) Conduct a study to compare the actual amount of reimbursement collected by drug treatment programs from Title XIX, Blue Cross/Blue Shield, and CHAMPUS with the potential amount of reimbursement indicated by the number of eligible clients.

At the present time in Maine, the only services needed by drug clients which are reimbursable by the sources listed above are medical services. The nature of the polydrug abuse problem in this State means that a relatively small number of clients require such

medical services; the majority are residents of Day One. Emphasis has therefore focused on increasing Title XIX reimbursement for residential clients at the program. Efforts by the new Director there have resulted in the collection of more than five-hundred dollars in reimbursement since November, 1977.

(c) In cooperation with drug program administrators, prepare a plan detailing proposed services and necessary dollars to request inclusion in the next Title XX State Plan.

Since Title XX provider agencies are now using all available Title XX funds, drug programs are competing for dollars which are already allocated. Although the current Title XX Plan advocates substance abuse services for youth, it is clear that it is expected that funds for those services would come from the current allocation to alcohol service providers. The process of developing awareness of the need for additional funds is a long one and demands close communication between OADAP drug service providers and alcohol service providers. OADAP will, however, prepare and present a plan detailing necessary substance abuse services and funds for inclusion in the next Title XX Plan scheduled for July, 1978.

(d) Sponsor the delivery of the NIDA Third Party Payments/ Financial Management course for up to fifteen substance abuse program administrators in the State.

Our dissatisfaction with the limited scope of the Third Party Payer Profile for Maine developed under NIDA Contract by the Northeast Regional Support Center has prevented our delivery of that portion of the indicated course. Expansion of the Profile to include private sources of reimbursement and correction of several sections of the existing Profile are required before it can be used for training purposes.

Objective (3): Establish a state-wide system of substance abuse counselor registration/credentialing.

(a) Hire a staff person with responsibility for insuring establishment of that system based on the substance abuse counselor registration model produced by the Task Force on Credentialing Substance Abuse Workers.

(b) Devise evaluation instruments for recommendations to the registration/credentialing body, using the refined task data generated by Functional Job Analysis.

(c) Assist the Board of Substance Abuse Counselor Registration to establish standards and adopt criteria for consideration of applicants.

OADAP initiated action in May, 1977 to hire a Credentialing Specialist* to complete the tasks described in b and c above, as well as various other tasks related to training and credentialing.

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* This position is referred to as the 'Training Specialist' in some sections of the Plan. This dual designation for the same position is a result of combining the language of two separate plans from last year into the present single Plan.

The Maine Legislature enacted a law creating a Board of Registration of Substance Abuse Counselors in July, 1977. Nine voluntary Board members were subsequently appointed by the Governor in January, 1978.

Because of a long delay in completing the personnel hiring action, the decision was made to contract for the development of an evaluation instrument and recommendation of standards and criteria. That contract has just been awarded and completion of the tasks is scheduled for October, 1978.

Objective (4): To conduct a review and comparison of the five treatment programs' current fee schedules and to present recommendations about the effectiveness of various schedules.

Each of the five drug treatment programs in Maine has developed a fee schedule and is currently collecting client fees. This objective was not completed during the past year simply because time and priorities did not permit. Its accomplishment could improve the success of fee collection attempts and result in increased amounts of funds for programs. It should be pursued in the coming year.

Objective (5): Assist the one OADAP-funded alternative school which provides services to drug abusers in obtaining funds from Vocational Rehabilitation to expand the vocational component of its program.

Although OADAP formally offered technical assistance in pursuit of additional funds from Vocational Rehabilitation, the program co-directors have decided to delay that pursuit. The availability of CETA funds for special projects has presented other alternatives for support of vocational services which are being explored.

Objective (6): Prepare an annual State Plan for Drug Abuse Prevention in Maine.

(a) Meet with regional alcohol and drug abuse councils, existing drug service providers and providers of related health and youth services to discuss problems and needs related to drug abuse prevention.

In January, 1978, OADAP decided to submit a combined State Plan for drug and alcohol services in reflection of OADAP's combined agency status and of the nature of the polydrug abuse problems we address in Maine.

In anticipation of writing the Plan, OADAP staff members prepared six position papers which paralleled the sections outlined in the combined Plan guidelines. Those papers were mailed to over four-hundred agencies and individuals concerned about alcohol and drug problems throughout the State. The mailing requested written comment and also invited people to attend a day-long hearing on the issues presented. That hearing was held and comments were recorded in each of six discussion sections, one focusing on each position paper. All comments received, both written and verbal, are being responded to either in the context of this Plan or by individual letter.

(b) Analyze objective data indicating drug abuse problems and resources collected by OADAP's Program Monitoring and Community Monitoring Systems.

That analysis has been accomplished and is included in the Part III - B Needs Assessment section of this Plan.

(c) Provide a draft of the Plan for review to the Health Systems Agency, the State Health Coordinating Council, and interested groups and individuals.

A draft version of the Plan will be available for reading by interested groups and individuals and the appropriate reviewing agencies by June 1, 1978.

(d) Make necessary revisions and submit final Plan to NIDA.

The final version of the Plan will be prepared during late June and early July, incorporating changes which are suggested in the draft version, during the review period. It will be submitted to NIDA and NIAAA on or before July 15, 1978.

Objective (7): Allocate additional monies secured for drug abuse services to geographic areas of the State where available treatment services are not sufficient to meet the need as evidenced by the State Plan.

Additional slots and funds were requested in the proposal submitted for Maine's 1978-79 Statewide Services Contract. The increase of one residential slot and twenty-nine outpatient slots will be allocated to provide service in areas of the State where the demand for service exceeds present program capabilities. Specifically, those areas are Cumberland and York Counties.

Objective (8): Provide specific opportunities for workers in alcohol programs and members of regional councils to gain information on drug abuse and to share information and priorities with drug abuse workers.

(a) Sponsor one training event on drug abuse information and issues for at least fifteen alcohol program workers.

OADAP used resources from the Northeast Regional Support Center to sponsor two training events, "Facts About Drug Abuse," during April and May, 1978. The five-day session was attended by 15 participants including workers from alcohol and drug programs and regional coordinators. Forty Maine Indians attended the four-day session.

(b) Sponsor three joint training sessions on substance abuse skills and issues for alcohol and drug program workers.

OADAP sponsored the following courses for alcohol and drug program workers during 1977-78: Facts About Drug Abuse (one course for substance abuse counselors and one course specifically oriented to the cultural needs of and attended by representatives of four Maine Indian tribes); Counselor Training: Short-Term Client Systems; and an adolescent group skills course.

(c) Promote membership of drug service providers on each regional alcohol and drug abuse council.

Currently, three of the five drug treatment programs are represented on the regional councils. Two employees of one of the programs serve as members of the Board of Registration of Substance Abuse Counselors.

Objective (9): Develop one concrete new planning link between the Juvenile Delinquency Prevention Specialist at Maine Criminal Justice Planning and Assistance Agency (MCJPAA) and the OADAP Drug Program Specialist.

(a) Investigate the possibilities for joint review of grants proposing prevention and intervention services to youth.

In the investigation of possibilities, the separate Committee structures of OADAP and MCJPAA and their different grant application cycles presented barriers to joint review of prevention/intervention grants. However, an informal agreement to share perspectives and information on particular programs or applications has proved workable. For example, an RFP issued by MCJPAA for pro-active prevention projects resulted in the submission of a proposal to produce a drug and alcohol film for youth. MCJPAA's Juvenile Justice Specialist provided a copy of the proposal to OADAP's Drug Program Specialist and Prevention Coordinator for review and comment.

(b) Establish a mechanism for reciprocal participation in the development of State Plans.

OADAP invited MCJPAA's involvement in the process to generate public comment on its position papers for the State Plan. Two representatives of MCJPAA responsible for correctional services participated in the public hearing held on the Plan. As a follow-up to that participation, OADAP staff met with those representatives to further discuss the need for drug and alcohol services in the State's correctional institutions. It is likewise anticipated that OADAP will participate in the development of the annual Plan prepared by MCJPAA.

Objective (10): Work directly with community mental health centers throughout the State to jointly fulfill our individual responsibilities for insuring the provision of necessary drug abuse services.

(a) Participate as an active member in the meetings and projects of the Mental Health Consortium established to insure that the federal mandates of P.L. 94-63 are met.

Since its initial establishment by the Department of Mental Health and Corrections in May, 1977, the consortium has not met.

(b) Continue providing funds for drug abuse treatment and prevention programs through three community mental health centers.

(c) Provide funds for drug abuse treatment in one additional community mental health center.

OADAP currently provides funds for drug abuse treatment and prevention services in the following community mental health centers: Aroostook Mental Health Center, Bath-Brunswick Mental Health Center, Mid-Coast Mental Health Center, and York County Counseling Services, Inc. Each of the centers provides funds from federal sources, local cash and/or client fees to support the delivery of those drug services. The services include outpatient counseling through a total of 70 slots and three prevention programs in the public schools.

Objective (11): Request the cooperation of at least four school systems in sharing the support of the two school-based drug counselors currently funded by OADAP.

One of the school-based counselors prepared requests for funding from three separate school systems in which she provides drug prevention services. In response to those requests, two schools provided a total of $6,000.

B. Management Information Systems

1) Alcohol Objectives

(From Management Information System (ASP))

This performance report is divided into two sections. It begins with a general narrative covering the significant events in the information system in the past year. Then each of last year's objectives is presented and the progress made toward achieving each goal is discussed.

The alcohol management information system has undergone a major change since the writing of last year's objectives. This change was consistent with the intent of objective 2, but was of a greater magnitude than had been anticipated.

Shortly after the objectives were written, this office was informed of state policy changes which mitigated against renewing our contract with a private firm for maintenance of the information system. It was agreed that this office could obtain an extension of the then current contract until September 30, 1977 to allow time for conducting a systems analysis and converting the system to the State's computer configurations.

An initial systems analysis indicated that some major changes in the information system could be very beneficial. It was decided to seize the opportunity presented by the system transfer to perform an extensive analysis of the system and, if indicated, to redesign it. Consequently, OADAP agreed to work with the Human Services Development Institute (HSDI) of the University of Maine, to obtain technical assistance in systems analysis, design, and implementation.

As the first step in this process, OADAP staff and alcohol program administrators were canvassed to assess their information needs.* The

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* NOTE: In this section "program administrator" shall mean an administrator in a local alcoholism treatment service delivery agency.

program administrators were also questioned concerning the procedures they used and the costs they incurred in complying with the various state, federal, and other funding source reporting requirements.

Two major information needs which were not adequately addressed by the existing system were uncovered. One was for cost data which was clearly related to program service elements. The other was client follow-up data.

Interviews with program administrators revealed that duplicate reporting requirements were not only an additional cost burden, but were also very detrimental to the morale and commitment of the data collection staff. This had adverse consequences on the timeliness and accuracy of reports.

It was discovered that 7 of the 16 reporting programs completed NIAAA's NAPIS forms on at least some of their clients. These programs strongly urged that the State switch to NAPIS to alleviate some of the burden of duplicate reporting.

Analysis of the NAPIS system indicated that it would provide information in the two vital areas of costs and follow-up. Converting to NAPIS would thus simultaneously reduce reporting redundancy for local programs and provide additional useful information for decision-making. Another feature which made NAPIS an attractive choice was that data collection procedures and edit, file maintenance, and output programming already existed. Thus, the State would not have to bear the cost of developing a completely new system. Once it was decided to adopt NAPIS, HSDI applied for, and received, financial assistance from the Alcohol and Drug Problems Association of North America.

Minor changes were made in the NAPIS system in order to meet some Maine-specific needs. These changes have been described earlier in the Plan under Part I - D Monitoring System. The resulting system was christened the "Maine Alcohol Program Information System" (MAPIS).

Once the forms were designed and a revised data collection manual written, training of program data collectors was begun. At the same time, OADAP staff and program administrators attended training sessions in the utilization of NAPIS output reports. While these training sessions were taking place, forms were printed, and work was begun on obtaining computer programs from NIAAA and in modifying them to fit Maine's computer hardware.

The process of analyzing and redesigning the system delayed the implementation of the new data collection beyond the anticipated October 1 start-up date. Programs continued to submit data under the old PMTES system for hand analysis through December 31, 1977. On January 1, 1978, all programs which had been reporting on the State PMTES system, plus an additional program which had been reporting solely on NAPIS, commenced to report on MAPIS.

The first output was due to be delivered on May 15. However, unforeseen crises in the Human Services key punch section, coupled with some programming problems engendered by the regionalization approach to data collection, have delayed production. The first output reports are now expected by June 9.

The overall goal and the specific objectives from last year's plan are quoted below. Each objective is followed by an assessment of the activities engaged in to bring it about, and the degree to which it was realized.

The goal of the OADAP management information system is to provide decision-making data for program management and monitoring information to aid in determining the effectiveness of the state-wide effort concerning alcoholism.

Objective (1): Continue receiving data from all alcoholism treatment programs in the State.

Data have been received from all treatment programs which received state funding and/or licensure, except for the native American program, throughout the year. On July 1, 1978, the native American program will begin reporting on the new MAPIS system. The Bangor Counseling Center, a federally-funded outpatient program, began reporting to the State for the first time on January 1, 1978.

Maintaining the flow of data from programs required a variety of activities. These included: providing the programs with usable feedback; demonstrating that the data was used by OADAP to justify the entire program to State executive and legislative officials; cajoling data coordinators to complete forms; and finally, reminding delinquent programs that reporting requirements were part of the conditions of funding and/or licensure. Of these activities, the first two proved to be the most rewarding. Not only did they produce the best and timeliest data, but they also served to reduce the level of tension between the local program data providers and the State data collectors. These findings served to confirm the validity of two important information systems concepts: timely, accurate, and flexible beedback and frequent personal contact produced high levels of compliance with reporting requirements. The former provides program administrators with sound reasons for investing program resources in data collection. The latter allows data-collection personnel to feel comfortable when seeking assistance, and also gives them a feeling of personal investment and involvement in the data system.

(a) Assist programs in submitting reports on time.

Between 80 and 90 percent of reports were submitted by the monthly deadline.

Many of the activities needed to ensure timely reporting have already been discussed above. Additional tasks would include providing sufficient supplies of reporting forms, and training program personnel in data-collection techniques and in meeting deadlines.

(b) Assist programs in submitting accurate data by conducting training sessions on forms completion.

No training workshops were conducted on the PMTES system. Extensive technical assistance and training was provided on an on-going basis for the implementation of MAPIS.

A series of five workshops was held in different parts of the State to familiarize all data coordinators and counselors with MAPIS reporting procedures.

In addition to the workshops, each reporting program was visited at least twice by the consultant and an OADAP staff member for the purpose of explaining the new system, and offering assistance in adapting system procedures to conform to program circumstances. In addition to these visits, programs which demonstrated need for additional assistance were visited on an as-needed basis. Over 100 visits were made to individual agencies. These on-site visits were supplemented by numerous telephone and letter contacts.

The major lesson learned in accomplishing this objective was that it would not have been possible without external assistance. The scope of the task is beyond the available manpower resources of OADAP. The entire episode has proved to be one of the better experiences this office has had with a consultant.

A second lesson was that immediate, systematic editing of forms is imperative in gaining agency cooperation in rectifying errors.

(c) Supply data forms and manuals to all programs as required.

All necessary forms and manuals have been distributed to all programs on time. At this time, a slightly revised data-collection manual is being completed. This manual contains new procedures for coping with areas identified as producing the most problems for data coordinators.

Meeting this objective will be easier in the coming year since we will merely be maintaining supplies of existing forms. A system exists for recording forms flow and anticipating shortages both at the State level and in individual programs. Much of the credit for ensuring that forms and manuals were printed and distributed on time is due to one member of the OADAP clerical staff.

Objective (2): Develop a system of reports, based on data collected for use by OADAP and alcoholism program administrators during first quarter fiscal year 1978.

On one level this objective has been achieved. The introduction of the MAPIS has provided OADAP with a system of reports on crucial aspects of program performance. However, on another level the objective has not been reached. The entire system of NAPIS output reports (with slight modifications discussed earlier) was adopted for MAPIS. There has been little prioritization of the reports, and little consideration of what, if any, additional reports may be needed. Nor have plans been made for generating executive summaries of the "raw" MAPIS output. Little consideration has been given to the problems of internal report distribution among OADAP staff. These hitherto neglected items form part of the proposed action plan for the coming year.

(a) Determine type and frequency of desired reports by July 1, 1978.

The level of achievement of this objective has been discussed immediately above.

The progress made to date was the result of several OADAP staff meetings, meetings between OADAP staff and program administrative staff, and conferences between the OADAP information system manager and the systems consultant. These meetings demonstrated that there exists a wide variety of information needs, as well as very different levels of commitment to the concept of management by "hard data" on the part of program administrators. The discussions in these meetings contributed heavily to the decision to institute a modified NAPIS system in place of the existing State system. Participants frequently identified needs for information on costs, staff time, and client outcome which was not available under PMTES. Little agreement was reached on the exact nature of the information, nor on the relative importance which should be attached to any particular type of information.

(b) Negotiate with data systems contractor for production of reports and design of report formats.

Processing is now done by the State's Central Computer Services (CCS) by arrangement with the Department of Human Services data-processing section. OADAP has been assigned the services of a systems analyst and programmer. Their efforts, so far, have been directed toward getting the system up and running, and in making the changes necessary to accommodate certain Maine-specific data elements. The continuing cooperation of CCS, consistent with their priorities, is assured. As soon as OADAP can identify additional report requirements, CCS will make the necessary programming modifications.

These results were obtained through an on-going series of meetings between OADAP staff and consultants and CCS staff.

(c) Begin report cycle in second quarter of fiscal year 1978.

The new system was begun on January 1, 1978. Thus, reports on the new system will cover the second quarter of fiscal 1978.

The efforts needed to realize this objective have already been described above.

Objective (3): Refine present system to provide decision-making data and monitoring for grant funding program.

The MAPIS system provides much more decision-relevant data than PMTES. It also contains more information useful for grants performance monitoring.

(a) Develop decision-making criteria by July 1, 1977.

Several PMTES-based criteria were developed. They have since been opened to question. It is clear that both OADAP staff and program

administrators agree in general terms on which criteria are the most important for program assessment. The difficulty lies in obtaining specific agreement concerning the specific definitions and priorities to be assigned each criterion. For example, positive client change and unit cost are both accepted as important criteria. However, there is little agreement on what aspects of a client's life ought to be examined for change, how much change is "enough" and how much more change needs to occur before it can be used to justify a higher per-unit cost.

(b) Monitor specific program data elements for unsatisfactory performance quarterly.

This objective was not achieved. There were no OADAP quarterly reports to analyze. Some analysis was done of reports from the Bureau of Resource Development on Title XX contracts and NAPIS reports from NIAAA-funded programs. The examination of the NAPIS reports resulted in a series of questions from the OADAP data system coordinator. Many of the exceptional performance items noted in NIAAA programs were due to inaccurate reporting practices or special local conditions which "explained away" unusual performance figures.

It is apparent that monitoring cannot proceed without several prior tasks being accomplished. First the reported data must be timely and accurate. Second there must be an agreed-upon set of parameters designated for each data element to be examined. The efforts made to achieve these objectives have been described already.

In addition, an effort must be made to schedule the delivery of the reports so as to ensure their predictable and timely arrival. OADAP staff must set up a schedule for reviewing the reports and a process for communicating the results of the review to programs.

(c) Provide assistance to programs based on quarterly evaluation.

This was not carried out during the year. Reports were produced for the period January 1, 1977 through June 30, 1977. However, these reports did not appear until September, 1977. This rendered them of little value as a basis for providing assistance, particularly since a new grant period had begun.

Three things are crucial to providing assistance based on analysis of quarterly reports. The first, of course, is timely and accurate reports. The second is an active effort by OADAP staff to diligently analyze the reports, and report the results to the program. The third element is a willingness on the part of the programs to accept the results of the information as valid.

The series of meetings between OADAP staff, the OADAP consultant, and the program directors laid the groundwork for the administrators' acceptance of the system. Plans for the forthcoming year include efforts to increase this acceptance. They also include efforts aimed at setting up an internal process for monitoring the reports on a consistent basis.

(d) Utilize past year performance data to formulate objective decision for funding process during grant cycle for fiscal year 1979 grant award program.

A full set of performance data was not available from the information system. Information on performance was gathered from grant applications, licensing, and other on-site visits, Bureau of Resource Development reports, and NIAAA reports.

These data were summarized and made available to the OADAP Grants Manager, the OADAP Director, and the State Advisory Council to assist them in making grant decisions.

2) Drug Abuse Objectives
(From Information Systems, Research, and Evaluation (DSP))

Objective (1): Manage the IDARP system to collect and analyze data from treatment programs which describe the drug treatment population and indicate treatment needs.

(a) Continue collection and editing of monthly CODAP reports from five drug abuse treatment centers.

This objective was accomplished. An additional treatment center began participating in CODAP in October and as of the year end, the reporting from two clinics within one program was combined.

(b) Master the SPSS system to produce tables and analyses of data from CODAP tapes issued quarterly by NIDA.

Processing the data by SPSS at the computer center was abandoned in favor of manually tabulating the data derived from the monthly edit of the CODAP forms. Data summarized in this fashion are more timely.

(c) Collect and edit annual NDATUS forms from six drug abuse treatment centers.

This objective was accomplished. An additional drug treatment center prepared a NDATUS form.

Collection and analysis of the data from CODAP and NDATUS should be continued for management purposes. Consideration of electronic processing of these data rather than manual processing at the State level, should only be given if the number of clients substantially increases or additional management data are desirable. Consideration may be given to combining the information systems from the alcohol and drug treatment centers which are currently prescribed by NIAAA and NIDA.

Objective (2): Maintain a Community Monitoring System to assess drug problems and identify resources to address the problems on an annual basis.

(a) Obtain, compile, and analyze data from the following agencies: Vocational Rehabilitation Services, Department of Mental Health and Corrections, Maine Criminal Justice Planning and Assistance Agency, Division of Special Investigation, Research and Vital Records, Public Health Laboratory, and U.S. Customs Service.

Updated information has been obtained from most of the same agencies. This is helpful in analyzing trends if the data are available in the same format. This is not always the case due to management and information system changes.

(b) Select assessment criteria and prepare a report on problems and resources for distribution to drug-related agencies.

Criteria have been selected to assess the drug problems for publication in this plan. Continuing the Community Monitoring System is essential for identifying the extent of drug abuse throughout the State. Treatment centers should be available to the offender population.

Objective (3): Revise the OADAP Program Monitoring System to include specific information on staff activity, the range of services delivered, and fiscal management in treatment and intervention programs.

(a) Replace the quarterly progress narrative with a quantitative program report for all OADAP-funded drug programs.

Each OADAP-funded drug treatment program is currently a subcontractor under the NIDA Statewide Services Contract. As a condition of the subcontract award, each program was required to submit quarterly reports detailing the types and amounts of direct service which were actually delivered to clients. A second reporting format was introduced for intervention programs which requested information on staff activity, types and amounts of actual services delivered, and the types of setting in which they were delivered.

(b) Design and implement a Financial Management Information System for drug treatment programs.

Four of the five drug treatment programs in Maine now operate with a financial management system - three are incorporated in a mental health center system and one system functions independently. OADAP has confronted the difficulties of imposing a single system on the programs and decided not to take action at this time. However, OADAP has awarded a subcontract under the Statewide Services Contract to recommend program and fiscal monitoring items for the five treatment programs. It is anticipated that as a result of that subcontract, financial management criteria will be identified. OADAP may then require that information on those criteria be submitted on a quarterly basis.

Objective (4): Prepare a report detailing the nature and extent of concurrent drug and alcohol use documented for clients of all OADAP-funded treatment programs.

It was decided in October, 1977 to change OADAP's alcohol information system to collect additional data on clients and on services delivered. Accordingly, since January, all alcohol treatment programs in the State have been participating in the Maine Alcohol Program Information System, modeled on the standard NIAAA information system. However, that new system does not routinely collect information on the client's use of drugs other than alcohol. The report described above has, therefore, been prepared only for the use of alcohol by clients of drug treatment centers. In the coming year, consideration should be given to the collection of comparable information on the use of other drugs by the clients of alcohol programs.

Objective (5): Conduct a study comparing marijuana use in Maine before and after the May, 1976 decriminalization of small amounts of marijuana.

(a) Pursue a proposal already submitted to MCJPAA for $3,300 to conduct the study.

(b) Investigate other sources of money to support the study, if necessary.

Although a proposal for funds to conduct the described study was presented to MCJPAA, funds were not forthcoming. After consideration of various other alternatives, a portion of the OADAP Research Analyst's time was allocated to complete the first piece of the study. It has since been initiated and that initial data-gathering phase will be finished by June. OADAP is now exploring resources for coding and compiling the data.

Objective (6): Encourage private human services agencies and educational institutions in the State to pursue research monies available for substance abuse projects.

In response to specific requests, OADAP has directed agencies and institutions to appropriate federal resources for funding research in areas related to substance abuse.

Objective (7): Participate as an active member of the Regional Coalition on Special Needs of Women Who Have Alcohol and Drug Problems in the development of a position paper on the special needs of women substance abusers.

OADAP's Research Analyst gathered source material from Maine and prepared a synthesis of it for the Northeast Regional Coalition. She participated in two meetings with other state captains from the Northeast to draft the regional Statement of Special Needs of Women who have Drug and/or Alcohol Problems. This, in turn, has been incorporated in the Final Reports on Drugs, Alcohol and Women's Health to the Acting Special Assistant for Women's Concerns in HEW. Special studies such as this focus attention on women's special needs for appropriate health care and ultimately may generate funding for special treatment needs.

2. Treatment, Rehabilitation, and Intervention*

1) Alcohol Objectives

(The following set of objectives are from Outreach Program Development (ASP))

The goal of OADAP's outreach program development is to make alcoholism treatment services available to all who have need of them. Certain populations are normally deprived of services for a variety of reasons. OADAP's intention is to improve the availability of services to the criminal justice population, the labor force, and the indigent citizen.

Objective (1): Improve access to the criminal justice population by way of the courts.

(a) Provide District Courts, via contract with the Office of the State Courts Administrator, with the personnel needed to screen, refer, and track problem drinkers from among OUI repeat offenders as of October, 1977.

(b) Provide, via contract with the Office of the State Court Administrator, two equivalent full-time positions at the Superior Court and four equivalent full-time positions at District Courts to provide problem drinker screening, referral, and tracking services for offenders, other than juveniles and OUI's as of October 1, 1977.

(c) Provide, via contract with the Office of the State Court Administrator, for screening, referral, and tracking of juvenile alcohol abusers from among juveniles in the District Courts.

The appropriations to achieve this objective were requested under L.D. 857 (Appendix K, L.D. 857) which did not become law. The achievement of the above objective was predicated upon the funds within that legislation.

OADAP does provide the direct services of one court counselor (described in Part I - G, Service Delivery System).

The Counseling Center Alcohol Program, Bangor, had sponsored a court counselor in the Bangor Court through the Comprehensive Employment and Training Act (CETA) up until February, 1978. That position has been phased-out because of termination of CETA funding and the NIAAA staffing grant termination before the 08 funding year.

In addition, the Kennebec Valley Comprehensive Alcohol Treatment Program (KVCATP) has one counselor assigned to the court system.

Lack of funding made further achievement of this objective impossible.

OADAP realizes the importance of this objective and will reassess the priority in the upcoming year.

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* See the definition of 'Intervention' in the Definitions section.

Objective (2): Develop Employee Assistance Programs in private industry to provide for the early detection and treatment of alcoholism.

(a) During State fiscal year 1978, the Governor of Maine should hold a Governor's Conference on Occupational Programs for Employed Problem Drinkers.

(b) Implement an Employee Assistance Program for State employees on or about July 1, 1977.

(c) Provide support for three full-time equivalent occupational program specialists by contract with existing alcoholism programs.

Thus far, the Governor's Conference has not been held. However, an Employee Assistance Program has been developed for State of Maine Employees (Part I - G, Service Delivery System).

The objective of contracting for three full-time equivalent occupational program specialists has not been achieved due to lack of funding for those positions. The funding of these additional positions was a part of the legislative package in L.D. 857 (Appendix K, L.D. 857).

The provision of positions for occupational program specialists has taken a step backwards because of the defunding of the Counseling Center's 08 year staffing grant which supported the OPC in Region IV. The services of the OPC in Region IV will terminate June 30, 1978.

The OPC program is outlined in Part I - G, Service Delivery System.

Objective (3): Upgrade existing outpatient counseling resources to increase the availability of such services to persons unable to pay for their own alcoholism treatment.

(a) Provide additional funds for purchase of service from local agencies to pay for outpatient counseling services to indigent persons.

The Title XX allocation for alcoholism services was slightly reduced. In addition, a 4% cut in all state agency budgets was requested in order to provide for an emergency contingency fund.* Therefore, there was no significant increase in the purchase of outpatient counseling services for indigent persons.

An increase in funds was requested through legislation but did not materialize.

Additional problems have arisen within Region IV with the refusal of NIAAA to fund the Counseling Center's 08 year outpatient service staffing grant in the amount of $361,890.00 not including local matching funds.

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* 4% returned to OADAP as explained later in this section.

The defunding of this grant would have terminated outpatient services in Region IV on December 30, 1977.

The Counseling Center requested and received approval to use unused federal funds to provide outpatient services for the months of January, February, and March.

At the time of notification from NIAAA that the Counseling Center would not be refunded, the alcohol service providers and the regional council received word that a grant could be submitted to NIAAA by an agency chosen by the alcohol community to provide outpatient services. The agency chosen was the Eastern Maine Medical Center (EMMC) which submitted a grant request in the amount of $263,398.00. The grant requested funds to provide outpatient services through contractual agreement with the Counseling Center.

In order to remain as the provider of outpatient services until funding of the EMMC grant request on July 1, 1978, the Counseling Center requested a grant in the amount of $34,196.00 from OADAP.

OADAP requested and received the funds reserved for the emergency contingency fund (4% of budget), enabling the purchase of outpatient services for the months of April, May, and June from the Counseling Center. The funds were granted under the condition that a phase-down plan would be submitted to OADAP if the EMMC-NIAAA grant request was refused.

On April 4, the EMMC received word that their grant would not be funded which meant no outpatient services would be available after June 30 in Region IV.

The Counseling Center submitted a phase-down plan to OADAP on April 26 which indicated they would cease to admit new clients after April 24. Because of a mandate to provide treatment to the referrals from the Driver Education Evaluation Program, arrangements were made with EMMC to provide interim services to DEEP clients.*

OADAP was confronted with the unavailability of funds to purchase outpatient services in Region IV. OADAP has made a decision, in conjunction with the State Advisory Council, to defund the Mid-Coast Rehabilitation Center** at Owl's Head (Region I), a short-term residential rehabilitation program (intermediate care). The defunding of the Mid-Coast Center and a small percentage of funds from other facilities and programs leaves $135,000.00 available for the funding of outpatient services in Region IV for the period July 1, 1978 through June 30, 1979.

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* Difficulty existed in setting-up services for DEEP clients because of the lack of notice of the Counseling Center's policy of discontinuing client admissions.

** The final hearing on the defunding of Mid-Coast Rehabilitation Center was on May 17, 1978. As of this date, the final decision has not been made. Should that decision reverse the OADAP decision, an addendum will be written.

OADAP has requested that EMMC submit a grant application in the amount of $135,000.00 to provide outpatient services. The amount of funds available does not provide sufficient services to the Region IV area.

In pursuit of the objective of upgrading services, York County Counseling Services (YCCS) reorganized its program to meet JCAH standards. During FY-78, YCCS achieved a two-year JCAH accreditation for outpatient counseling. In addition, YCCS has been granted a Certificate of Approval by the Department of Human Services through OADAP.

(b) Continue to cooperate with the Maine Criminal Justice Planning and Assistance Agency in administering a grant to provide direct alcoholism counseling services to resident populations of all correctional facilities in Maine. Current grant year runs from April 1, 1977 to March 31, 1978.

OADAP has achieved the objective of continuing to cooperate with the Criminal Justice Planning and Assistance Agency. A description of the Criminal Justice Project appears in Part I - G, Service Delivery System.

Positive results have been achieved with the Criminal Justice Project, as indicated by continuance of some programs. The project run by Community Alcohol Services in Belfast, within the Maine State Prison, is recognized as achieving especially good results through the work of Russell Didsbury, Counselor. The MCJPAA has continued partial funding for the MSP project due to the positive results realized.

Objective (4): Seek to have responsibility for the Driver Rehabilitation Course with its screening and referral component reassigned by the State Legislature from the Department of Motor Vehicles to OADAP as of July 1, 1977.

The objective of responsibility for the Driver Rehabilitation Course (DRC) was achieved as explained in Part I - G, Service Delivery System.

Relocating the DRC (now DEEP) within OADAP has provided improved opportunities for coordination between the DEEP function of referring to treatment services and other OADAP functions of funding and planning for services.

One indication of this coordination has been the way in which the outpatient service problems experienced in Region IV have been addressed.

In addition, since individuals and agencies providing services to the DEEP are required to receive approval, this effort can also be coordinated more effectively. The approval regulations were developed through a coordinated effort of OADAP and DEEP staff.

(The following set of objectives are from Alcoholism Treatment and Rehabilitation Assistance and Development (ASP))

Objective (5): Provide funds for the correction of structural deficiencies for existing alcoholism treatment facilities resulting from "shoe string" operating budgets and inadequate start-up funding.

(a) Survey existing facilities to determine need for repair and refurbishment during first half of fiscal year 1978.

(b) Provide construction grants to facilities in need of such funding during last half of fiscal year 1978.

(c) Encourage existing programs to periodically monitor physical plant condition to prevent deterioration and hazard to client groups or employees.

The goal of OADAP in this area is to fulfill the State's responsibility to ensure that a quality level of alcoholism services is available to its population.

Adequate funds for correcting deficiencies were not available during FY-78 due to the cost of direct service programming. Limited funds were allocated on a request-by-request basis to correct emergency deficiencies. Most requests granted were necessitated by non-compliance with licensing regulations in the areas of health and fire safety.

Subjective deficiency assessments were made during on-site licensing inspections. In a few cases, deficiencies were mentioned to the directors of facilities with the hope that local funds could be obtained to make improvements.

The structural condition of Hope House, an emergency care shelter facility in Region IV, has caused the Board of Directors to search for a more adequate facility to house the program. OADAP has encouraged the effort by the Board of Directors although a major increase in funds to acquire a facility would not be available.

The Bangor Halfway House facility was declared a historical building in the City of Bangor. Funds from OADAP, United Way, social clubs, and private doners were used for materials. Employees, hired through the Comprehensive Employment and Training Act (CETA), have completed major repairs and exterior decorating of the facility. Although work is not yet complete, the renovations have provided a very attractive building in the Bangor area.

Several programs and facilities have indicated a need to move to new quarters. Some require additional space, although one facility is contemplating a change in programming with a different setting.

OADAP will continue to request funds for this much needed objective.

OADAP requested each grant applicant to address the area of accessibility for the handicapped because of newly-adopted federal regulations. The grants indicate that all facilities either are currently accessible or have viable plans to become accessible.

Objective (6): Assist alcoholism treatment and rehabilitation facilities in obtaining Title XX and other third-party payers' support.

(a) Provide local matching share for Title XX funding to facilities unable to obtain sufficient catchment area support.

The above section of this objective was achieved by OADAP through the funding cycle. Grant requests were reviewed and funded with local, State, and Title XX monies, sharing budgets where appropriate. The amount of State money used for seed in FY-78 was $291,249.50 which generated a total of $873,748.50 in federal funds. This amount of State seed was $16,259.50 less than the amount available in FY-77.

(b) Submit legislative proposals which provide for counselor registration and other measures that tend to encourage third-party payer participation.

Legislative Document 530 was submitted to the 108th Legislature by Ms. Clark of Freeport to create a Board of Registration of Substance Abuse Counselors. It was enacted and became Public Law 466 (see Appendix L, P.L. 466). In January, 1978, Governor Longley appointed members of the initial Board. The Board has begun holding organizational meetings in preparation for implementing the process for counselor registration which was outlined in the legislation.

(c) Assist alcoholism treatment and rehabilitation programs in obtaining alternative funding sources as federal project grants are reduced and withdrawn.

An alternative funding source for federally-funded projects was sought through L.D. 857. The present funding situation has not allowed OADAP to replace portions of federal funds with the exception of the Counseling Center 08 year staffing grant. In order to replace a portion of those funds, a facility has had to be defunded beginning July 1, 1978.

Programs receiving both state and federal funds have been encouraged to explore other avenues of funding to compensate for reduced state and federal funds for programs. Technical assistance in seeking such funds has been given when requested through the OADAP Grants Manager and Regional Coordinators.

In addition, L.D. 1104 (Appendix M, L.D. 1104) was presented to the Legislature by Representative Norris of Brewer during the 108th Legislature to achieve third-party payment for alcoholism treatment and rehabilitation.

L.D. 1104 was not passed, eliminating an additional resource of funds for residential and non-residential programs.

(d) Seek to eliminate or alleviate problems experienced by local service provider agencies arising out of their contractual relationships with the Title XX funding mechanism.

OADAP was granted supplemental funds through the legislative efforts of Senator Gerard P. Conley of Portland in FY-78. The funds received were allotted to direct service programs throughout the State. The supplemental funds allow twelve Title XX programs to accept clients other than those eligible under Title XX income guidelines. This allows more flexibility in admissions of clients. The flexibility created by the supplemental funds has alleviated some problems experienced by the programs in making services available to a larger group of alcoholics within their area of service.

Objective (7): Maintain funding support for treatment services for which a real need exists but which cannot generate sufficient non-State funding.

(a) Requests for funding due on February 1, 1978 for fiscal year 1978 will be reviewed and acted upon by May 1, 1978.

This year of funding for alcoholism treatment has been an extremely difficult one due to lack of funds, complicated by the defunding of the Counseling Center 08 year staffing grant.

Funding decisions have been made by the OADAP staff in conjunction with Regional and State Advisory Committees, and funding to maintain all existing services has been secured.

(b) Develop standard forms for use by all alcoholism programs to reduce inconsistencies in record keeping by July 1, 1979.

As a first step in this process all programs were asked to submit copies of their current forms and reporting requirements. Some programs were uncooperative in complying with this request. The slow response coupled with the imposing variety of forms has delayed further progress toward this objective. It will remain as a future project for OADAP staff.

(c) Restructure system of grant review to include participation by the State Health Planning and Development Agency (SHPDA) as necessary.

Proposed federal guidelines (Federal Register, May 9, 1978) indicate that SHPDA review of local service grant applications to OADAP is not mandated.

We have, however, worked very closely with the staff of the SHPDA in developing and reviewing our State Plan.

Our close relationship with the staff will allow us to make any necessary changes in the future.

Objective (8): Assist in the establishment of three intermediate care facilities, one long-term shelter facility and a women's treatment program during fiscal year 1978.

(a) Determine location and associated costs for each proposed facility by second quarter fiscal year 1978.

(b) Assemble necessary funding support base by third quarter fiscal year 1978.

(c) Assist in staff recruiting and administrative structuring during third quarter fiscal year 1978.

The objective of establishing additional facilities was dependent on the increased funding connected with enactment of L.D. 857. Since the legislation was not enacted, it was not possible to establish intermediate care facilities and a long-term shelter program.

The objective of establishing these facilities will be reassessed during this year through planning meetings with the Regional and State Advisory Planning Committees. The adoption of a client-oriented treatment system by OADAP makes reassessment necessary.

The assessment of need for a women's program was completed by Kennebec Valley Regional Health Agency. As a result, a grant was written and submitted to NIAAA. It was approved but, as yet, has not received funding.

Objective (9): Determine whether or not a residential setting is required for treatment of a significant number of teenage alcohol abusers.

(a) Conduct needs assessment during first three quarters of fiscal year 1978.

(b) Report our findings and develop necessary course of action based on needs assessment during last quarter of fiscal year 1978.

A needs assessment for a residential setting for treatment of youth has not been conducted. Limited available staff has made this objective unattainable.

The Regional Coordinators and Councils are expressing an increased interest in the problems of youth with alcohol and/or drugs; therefore, this objective will be maintained and become part of the action plan for next year.

Objective (10): Determine the extent to which alcoholism treatment and rehabilitation meets the needs of Maine's elderly.

(a) Conduct survey of existing program utilization to determine types of service and availability to persons 65 or older during first three quarters of fiscal year 1978.

(b) Report-out findings and develop necessary course of action based on needs assessment for implementation commencing with first quarter of fiscal year 1979.

As discussed in the Part III - Needs Assessment section, persons 60 and older appear to be well-represented in the treatment population. However, no formal assessment of our treatment and rehabilitation system's ability to meet the needs of the elderly has been done.

This objective will be maintained and become part of the action plan for next fiscal year.

(The following set of objectives are from Indian Alcoholism Programs (ASP))

All of the goals of OADAP are designed to provide a comprehensive program effort which applies to all segments of the State's population. However, since this office has agreed to comply with the Maine Indian community's stated desire to develop its own programs by Indians and for Indians, it is necessary to include certain specific objectives in the State Plan.

Objective (11): Monitor Maine Indian alcoholism program efforts to provide a more complete assessment of the total alcoholism program effort in the State.

(a) Review federal grant requests as necessary to determine the extent of alcoholism efforts mounted by Maine Indians.

The federal grant was reviewed by OADAP. The comments were positive toward the grant, with a statement that OADAP feels the native American in Maine does not get the amount of funds for services required to address the amount of alcoholism within the culture.

(b) Ensure representation of Maine Indian interests on the appropriate regional and State-wide councils.

The Maine Indian is represented on the Maine State Advisory Council in the person of Alberta Nicola. George Mitchell, Executive Director of the Wabanaki Corporation's Alcohol Services, is a member of the Board of Directors of the Eastern Regional Council on Alcohol and Drug Abuse. The largest number of native Americans are located in the eastern region. Mr. Mitchell has also been nominated for the Maine State Advisory Council.

(c) Solicit the participation of Maine Indian alcoholism programs in the OADAP management information system reporting.

Mr. Mitchell has indicated that the Wabanaki Corporation's Alcohol Services will participate in the Maine Alcohol Program Information System (MAPIS) beginning July 1, 1978.

Objective (12): Support funding efforts for Maine Indian alcoholism services.

(a) Provide portion of seed money for match with Title XX funds for fiscal year 1978.

(b) Assist in the contract development process between the State Title XX program and Maine Indians.

The Wabanaki Corporation has been awarded a grant in the amount of $7,705.00 to match with Title XX to provide counselor services for the native American.

The OADAP Grants Manager has indicated to Mr. Mitchell that he will offer technical assistance as needed.

Objective (13): Provide program assistance to Maine Indian alcoholism programs as required or requested.

The OADAP staff is available to provide program assistance as requested.

It should be noted that there has been an atmosphere of cooperation between the Wabanaki Corporation Alcohol Services and the other service providers, the regional coordinators, regional council, and OADAP in recent months. Mr. Mitchell, Executive Director, has done much to improve communication between the native American Alcohol Program and the other elements within the field.

(The following set of objectives are from Treatment and Rehabilitation (DSP))

Objective (14): Maintain existing outpatient drug abuse treatment services through 175 drug-free slots at 90% utilization to serve a total of 550 clients.

During the past year, 165 drug-free slots were maintained to deliver outpatient treatment services. It is projected that a total of 491 clients will have received those services by June 30, 1978. Utilization of the slots has averaged 105% per month since July, 1977. The decrease from 175 projected slots occurred because of a reallocation of staff at Day One, Maine's only residential drug treatment center which is located in Portland. That reallocation allowed concentration on building and improving the residential program there. Since that objective has now been largely accomplished, an increase in outpatient programming is anticipated at Day One for the coming year.

Objective (15): Maintain residential drug-free treatment services through the provision of eight slots at 90% utilization to serve 30 clients per year.

Eight slots for residential, drug-free treatment were maintained at Day One during the past year. It is projected that a total of 43 clients will have received services from that program by June 30, 1978. Utilization of the eight slots has averaged 103% since July, 1977. Since November, 1977, the program's monthly census has averaged more than 9 clients. Allocation of at least one additional treatment slot is indicated.

Objective (16): Assess whether the current level of residential drug treatment services is consistent with the actual need for those services.

(a) Analyze data from a survey of potential referral agencies completed in June, 1977.

(b) Contact other State agencies responsible for residential treatment of adolescents and young adults to determine the demand for those services.

Information obtained from a survey of twenty-three agencies and service providers indicated that at least 250 of their clients are appropriate for referral to Day One on an annual basis. This number represents an average of approximately 6.5% of the agencies' combined caseload of clients. Such information indicates a need for residential drug treatment services in Maine. If under-utilization of existing services occurs, then factors other than demand for service must be investigated, such as public awareness of existing services and attitudes toward them.

(c) Determine the availability and current utilization of residential drug services in the New England region.

The results obtained from activities (a) and (b) above focused attention on improving existing under-utilized services to meet the indicated demand for service. Because the decision was made to develop Maine's existing treatment resource, this activity was not pursued.

Objective (17): Review the utilization of the twenty-five new outpatient treatment slots allocated under the Statewide Services Contract and prepare recommendations for continuing allocation.

A formal three month and six month review of contract progress was conducted on each subcontractor. The results of those reviews of types and amounts of service delivered were used to develop Maine's Statewide Services Contract for 1978-79.

Objective (18): Negotiate continuation of the Statewide Services Contract with NIDA for 1978-79.

Maine's proposal for continuation of the Statewide Services Contract has been submitted by NIDA as a request for fifty-four outpatient drug-free and nine residential drug-free treatment slots. Final negotiation of the contract slots and amounts will occur in June, 1978.

(The following set of objectives are from Criminal Justice (DSP))

Objective (19): Provide the following levels of substance abuse counseling service at six county jails, with average overnight populations greater than 10, and two adult correctional institutions:

Waldo, Knox, Aroostook, Androscoggin, Somerset and Cumberland County jails ..... ½ day per week

Maine Correctional Center ..... 1 day per week

Maine State Prison ..... 3 days per week

(a) Secure $22,000 in funds from the Maine Criminal Justice Planning and Assistance Agency for this purpose.

(b) Select appropriate substance abuse agencies to provide the service and award necessary funds to each.

A report on the completion of the Criminal Justice Project described in this objective is presented in the Plan under Part I - G, Service Delivery System.

(c) Monitor the progress of each agency by requiring quarterly program and fiscal reports.

(d) Generate a quarterly activity report summarizing results in all the institutions.

Each agency which received a grant under this project was required to submit standard program and fiscal reports on a quarterly basis. The OADAP Grants Manager then prepared a quarterly activity report on the entire project which indicated number of clients served and the variety of services delivered.

Objective (20): Having completed the 18-month experimental phase of the project to provide counseling in correctional institutions (Objective 2 above), turn administration of the project over to the MCJPAA for continuance.

(a) Provide MCJPAA with a final report evaluating those agencies and approaches involved in the project during the experimental phase.

(b) Offer technical assistance to substance abuse agencies in preparing proposals to MCJPAA for the continuing provision of counseling services.

The quarterly activity reports prepared by the Grants Manager were used to generate a final report to MCJPAA on the entire project. The report documented the types and amounts of service delivered and compared success rates for the different approaches used by each agency.

Two agencies subsequently applied to MCJPAA for continuation of the services they were delivering; one received OADAP assistance in making application. At this point, it is anticipated that the agency will receive funds for continuation.

Objective (21): Collect the indicated data from the following components of the criminal justice system:

1) MCJPAA - Uniform Crime Report Data
2) Division of Special Investigation, Maine State Police - drug seizures by the Division
3) Public Health Laboratories - analysis of the drugs submitted.
4) U. S. Customs Service - accounting of drug confiscations on the Maine-Canadian border.

Accomplishment of this objective is covered under Management Information Systems, Objective 5, in the Administrative Services section of this Plan.

Objective (22): Develop one concrete new planning link between the Juvenile Delinquency Prevention Specialist at Maine Criminal Justice Planning and Assistance Agency (MCJPAA) and the OADAP Drug Program Specialist.

(a) Investigate the possibilities for joint review of grants proposing prevention and intervention services to youth.

(b) Establish a mechanism for reciprocal participation in the development of State Plans.

Accomplishment of this objective is covered under Planning and Coordination, Objective 9, in the Administrative Services Section of this Plan.

3. Quality Assurance and Evaluation

1) Common Objectives

Ultimately, all the activities of this office are geared to ensuring the delivery of quality services. All the steps from needs assessment through funding to final project evaluation are designed with this end in mind. Within this broad range of activities, some have been specifically identified as relating to quality assurance. These are the program licensing/approval and the counselor registration processes.

OADAP was granted the authority to license programs in 1975. The present licensing/approval regulations contain minimum standards designed to protect the client's health, safety, and civil rights; to protect the rights of program employees; and to enhance program accountability. In general, the regulations do not address the issue of program philosophy. Thus, it is possible that programs with treatment philosophies which are highly conducive to positive client change may do poorly in regard to compliance with licensing regulations. The licensing process is described in detail in Part I - G, Service Delivery System.

The second mechanism for assuring quality is the counselor registration process. This process has two goals. The primary one is to assess the competency of persons treating alcoholics and drug abusers, in order to assure that clients receive high quality treatment. The other is to provide workers in the field with a mechanism for obtaining recognition of their skills.

Although a great deal of initial work has been done, the counselor registration process has not been completely implemented. A registration task force developed minimum counselor standards, and outlined a general process for achieving registration. The Board of Registration of Substance Abuse Counselors was established by legislative action in 1977. This legislation placed the Board under the jurisdiction of the Department of Business Regulation. The first meeting of the Board was held in February, 1978. One of the Board's first tasks is to develop performance-based measures to judge the competency of individual applications for registration. The OADAP staff has provided technical assistance to the Board, as needed, and will continue to be available. The new OADAP Training Specialist has the task of acting as liaison between OADAP and the Board.

2) Alcohol Objectives

(The following objective is from Alcoholism Treatment and Rehabilitation Program Assistance and Development (ASP))

Objective (1): Continue to enforce provisions of licensing regulations for alcoholism programs.

As described in Part I - G, Service Delivery System, the licensing and approval mechanisms on alcohol and drug abuse residential and non-residential programs respectively have been combined.

All residential programs were licensed during FY-78 and received appropriate licenses. Certificates of Approval were granted to five additional outpatient programs or components during the year. The primary reason for the increase in the number of applicants for Certificates of Approval is because of the regulations for approval adopted by the DEEP program.

Several problems have been realized in the licensing process. Client safety in the areas of medication control, confidentiality, and physical environment are not addressed sufficiently.

To correct this, the OADAP licensing team has begun to review the licensing process. The regulations will be examined for clarity, consistency, and relevance. The scoring system will be revised. A weighted system of scoring will be developed to allow optimum client and employee safety.

An additional problem exists because OADAP is a funding agency and has the additional responsibility of a regulatory agency, which is a conflicting role, especially in the area of physical environment and adequate staff because of lack of funds.

Presently, a problem exists because the Alcohol Program Specialist is responsible for licensing, certificates of approval, and individual approval (DEEP treatment) which requires at least 50% of his time (individual approval time not included). Planning and program development are affected by time shortage.

3) Drug Abuse Objectives

(The following objectives are from Information Systems, Research, and Evaluation (DSP))

Objective (2): Perform annual evaluation of all OADAP-funded programs through the grant review process.

(a) Assist regional councils in developing evaluation criteria.

The OADAP Grants Manager prepared and distributed guidelines to assist regional councils in performing their review responsibilities. Those guidelines contained programmatic and budgetary criteria for evaluating grant applications.

(b) Complete a wage and salary survey of OADAP-funded substance abuse programs to be used in reviewing grants.

The OADAP Grants Manager met with a committee representing the Maine Association of Alcoholism Program Directors (MAAPD) and developed salary standards (Appendix N - Salary Standards). Although a lack of available funds required that OADAP place a ceiling on salary increases during the last grant cycle, special allowance was made for increases which brought certain salaries in line with the wage and salary guide. This same activity was addressed in last year's ASP.

(c) Establish standard system cost criteria for typical line items included in drug abuse program budgets.

This objective was not accomplished last year because the substantial amount of time it would require was not available from current OADAP staff members. OADAP continued to compare costs for specific line items between various similar programs when reviewing the budgets submitted in grant applications.

(d) Assure review by regional councils, State Advisory Council, and OADAP staff.

This objective is covered under Planning and Coordination, Objective 1, in the Administrative Services section of this Plan.

Objective (3): Continue annual licensing or accreditation of drug treatment facilities under the Regulations for the Residential Licensing of Substance Abuse Treatment Facilities in the State of Maine.

(a) Require completion of an application for licensure 90 days prior to the expiration date of each current license.

(b) Insure necessary inspections of the two residential drug treatment facilities at least thirty days prior to the expiration date.

(c) Issue the appropriate license or denial of license on or before the expiration date.

The Licensing Team inspected Day One and the six facilities of Elan Corporation during the past year. Each of those facilities was subsequently issued a full license for the provision of residential drug treatment services.

(d) Determine advantages and/or drawbacks to drug treatment programs of substituting licensure for compliance with the Federal Funding Criteria and make indicated recommendation to the SSA Director for action.

OADAP has submitted a copy of its Licensing Regulations to NIDA's Program Analyst for Standards and Evaluations for review. We have recently been notified that a formal review is now being coordinated to determine the degree to which the Regulations are consistent with the Federal Funding Criteria. Once we receive the results of that review, we will analyze changes which may need to be made. We will also weigh the resources available to OADAP for conducting additional licensing inspections. Recommendations for action will then be made.

(e) Continue to offer an optional Certificate of Approval to nonresidential drug treatment programs.

(f) Consider the establishment of a requirement for a Certificate of Approval for nonresidential drug treatment programs.

Although the option of a Certificate of Approval continues to be available to the five outpatient drug treatment programs in Maine, only one has applied for and received a certificate. That program operates in the substance abuse component of a community mental health center. The component was approved to provide both alcohol and drug outpatient services. Consideration of requiring a Certificate of Approval for all outpatient facilities will proceed after the completion of the NIDA review of OADAP's Licensing Regulations as indicated above.

(g) Establish a process for the periodic review of the licensing standards as required by the Regulations.

A process and schedule for annual review of the Licensing Regulations by the OADAP Licensing Team has been established. When that review results in recommended changes, the legislation which authorized the development of regulations prescribes public review and comment on those proposed changes.

Objective (4): Perform a quarterly evaluation of drug treatment programs receiving OADAP funds and prepare specific recommendations for those programs exhibiting inadequate progress toward completion of goals and objectives.

(a) Review information submitted on both the quarterly financial report and the quarterly program report.

On a quarterly basis, the OADAP Drug Specialist reviews the quarterly program reports submitted by agencies funded by drug monies. Progress toward achievement of objectives stated in the grant application is assessed. Oral and/or written comments are conveyed to programs which do not exhibit sufficient progress. Needs for technical assistance are identified and arrangements for its delivery are made. The OADAP Grants Manager reviews the quarterly financial reports as they are submitted, monitoring for the consistency of expenditures with the program's line item budget.

(b) Visit each program at least once per quarter to discuss the results of the review and recommendations for successful completion of program goals.

The OADAP Drug Program Specialist visited each drug treatment program on a quarterly basis and all other prevention/intervention programs funded by drug monies on a semi-annual basis. The purpose of the visits was to review general progress toward administrative and treatment objectives and to address any special problems which had arisen.

4. Prevention and Education

1) Common Objectives

(The following objectives are from Alcoholism Prevention Program (ASP) and Prevention/Intervention (DSP))

The ultimate goal of OADAP's primary prevention program is to bring public policy, individual attitudes, and persuasiveness of community leaders, parents, and institutions to bear in a coordinated effort aimed at giving people an opportunity to develop the skills necessary to deal with the challenges of life, specifically decisions about drugs.

Objective (1): Continue prevention efforts which currently include state-wide media presentations, a speakers' bureau, distribution of pamphlets, and film lending library.

We have sent out an average of seven films and 150 pamphlets each week in the past year. OADAP has also worked with the State Library to encourage the use of the video cassettes of "Jackson Junior High" and "Dial Alcohol." They were used 117 times in public schools, as well as being viewed on Instructional TV by 1,456 more students. Radio and TV presentations have not regularly been tabulated, but far more than the 30 projected presentations were made. Presentations at civic groups, clubs, and professional clubs have also far exceeded the projected 25.

Library research projects on drug use and abuse have been infrequent, but time consuming. A total of 15 to 20 research efforts were made throughout the year. Consultation with prevention projects throughout the State has been almost a daily activity.

The State Legislature required some assistance in their deliberations; specifically on the subject of the legal age for buying alcoholic beverages, and community-wide prevention legislation.

We have far exceeded the proposed tasks in this objective. The increase is basically due to people becoming aware of our services and requesting help from us.

Objective (2): Implement community-wide prevention projects in five Maine communities.

This objective was not achieved since funds were not made available through the legislative process. One small community-wide project was completed; but due to a lack of funding, this was extremely limited. It did point to the potential for this type of project, as well as point out the difficulties.

Objective (3): Assist schools outside of the selected target areas (see objective 2) with development and delivery of prevention activities.

The intention was that this objective would also be funded by proposed legislation which did not become law. We were able to develop a few extensive school projects and support many minimal presentations. We funded two staff persons in the State Department of Education to produce teacher workshops. They have held teacher workshops called "Student, Teacher, Parent Workshops" which brought 36 or more teachers and parents together for four days to study drugs, causes of drug abuse, and resources to deal with drug-related problems. The Department of Education's staff also presented a four-day workshop titled "Drugs, Alcohol, Tobacco, and Human Behavior" for teachers. This workshop introduced a K-12 curriculum to the teachers. A third workshop was called "Human Development Workshop" which is basically a values clarification presentation for teachers, to help them develop tools for the healthy sharing of feelings in the classroom. Eighteen of these workshops have been held in this past year. This facet of the objectives met last year's expectation.

A person was funded to work in the Lewiston, Turner, and Auburn Junior High Schools; her office is located at the Auburn YWCA. She worked with over 2,000 students and adults individually and/or in group presentations. She also helped teachers and administrators in understanding drugs and drug abuse.

Another person was funded by OADAP and LEAA to work in the Kennebunk School District. This project included a great deal of community group work. This man also taught courses in values clarification and decision-making skills to school students and adults. Peer counseling was another component of this project.

The "Youth Environmental Services Project" was an alternative project to group and individual counseling for Aroostook County youth. Assistance to youth in obtaining employment was a major component of the Aroostook efforts. This project reached 200 students.

The Waldo County Youth Alternatives Project, also funded by OADAP, assisted youth in obtaining employment; and the agency helped to develop recreational alternatives. The efforts of this project reached 40 students. The "Youth Services Development Project" provided high-risk adolescents in public schools with counseling, while also working with the parents and school personnel on understanding adolescent drug abuse problems. This project reached 500 students in group or individual activities.

Other agencies which were funded by OADAP for intervention and/or treatment did contribute to prevention activities in many schools. There were yet other agencies which were not funded by OADAP who also contributed a great deal. Those agencies and a description of their activities are described in Chart 20. The results from these grants met or passed our expectations.

Films, pamphlets, one-hour lectures, the Jackson Junior High and Dial Alcohol series were also presented in many schools, as indicated in the first objective.

CHART 20

PREVENTION RESOURCE ASSESSMENT

INFORMATION

RESOURCES	NUMBER OF CLIENTS SERVED PER YEAR	DESCRIPTION OF SERVICES/GEOGRAPHIC AVAILABILITY
Office of Alcoholism and Drug Abuse Prevention	300 film showings, 8,000 pamphlets, 500 posters	Maintenance of circulating film library; distribution of pamphlets and brochures; response to requests from schools and community groups for presentations, state-wide.
Human Development and Guidance Resources Unit, Department of Educational & Cultural Services	200 film showings and 1,000 pamphlets	Circulation of films; distribution of pamphlets; collection of substance abuse curriculum materials, state-wide.
YWCA Drug Education Project	2,100 students receive general presentations; 120 students in weekly sessions in 3 schools	Presentation of information related to substance abuse for public school classes; church; and civic and community groups, Lewiston-Auburn area.

INTERVENTION

RESOURCES	NUMBER OF CLIENTS SERVED PER YEAR	DESCRIPTION OF SERVICES/GEOGRAPHIC AVAILABILITY
Youth Environmental Services Project	200	Group and individual counseling for high-risk youth; diversion for juveniles apprehended by five municipal police departments, Aroostook County.
Waldo County Youth Alternatives Project	40	Individual counseling; remedial education and vocational assistance for high-risk youth; and family counseling, Waldo County.

CHART 20 (CONTINUED)

INTERVENTION

RESOURCES	NUMBER OF CLIENTS SERVED PER YEAR	DESCRIPTION OF SERVICES/GEOGRAPHIC AVAILABILITY
YWCA Intervention Project	60	Individual counseling; group counseling; and recreational activities for adolescent girls, Lewiston-Auburn area.
Career Education Program, Crisis & Counseling Center	30	Career counseling for adolescent dropouts and those who are considering quitting school, Augusta-Waterville areas.
YWCA Drug Education Project	120	Group counseling for junior high-school students in four public school systems, Lewiston-Auburn area.
Youth Services Development Project	330 500 student presentations	Counseling of high-risk adolescents in the public schools; consultation with parents and school personnel; training of secondary teachers in working with adolescents who have substance abuse problems, Waldo and Knox Counties.
Substance Abuse Prevention Component, Full Circle	25	School-based group and individual counseling services, Bath-Brunswick areas.
Prevention Component, Day One	135 students 800 involved in presentations	School-based counseling of students at Portland High School
The Community School	12	Offers an educational alternative to high-school dropouts which includes: individual counseling, tutoring, vocational internship located in Camden, accepts state-wide referrals.
Project Atrium	12	Offers a residential alternative to adolescents for whom foster homes are unavailable but for whom institutional care is unnecessary. Counseling, tutoring, and an emphasis on developing skills for community living are important elements of the Project, Bangor area.

CHART 20 (CONTINUED)

EDUCATION

RESOURCES	NUMBER OF CLIENTS SERVED PER YEAR	DESCRIPTION OF SERVICES/GEOGRAPHIC AVAILABILITY
Human Development and Guidance Resources Unit, Department of Educational and Cultural Services	1,000 initial confrontations 350/year teachers, in depth 3,500 students indirectly	Presentation of Student/Teacher/Parent Workshops; Human Development Program Workshops; and Drug, Alcohol, Tobacco, and Human Behavior Workshops in public schools, State-wide.
'Pro-Act' Course, Crisis and Counseling Center	50/year in depth 500 in one-time presentations	Presentation of a ten-week, ten-hour, mini course in the public schools including drug information, values clarification, and development of decision-making skills related to substance abuse, Augusta-Waterville areas.
Kennebunk-Kennebunkport Youth Services Project	500 students 1,000 parents and community people	Peer counseling; implementation of an affective education model; parent communication training; and staff development training for teachers, Kennebunk School Administrative District.
Farmington Alcoholism Primary Prevention Project	30 community groups Approximately 4,000 community people reached	Design and testing of a model for community-based alcoholism primary prevention including: survey of community attitudes, development of concrete information and education approaches, selection of indicators of alcohol use and assessment of the effects which information and education have had on those indicators.
Tri-County Mental Health Services	10 schools needs assessment	Needs assessment of school population in Androscoggin, Oxford, and Franklin Counties, followed by development of appropriate material. This is a new project funded by NIMH and it is now in the needs assessment stage.

CHART 20 (CONTINUED)

ALTERNATIVES

RESOURCES	NUMBER OF CLIENTS SERVED PER YEAR	DESCRIPTION OF SERVICES/GEOGRAPHIC AVAILABILITY
Youth Environmental Services Project	100	Recreational activities; two youth employment programs - one is a summer program for disadvantaged youth; the other a year-round employment program for high-risk youth, Aroostook County.
Waldo County Youth Alternatives Project	200	Recreational activities through an organized youth center; youth employment opportunities for disadvantaged or high-risk youth, Waldo County.
Kennebunk-Kennebunkport Youth Services Project	500 people	Recreational activities for joint youth and adult participation, Kennebunk School Administrative District.
Channel 1	20 students and adults involved	This is a newly-established program, based on the Gloucester Experiment, which promotes participation of diverse community elements in projects beneficial to the community as a whole, Portland.
Wabanaki Wilderness Pursuits Program	300	Outdoor recreational activities for Indian youth organized as a part of year-round camping expeditions led by trained instructors.

A conservative estimate of the total number of students who were reached directly by the various projects is over 20,000. The number of teachers and parents is not well-documented, but an estimate would be over 10,000. The depth of the contact varied greatly from one hour in a group to forty hours of group activity. Some individuals had one hour of counseling while others had several hours. In addition to these figures, TV and radio spots may have been seen or heard by over half of the population of Maine.

OADAP was able to meet and pass all objectives except those relating to the community-wide prevention activities. The lack of the hoped-for legislation blocked the plans to significantly develop the community approach.

5. Manpower and Training

1) Alcohol Objectives

(The following objectives are from Alcoholism Training Programs (ASP))

Objective (1): Provide, via contract with the Office of the State Court Administrator, for the funding of tuition and expenses of six Superior and District Court Judges annually, to enable their participation in specialized alcoholism-related judicial education courses provided by one of the national judicial education centers.

(a) Determine the availability and costs of specific courses by September 30, 1977.

(b) Fill quotas for courses with specific judges during the remaining fiscal year period.

(c) Continue to cycle judges as appropriate through the available courses.

Objective (2): Develop an audio-visual instruction package to cover the recognition of the physical and behavioral symptoms of problem drinking, cross addictions, withdrawal, and other aspects of alcoholism basic to the role of physicians.

(a) Contract for the development of the audio-visual package within the first quarter of fiscal year 1978 with an expected completion date of April 1, 1978.

(b) Schedule presentations and make available for physician audiences beginning May 1, 1978.

(c) Provide funds to cover costs of maintaining, transporting, and presenting the audio-visual instruction annually commencing with fiscal year 1979.

Objective (3): Provide tuition assistance for training of alcoholism program staff personnel to encourage the professional development of the para-professional alcoholism worker.

(a) Notify alcoholism program staff personnel of the availability of tuition assistance during the first quarter of fiscal year 1978.

(b) Screen applicants and select on the basis of need and future benefits which might accrue to the field of alcoholism services as a result of training the individual.

(c) Monitor progress of tuition recipients to ensure completion of training objective.

Objective (4): Provide training for non-alcoholism service workers to give them the knowledge and skills necessary to assist problem drinkers.

(a) Determine target groups and training needs by July 1, 1978.

(b) Develop workshops for delivery on or after July 1, 1978 based on findings.

(c) Deliver and evaluate workshop training sessions for target groups during fiscal year 1979 and 1980.

Funds for completion of each of these objectives were included in a legislative proposal for establishment of a tax on alcoholic beverages (Appendix K, Legislative Document 857). Since that proposal failed to pass, and it was necessary to allocate all available funds for maintenance of services provided by existing programs, the objectives were not accomplished. Although OADAP continues to recognize the importance of each training objective listed, they will not be actively pursued until additional funds are obtained. The possible initiation of a State Alcohol Manpower Contract between OADAP and NIAAA presents one good alternative for funding selected activities under one or more of these objectives.

Objective (5): Continue development of substance abuse counselor training model.

(a) Assess progress on present contract with Human Services Development Institute for model development by July 1, 1977.

(b) Take necessary steps to complete development of model based on progress assessment.

Accomplishment of this objective is covered under Planning and Coordination, Objective 3, in Part II - 1, Administrative Services.

Objective (6): Continue to promote training opportunities which exist in Maine for alcoholism field people.

(a) Continue to participate in activities of the New England Institute of Alcohol Studies.

During the past year, the OADAP Director and the Alcohol Program Specialist have served as Board members for the New England Institute of Alcohol Studies (NEIAS). Their Board role has involved them in the planning and development of both the 1977-78 NEIAS Alcoholism Counselor Training Program and the New England Summer School of Alcohol Studies, 1978. OADAP is financing tuition to the Summer School for twenty-five (25) employees of drug and alcohol programs in Maine.

(b) Assist the Human Services Development Institute's efforts to provide training for Title XX alcoholism service provider personnel.

In September, 1978, the Title XX Training System developed by the Human Services Development Institute was incorporated in the internal operations of the Department of Human Services. The System depends upon a network of regional advisory councils which make recommendations on the training to be delivered in each region of the State. In each region, a representative of alcohol service providers participates as a member of the council. Additionally, the OADAP Training Specialist consults with the staff of the Title XX System on a regular basis. Such consultation allows for joint efforts in providing alcohol training. For example, the Title XX Training System is financing the tuition for Title XX-eligible employees of alcohol programs at the New England Summer School. Also, Title XX has developed the Substance Abuse Counselor Training Program to improve the clinical skill of counselors. The OADAP Training Specialist helped review the structure and content of that course.

(c) Provide funds through grants to alcoholism service provider agencies for staff training and development activities.

OADAP awarded FY-78 funds for staff training and development activities in alcoholism service provider agencies through its annual grants process in April, 1977. Several agencies included a line item for such activities and a justification for expenditures in that line in their grant requests. In 1978, all applicants for OADAP funds were encouraged to submit line items in their budgets for training activities not to exceed $250.00 per direct service full-time employee. They were also required to submit an accompanying staff training plan, describing planned activities.

2) Drug Abuse Objectives

(The following objectives are from Manpower and Training (DSP))

Objective (7): Assess the needs and solicit the opinions and recommendations of workers in the substance abuse field on all training-related issues.

(a) Administer both training content and training structure needs assessments for substance abuse workers annually.

During the past year, an update of the original training content needs assessment for substance abuse counselors was performed through structured telephone interviews with program administrators. Incorporated in the interviews were questions relating to training structure. Additionally, a training needs assessment survey for administrators was completed by the directors of alcohol and/or drug programs. The survey addressed both content and structure needs. The results of both assessments were summarized in report form for use in planning training events.

(b) Maintain a Training Advisory Committee to OADAP comprising substance abuse personnel and representatives of related training and education systems that will be staffed by OADAP and will meet no fewer than six times a year.

The Training Advisory Committee to OADAP currently consists of seven members representing service providers and education institutions. During the past year, the Committee has met five times; the final meeting is projected for June. The Committee has discussed various training and credentialing issues, making recommendations to OADAP on various decisions related to design, delivery, and evaluation of training.

Objective (8): Provide a minimum of five training opportunities for substance abuse workers that will directly respond to the priority training needs identified through Objective 7 above.

(a) Provide the recently completed Comprehensive State Training Plan and information on all available training resources to the Training Advisory Committee for recommendations.

Copies of Maine's Substance Abuse Training: A Planning Report have been distributed to members of the Training Advisory Committee and other individuals and groups which have expressed interest in the training issues it addresses. Information on available training resources is regularly provided to the Committee through mailings and in the context of Committee meetings.

(b) Provide at least:

3 training opportunities for substance abuse counselors;
1 training opportunity for substance abuse administrators; and
1 training opportunity for other substance abuse workers such as outreach staff or prevention people.

By July 1, 1978, the following training courses will have been delivered to people working in Maine's substance abuse programs:

Course Title	Number of People Attending
Modified Assessment Interviewing for Treatment Planning	9 staff of OADAP Driver Education and Evaluation Program
Facts About Drug Abuse	15
Modified Facts About Drug Abuse	40 (projected)
Counselor Training: Short-Term Client Systems	16
Adolescent Group Counseling	10 (projected)

(c) Utilize the training and technical assistance resources being offered to Maine by the Northeast Regional Support Center, i.e.

25 days of Training/Technical Assistance;
20 days of in-state training;
18 consultant days for T/TA; and
10 days of centralized training.

The number of available days of Training/Technical Assistance was reduced in final contract negotiations and, in fact, centralized training was not offered during the contract year. It is anticipated that by the end of the Northeast Regional Support Center's contract in June, 1978, Maine will have used the following amounts of resources:

Training - 16 days
Technical Assistance - 19 days

The topics covered by training events are indicated immediately above after (b). The technical assistance that was provided addressed the following areas: training system development for OADAP, implementation of credentialing for the Board of Registration, grantmanship, and information on drug abuse for local programs.

Objective (9): Insure that training opportunities provided by OADAP address the knowledge/skills/attitudes upon which the requirements and testing instruments for credentialing of substance abuse counselors will be based.

(a) Incorporate in the certification model a clause which requires the consultation and approval of OADAP before implementation of additional credentialing standards, including testing instruments.

The certification model which was enacted by the Legislature contains two specific references which require the Board of Registration of Substance Abuse Counselors to consult with OADAP. Those references relate to the establishment of additional standards of eligibility and design and adoption of examinations or other suitable criteria for determining a candidate's competency (Appendix L).

(b) Assign the STSP Project Director the task of test development for credentialing based on the knowledge/skill/attitude statements for counselors previously generated by Functional Job Analysis.

Because of the delay encountered in hiring a new person as the OADAP Credentialing Specialist who would assume the responsibility of the STSP Liaison, the task described was subcontracted. The urgency of contracting an examination for use by the Board of Registration of Substance Abuse Counselors necessitated the choice of an alternative method for accomplishing the task.

(c) Charge the Training Advisory Committee to OADAP with monitoring the link between training and credentialing requirements.

The Training Advisory Committee has discussed the necessary link between training options and credentialing requirements at length. It has identified the monitoring of that link as a primary responsibility. However, until the full range of credentialing requirements is established, no substantive action can be taken by the Committee.

Objective (10): Invite interested workers from related human service fields to participate in the training detailed in Objective 8 and likewise pursue opportunities for substance abuse workers to participate in training events sponsored by other human service or educational agencies.

(a) Coordinate the delivery of OADAP-sponsored training sessions through the Title XX Training System developed by the Department of Human Services.

The process of transferring the Title XX Training System from the contractor which developed it into the Department of Human Services took three months longer than originally anticipated. This delay when combined with OADAP's difficulties in hiring a Credentialing Specialist, meant that coordination of training courses could not be accomplished during the last training cycle. But, since the problems encountered were due to special circumstances which no longer exist, coordination in the future should proceed as first planned.

(b) Keep substance abuse workers advised of training opportunities available through the established Mental Health Training Program.

Announcements of opportunities available through the Mental Health Training Program are routinely publicized to substance abuse programs. During the past year, OADAP has worked cooperatively with that program to design a group-skills course on counseling adolescents. The course, to be delivered in June, 1978, will be open to substance abuse workers and employees of community mental health centers.

Objective (11): Secure additional training resources as required by the needs assessments performed or when indicated for special training purposes.

The cooperative planning with the Mental Health Training Program described immediately above in Objective 10, is one example of securing additional resources when required to meet a special training need.

PART III

NEEDS ASSESSMENT

PART III: NEEDS ASSESSMENT

I. Alcoholism

A. Estimates of the Total Number of Alcohol Abusers and Alcoholics in Maine

There are numerous methods for estimating the number of alcohol abusers and alcoholics in a given population. One of the most reliable is to survey a scientifically selected sample of persons who are representative of the entire population in question. This is also the most costly and time-consuming method. It has not yet been attempted in Maine.

OADAP staff decided that the constraints of time and financial resources precluded conducting a survey for this Plan. However, we have made a commitment to analyze the costs and benefits of conducting various kinds of needs assessments during the coming year. This analysis should be completed by July first.

There is a generalized feeling among service providers that a sophisticated statewide needs assessment is not necessary. They would prefer to see the resources necessary for such a project devoted to direct service delivery.

The estimates of the number of alcoholics and alcohol abusers given in this year's plan are identical to those given in last year's plan. Since these measures are "synthetic estimates" based upon the application of standard formulas to Maine's population, it was felt that re-calculation of the estimates with slightly updated population data would not appreciably improve their validity. These estimates have been supplemented by updated information from the Community Monitoring (CMS) and Program Monitoring Systems (PMTES).

The CMS contains data collected from other agencies on the incidence of alcohol and drug related problems within the state. Use of CMS data in the needs assessment is within the tradition of the social indicators approach to needs assessment.

The PMTES contains information on the characteristics of clients in treatment. This provides information on the actual utilization patterns of existing resources. Differences between expected and actual usage patterns point to the need for reassessment of the service delivery system.

The most common method employed in the past has involved the application of some standard formula or percentage to the population in question. Often, as in the case of the "Maine State Plan for Prevention, Treatment and Rehabilitation of Alcohol Abuse and Alcoholism, December, 1974," this is the Jellinek formula (see, for example, N. Jollife and E.M. Jellinek, "Vitamin Deficiencies and Liver Cirrhosis in Alcoholics," Quarterly Journal of Studies on Alcohol, II, pp. 544-583, 1941), which is based upon statistics on deaths due to cirrhosis of the liver. By means of this formula, the total number of alcoholics in Maine's 1970 population was estimated as 26,300 with a male-female ratio of almost exactly 4-1.

Note that the Jellinek formula does not include consideration of alcohol abusers, but only alcoholics. Mark Keller of the Rutgers Center of Alcohol Studies has estimated ("Problems of Epidemiology in Alcohol Problems," Quarterly Journal of Studies on Alcohol, XXXVI, pp. 1442-1452, 1975) that for each alcoholic there is another pre-alcoholic whose drinking is already causing problems. On this basis the number of alcoholics estimated by means of the Jellinek formula would have to be doubled -- to 52,600 -- to arrive at an estimate of the total number of problem drinkers, i.e., alcohol abusers and alcoholics.

Similar to the Jellinek formula is another (see W. Schmidt and J. deLint, "Estimating the Prevalence of Alcoholism from Alcohol Consumption and Mortality Data," Quarterly Journal of Studies on Alcohol, XXXI, pp. 957-964, 1970) based on the number of suicides in a given year, the proportion of alcoholics among suicides (.25) and the suicide rate of alcoholics (12.39 per 10,000). Based on this formula, the estimated number of alcoholics in Maine for 1970 was 26,836. Again, depending upon the reliability of Keller's estimate of the ratio of alcoholics to alcohol abusers, this would yield an estimated total of 53,572 alcohol abusers and alcoholics.

A third and less reliable method is based upon the estimate of Keller, cited above, that 5.2% of those who drink are alcoholics, and upon another estimate of the percentage of Americans who drink -- 68% of those 21 and older (First Special Report to U.S. Congress on Alcohol and Health, U.S. Department of Health, Education, and Welfare Publication No. HSM 73-9031, 1972). This formula would yield an estimate for Maine in 1970 of 50,294 adult alcohol abusers and alcoholics.

Still other methods could be cited which are too crude and unreliable to be employed. Even the three methods cited above can be criticized in that they are actually a combination of several estimates, and they do not reflect the fact that people of different sex, age, race, ethnicity, socio-economic status, residence and religion will have different probabilities of being alcohol abusers or alcoholics. This section will conclude with a fourth estimate based on a formula which does take into account the most important of these differences and which in the judgment of OADAP is the most sensitive and reliable formula developed to date. It is taken from "A Procedure for Estimating the Potential Clientele of Alcoholism Service Programs" authored by Parker G. Marden, Ph.D. in 1974 for the National Institute on Alcohol Abuse and Alcoholism.

Based on the work of Cahalan and colleagues (D. Cahalan and I.H. Cisin, "American Drinking Practices: Summary of Findings from a National Probability Sample: I. Extent of Drinking by Population Subgroups," Quarterly Journal of Studies on Alcohol, XXIX, pp. 130-151, 1968; D. Cahalan, I.H. Cisin, and H.M. Crissley, American Drinking Practices, New Brunswick, Rutgers Center of Alcohol Studies, 1969; D. Cahalan and R. Room, Problem Drinking Among American Men, Monograph No. 7, New Brunswick, Rutgers Center of Alcohol Studies, 1972), Marden arrived at proportions of drinkers with problems for women by age and for men by age and, except for those 19 and under or 70 and above, by occupation. These proportions are represented by the first figure in the cells of the following "Marden Grid."

MARDEN GRID (1970 pop.)

TABLE 1

MEN	15-19	20-29	30-39	40-49	50-59	60-69	70 +
Professional, Technical		.111 x 8,000 = 888	.151 x 6,700 = 1,012	.113 x 5,100 = 576	.089 x 3,500 = 311	.042 x 2,400 = 101	
Managers, Administrators		.250 x 3,600 = 900	.250 x 6,300 = 1,575	.122 x 9,300 = 1,135	.127 x 6,600 = 838	.171 x 2,600 = 445	
Sales Workers		.261 x 2,900 = 725	.136 x 2,500 = 340	.097 x 2,700 = 262	.078 x 1, 900 = 148	.053 x 1,100 = 58	
Clerical	.050 x	.261 x 2,700 = 705	.136 x 2,200 = 299	.097 x 3,400 = 330	.078 x 2,600 = 203	.053 x 1,500 = 79	..014 x
Craftsmen	47,496	.250 x 11,400 =2,850	.146 x 10,700 =1,562	.280 x 13,500 = 3,780	.177 x 11,200 =1,982	.179 x 6,300 =1,128	30,776
Operatives, Ex. Transp.	=2,375	.379 x 11,200 =4,245	.113 x 7,400 = 836	.250 x 7,700 =1,925	.292 x 6,700 =1,956	.067 x 2,400 = 161	= 431
Transport Operators		.379 x 3,700 =1,402	.113 x 2,800 = 316	.250 x 2,800 = 700	.292 x 3,000 = 876	.067 x 1,600 = 107	
Laborers, Ex. Farm		.248 x 5,100 =1,265	.450 x 4,500 =2,025	.080 x 3,500 = 280	.118 x 3,700 = 437	.200 x 1,300 = 260	
Farmers Farm Managers		.261 x 400 = 104	.136 x 1,600 = 218	.097 x 800 = 78	.078 x 1,100 = 86	.053 x 700 = 37	
Farm Laborers, Foremen		.379 x 12,00 = 455	.113 x 400 = 45	.250 x 700 = 175	.292 x 500 = 146	.067 x 800 = 54	
Service Workers		.261 x 4,200 =1,096	.136 x 1,900 = 258	.097 x 2,800 = 272	.078 x 4,100 = 320	.053 x 3,600 = 191	
WOMEN	.01 x 46,846 = 469	.02 x 66,988 =1,398	.079 x 53,398 =4,218	.068 x 58,107 =3,951	.019 x 52,646 =1,000	.012 x 45,136 = 542	.004 x 45,853 = 183

It should be noted that the proportions listed for males and females aged 15-19 are not given by Marden, but are supplied by OADAP on the basis of other sources ("High School Survey on Drinking and Driving, Phoenix, Arizona," prepared for NHTSA, U.S. Dept. of Transportation, City of Phoenix, Alcohol Safety Action Project, 1973; "Survey of Adolescent Alcohol Drinking Behavior, Attitudes and Correlates," prepared for NIAAA, U.S. Dept. of HEW, Research Triangle Institute, 1975). The second figure in each cell is a 1970 population figure for that subgroup (U.S. Bureau of the Census, Public Use Samples of Basic Records from the 1970 Census: Description and Technical Documentation, Washington, D.C., 1972).

The total number of problem drinkers from this grid is 57,115. The ratio of men to women is almost precisely 4 to 1. If the total number is adjusted simply according to the 5.3% increase in Maine's population since the 1970 census, the current estimate becomes 60,142 problem drinkers, or 5.7% of Maine's 1976 population. The recent Ploch report to the Commission on Maine's Future states that Maine's population is increasing currently at the rate of 1.2% per year.

B. Estimates of the Numbers of Particular Types of Alcohol Abusers and Alcoholics in Maine

It is possible to use the Marden formula to estimate the numbers of problem drinkers in particular segments of the population. The formula shows that in 1970 there were 11,761 women problem drinkers. Adjusted for population increase, this becomes 12,384 in 1976. These same procedures yield a current estimate of 45,000 employed problem drinkers aged 20 and over. In the previous section, it was noted that OADAP has made its own conservative estimate of the proportion of young (15-19) problem drinkers. This proportion yielded an estimate of 2,375 such young persons in 1970, and 2,500 in 1976. (See Table 1). These figures have practical importance, as will be seen in subsequent sections, because the means both of reaching these different types of troubled persons as well as the kinds of services they need also differ. The same can be said of other types of problem drinkers -- problem drinking drivers, other criminal justice offenders (misdemeanants and felons who are probationers, inmates and parolees), public inebriates, and Indian problem drinkers.

Obviously, these seven groups or categories overlap. While not likely, it is conceivable that a single individual could belong to six of these seven groups. To state the matter in a different way, the estimate made below of the number of problem drinking drivers indicates that approximately three out of every four problem drinkers in Maine hold drivers licenses. This would indicate not only strong overlap, but also that an effective statewide system for screening out the problem drinkers from among all drinking driver offenders and requiring that these problem drinkers enter a treatment program would be one of the most important steps which could be taken to reduce the problems of alcohol abuse and alcoholism in Maine. To make estimates, then, of the numbers of problem drinkers in seven categories is not to separate a group into distinct parts which by simple addition equal the whole, but rather to "dehomogenize" the group called "alcohol abusers and alcoholics," i.e., to look more closely at this group, to begin to uncover different and sometimes multiple means of access to its members, and to lay the foundations for treatment services which respond to individual needs.

The National Highway Traffic Safety Administration of the U.S. Department of Transportation estimates (Evaluation of Presentence Investigation and Probation Countermeasure Activities, U.S. Department of Transportation Publication HS 801728, p. 2, 1975) that 7% of all licensed drivers are problem drinkers. The Maine State Division of Motor Vehicles indicates that there are now approximately 640,000 drivers licensed in Maine. On this basis, there are 44,800 problem drinkers with drivers licenses. The Department of Transportation's definition of "problem drinker" is based on a complex combination of the quantity of alcohol consumed per occasion and the frequency of drinking, and it includes those in the early stages of alcohol abuse as well as those suffering from advanced alcoholism. It appears likely that few of these problem drinkers make a practice of never driving while intoxicated.

Early in 1976 the Maine Criminal Justice Planning and Assistance Agency (MCJPAA) conducted a survey of correctional officers to obtain their estimate of drug and/or alcohol problems among their clients. They responded that 40% of all correctional clients have alcohol problems, 34% have marijuana problems, 11% have narcotics problems, and 15% have problems with other drugs. "Correctional clients" includes:

a) all persons on probation or parole,
b) all persons in county jails, and
c) all persons in State correctional institutions.

While the figure of 40% for alcohol abuse problems may seem high, it coincides very closely with a "conservative" estimate made at the National Institute on Alcohol Abuse and Alcoholism ("Proceedings of the Seminar on Alcoholism Detection, Treatment and Rehabilitation in the Criminal Justice System," Department of Health, Education and Welfare, 1974). In calculating the estimated daily number of problem drinkers in the correctional system at 2,274 persons, the chart below takes into account that the three types of correctional clients mentioned above differ both in numbers and in rates of problem drinking.

	Approximate average daily population*	Percent of problem drinkers	Approximate # of problem drinkers in daily population
Probation and Parole	4,600	33.5%	1,541
State Correctional Institutions	850	70.3%	598
County Jails	287	47.1%	135

* These approximations are made on the basis of data collected by OADAP from both MCJPAA and the Department of Mental Health and Corrections.

Using the NIAAA estimate of 3.5% of the total number of problem drinkers, Maine's estimated number of public inebriates ranges between 1,800 and 3,000 persons.

Finally, an estimate of the number of Indian problem drinkers in Maine must be even more approximate. According to the 1970 Census, there were then 2,195 Indians in Maine. This Census had serious problems in enumerating minorities; and later analyses indicated that 9.5% of the non-white population may have been missed. Some among Maine Indians place their true current population at approximately 4,000, of whom 25% live on reservations. NIAAA, in its 1971 report to the U.S. Congress, stated that alcoholism is at least twice as prevalent among Indians as other Americans; and on some reservations has reached rates of 25 to 50%. Information gathered by the Wabanaki Corporation and the Department of Indian Affairs indicates that the prevalence of problem drinking in this population is most probably in the upper range of this estimate, i.e. in the neighborhood of 1,500 persons on and off the reservations.

In summary, it is estimated that there are approximately 60,000 problem drinkers in Maine at present, or 5.7% of the total population. Approximately 98% of these persons are employed, 75% hold drivers licenses, 20% are women, and 5% are between the ages of 15 and 19. Other smaller, but important, target populations are chronic public inebriates, Indian problem drinkers, and problem drinkers in the criminal justice system.

C. Analysis of Community Monitoring System Data

During 1977, OADAP received a report on selected CMS data for the calendar years 1973 through 1976. The report was based on the results of statistical analysis of 13 CMS variables. The analyst used analysis of variance and Duncan's Multiple Range test to determine if there were statistically significant differences among the variables across regions, through time, and by region and time interaction.

The analysis revealed very few significant differences. Region V was significantly higher than all other regions in the rate of admissions to general hospitals for diagnosis of alcoholic psychosis and for alcoholic cirrhosis. Region V also had a significantly higher unemployment rate than any other region. Region V was significantly lower than all other regions in the rate of divorces. Region II was significantly lower than all other regions in the rate of alcohol-related traffic accidents.

The rate for court appearances for operating under the influence was significantly higher in 1974 than for any other year. This is probably due to the presence of an Alcohol Safety Action Project (ASAP) in two heavily-populated counties during the years 1971 through 1974. The effects of increased resources and training for police and prosecutors reached a peak in 1974 and diminished with the dismantling of the project. The fact that driver education courses became available for OUI offenders on a State-wide basis in 1975 may also have had some impact on reducing OUI recidivism.

Unemployment was significantly higher in 1975 than in any other year.

The rate of court appearances for assault and battery showed a significant region/time interaction effect. It reached an extreme peak in Region V in 1974.

In addition to the significant differences cited above, Region V was higher than all other regions on four other variables. These are: court appearances for assault and battery; alcohol-related traffic accidents; general hospital admissions with a diagnosis of alcoholism; and mental health facility admissions for problem drinking.

On the other hand, as previously mentioned, Region V has a significantly lower divorce rate than any other region. It is also lower than any other region in the rate of OUI court appearances.

Thus, Region V occupied the extreme position (highest or lowest) on 9 of the 13 variables. This may be partially explained by the fact that, while geographically as large as the other regions, Region V consists of only one county. Rates for the other regions represent an average of the rates for more than one county. Such a "pooling" effect has the tendency to reduce extremes. Region V has no such pooling effect.

While the effect of pooling on the extreme rankings of Region V has not been subjected to rigorous statistical analysis, we have concluded that the region does indeed have a higher incidence of certain types of alcohol-related problems than other regions of the State. Subjective reports of the drinking habits of the region's residents indicate that binge drinking of distilled spirits is a prevalent pattern. These periods of binge drinking are linked with the seasonal fluctuations of the labor market which is dominated by the demands of the potato industry. The concentrated periods of heavy drinking of distilled spirits would be expected to produce numerous cases of acute disorders for which hospitalization would be necessary. They would also produce eruptions of violent behavior and unsafe driving. As mentioned above, indicators for all of these events were quite high in the region.

The severity of problems in the region would lead one to expect that a relatively high proportion of persons in treatment would be residents of the region. This is not the case. In fact, the reverse is true. Aroostook County has approximately 9% of the State's population, but only 4% of the persons admitted to treatment were Aroostook County residents. From this, it must be concluded that Aroostook County's alcohol abuser population is underserved.

D. Analysis of Treatment Utilization Data

Table 2 presents a summary of data on selected client characteristics for the period January 1, 1977 through June 30, 1977. This table shows that the "typical" client may be described as a male in his mid-forties who is currently not married, who is unemployed and who, when employed, works as a laborer with a total household income of under $5,000. Since his educational level equals that of the general population in the State, his low occupational and income level probably indicates that his alcohol use patterns seriously undermine his economic potential. Typically, he has received prior professional treatment for alcoholism and has attended AA. During treatment he was likely to receive individual counseling and detoxification services.*

* Information on treatment services was obtained from a different section of the PMTES report. It is not included in Table 2.

A PROGRAM MONITORING SYSTEM DATA FOR: ENTIRE STATE

TABLE 2

For Time Period: 1/1/77 - 6/30/77

	T	%
Admissions		
Male	1,892	
Female	427	
Total		18.3
Terminations		
Male		
Female		
Total		
In Treatment		
Female		
Male		
% Female		

Age	M#	M%	F#	F%
14 & under	6	*	0	0
15 - 19	41	2	18	4
20 - 24	136	7	27	6
25 - 29	164	9	30	7
30 - 39	504	27	101	24
40 - 49	456	24	137	32
50 - 59	342	18	82	19
60 & over	242	13	30	7
Unknown	4	*	1	*
Average				

Condition on Admission		
Sober	896	39
Intoxicated	779	33
Withdrawal	607	26
Unknown	44	2

County of Residence	T	%
Androscoggin	310	13
Aroostook	102	4
Cumberland	517	22
Franklin	40	2
Hancock	46	2
Kennebec	119	5
Knox	144	6
Lincoln	39	2
Oxford	109	5
Penobscot	319	14
Piscataquis	13	1
Sagadahoc	62	3
Somerset	54	2
Waldo	64	3
Washington	28	1
York	250	11
Total State	2,216	95
Out of State	64	3
Unknown	46	2

Marital Status		
Never married	503	22
Married	704	30
Widowed	112	5
Divorced/Annulled	788	34
Separated	200	9
Unknown	19	1

Client Resides		
Spouse	655	28
Family, other than spouse	422	18
Friends in private house	229	10
In group quarters	98	4
Alone	858	37
Unknown	54	2

Occupation	T	%
Professional/Tech	121	5
Managers	61	3
Sales	53	2
Clerical	60	3
Craftsmen	289	12
Operatives	75	3
Transport operatives	63	3
Non-Farm labor	757	33
Farmers	51	2
Farm laborers	15	1
Service workers	264	11
Private household	5	*
students	23	1
Housewife	112	5
Retired	100	4
Disabled	109	5
Unknown	168	7

Attended AA		
No	680	29
Last month	416	18
In past	1,178	51
Unknown	52	2

Prior Treatment		
No	711	31
Yes, other program	588	25
Yes, this program	280	12
Yes, this and other program	696	30
Unknown	51	2

Months Since Last Treatment		
Not applicable	742	32
Still in	345	15
Under 1 month	105	5
1 - 12 months	710	31
over 12 months	196	8
Unknown	228	10
Average # of months	6.9	

A PROGRAM MONITORING SYSTEM DATA FOR: Entire State

FOR TIME PERIOD: 1/1/77 to 6/30/77

TABLE 2 (continued)

	T	%
Education		
None	4	*
Grade 1 - 6	131	6
Grade 7 - 8	430	18
Grade 9 - 11	556	24
High School	762	33
Voc/Bus/Tech	79	3
College, 1 - 3	193	8
College	78	3
Graduate School	33	1
Unknown	60	3
Median		
Receiving Public Assistance		
Yes	395	17
No	1,796	77
Unknown	135	6
Income		
Under 2,000	416	18
2,000 to 3,999	604	26
4,000 to 5,999	324	14
6,000 to 7,999	167	7
8,000 to 9,999	114	5
10,000 to 11,999	71	3
12,000 and over	190	8
Unknown	440	19
Average income	5,341	--
No. of reported income	1,886	--

	T	%
Duration of Treatment		
Less than 1 day	33	2
1 to 3 days	345	18
4 to 7 days	408	22
8 to 14 days	518	27
15 to 30 days	329	17
31 to 91 days	140	7
92 to 182 days	66	3
183 to 365 days	38	2
Over 1 year	9	*
Unknown	0	0
Ave. Median 10.1	23.7	
Cause of Termination		
Completion	1,174	62
Dropped out against advice	571	30
Inactive - 3 or more months	13	1
Terminated by facility	83	4
Client moved or institutionalized	32	2
Client died	3	*
Unknown	10	1

Use of Other Drugs	A#	T#	A%	T%
Yes	155	40	7	2
No	1765	1390	76	74
Unknown	406	456	17	24

Employment	A#	A%	T#	T%
Full time	530	23	419	22
Part time	111	5	68	4
No	1284	55	1030	55
Not applicable	355	15	306	16
Unknown	46	2	63	3

Ave. Therapist Rating	Total A	Total T
Medical condition	2.80	1.85
Positive attitude toward others	3.24	2.75
Accept self as problem drinker	3.28	2.73
Intent to modify problem drinking	3.25	2.81
Realistic action toward solving problems	3.37	2.91

SUBSTANCE ABUSE FORM CLIENT ANALYSIS

REPORTING PERIOD 01/01/77 - 06/30/77 ENTIRE STATE

REFERRAL SOURCE	NUMBER	PERCENT	AT TERMINATION NUMBER	PERCENT	DURING TREATMENT NUMBER AD QTRS	PRCNT TOT AD QTRS
NO	1	.0	582	30.8	1826	71.4
YES	2325	99.9	1304	59.1	730	28.5
24 HOUR CLUB DETOX UNIT	3	.1	0	.0	0	.0
24 HOUR CLUB SHELTER UNIT	21	.9	2	.1	0	.0
24 HOUR CLUB TOTAL PROGRAM	50	2.1	2	.1	0	.0
SERENITY HOUSE TOTAL PROG	9	.3	35	1.8	7	.2
SERENITY HOUSE RESIDENTIAL	0	.0	0	.0	2	.0
MILESTONE TOTAL PROGRAM	54	2.3	0	.0	2	.0
MILESTONE DETOX	8	.3	0	.0	0	.0
MILESTONE SHELTER	1	.0	0	.0	0	.0
MILESTONE AFTERCARE	0	.0	1	.0	0	.0
MERRYMEETING TOTAL PROG	61	2.6	47	2.4	10	.3
MERRYMEETING DETOX	20	.8	0	.0	0	.0
MERRYMEETING REHAB	0	.0	32	1.6	3	.1
MERRYMEETING AFTERCARE	0	.0	20	1.0	3	.1
YORK COUNTY TOTAL PROGRAM	14	.6	60	3.1	3	.1
YORK COUNTY OUTPATIENT	7	.3	0	.0	4	.1
CAS-PORTLAND TOTAL PROG	50	2.1	143	7.5	14	.5
CAS-PORTLAND OUTPATIENT	13	.5	0	.0	5	.1
CAS-PORTLAND AFTERCARE	1	.0	2	.1	0	.0
CAS-BELFAST TOTAL PROGRAM	9	.3	31	1.6	5	.1
CAS-BELFAST OUTPATIENT	0	.0	0	.0	2	.0
CAS-BELFAST AFTERCARE	0	.0	1	.0	0	.0
MID-COAST TOTAL PROGRAM	59	2.5	54	2.8	41	1.5
MID-COAST REHAB	10	.4	3	.1	1	.0
MID-COAST AFTERCARE	0	.0	2	.1	0	.0
CROSSROADS TOTAL PROGRAM	2	.0	0	.0	0	.0
CROSSROADS DETOX	15	.6	0	.0	0	.0
CROSSROADS REHAB	0	.0	19	1.0	0	.0
CROSSROADS OUTPATIENT	0	.0	1	.0	0	.0
CROSSROADS AFTERCARE	1	.0	18	.9	0	.0
FELLOWSHIP TOTAL PROGRAM	28	1.2	2	.1	7	.2
FELLOWSHIP HOUSE DETOX	4	.1	0	.0	1	.0
TRI-COUNTY TOTAL PROGRAM	34	1.4	20	1.0	5	.1
TRI-COUNTY OUTPATIENT	5	.2	0	.0	0	.0
TOGUS TOTAL PROGRAM	9	.3	11	.5	9	.2
KVATC TOTAL PROGRAM	20	.8	63	3.3	19	.7
KVATC OUTPATIENT	0	.0	1	.0	0	.0
KVATC WATERVILLE AFTERCARE	0	.0	15	.7	0	.0
ALCOHOL INST TOTAL PROGRAM	4	.1	5	.2	17	.5
ALCOHOL INSTITUTE DETOX	2	.0	0	.0	0	.0
ALCOHOL INSTITUTE REHAB	1	.0	0	.0	0	.0
HOPE HOUSE TOTAL PROGRAM	31	1.3	8	.4	1	.0
HOPE HOUSE DETOX	6	.2	8	.4	0	.0
HOPE HOUSE SHELTER	0	.0	17	.9	0	.0
BANGOR HALFWAY TOTAL PROG	1	.0	12	.6	10	.3
BANGOR HALFWAY RESIDENTIAL	0	.0	0	.0	1	.0
AROOSTOOK MHC TOTAL PROG	1	.0	1	.0	1	.0
SELF	742	31.9	0	.0	0	.0
RELATIVE/FRIEND	246	10.5	1	.0	1	.0
POLICE	75	3.2	1	.0	1	.0

SUBSTANCE ABUSE FORM CLIENT ANALYSIS

REPORTING PERIOD 01/01/77 - 06/30/77 ENTIRE STATE

REFERRAL	SOURCE NUMBER	SOURCE PERCENT	AT TERMINATION NUMBER	AT TERMINATION PERCENT	DURING TREATMENT NUMBER AD QTRS	DURING TREATMENT PRCNT TOT AD QTRS
SOCIAL SERVICE	43	1.8	27	1.4	326 6	.2
MENTAL HEALTH CENTER	38	1.6	80	4.2	77	3.0
DOCTOR	94	4.0	4	.2	6	.2
HOSPITAL	142	6.1	20	1.0	29	1.1
AA	91	3.9	425	22.5	194	7.5
ALCOHOLISM WORKER	31	1.3	8	.4	4	.1
JAIL	27	1.1	1	.0	0	.0
DRUG PROGRAMS	0	.0	2	.1	2	.0
OTHER	96	4.1	54	2.8	40	1.5
UNKNOWN	146	6.2	56	2.9	201	7.8
ADDITIONAL REFERRALS						
YES			286	15.1	486	19.0
NO			1305	69.1	1914	74.8
UNKNOWN			295	15.6	156	6.1

He left treatment after almost two weeks, and typically completed the treatment program before discharge.

The portrait has shown much stability from 1974 to 1976, but some items have changed. The proportion of female admissions declined from 22% in 1974 to 17% in 1976 to 18% in 1977. The geographic dispersal of admissions has increased. In 1974, 68% of all admissions were from two adjacent counties. By 1976, these two counties accounted for just 33% of all admissions. The proportion of clients who were referred from a State-funded alcoholism treatment program upon admission increased from 14% to 23%. In an encouraging response to the State's emphasis on continuity of care, the proportion of clients who were referred for additional treatment upon termination increased from 57% to 77% in 1976. This dropped to 69% in 1977. A large part of this decline is due to the increased number of terminations of outpatient clients, many of whom need no further services at the end of treatment. Median income for clients with known incomes increased from $3,411 to $3,960. Given the rate of inflation, such an increase probably does not represent a substantial improvement in the client's economic condition. The most readily apparent change has been the marked increase in the total number of admissions. The annual rate of admissions in 1977 was almost 2½ times that of the rate in 1974. Much of this increase has been due to the funding of new treatment programs. Some has been the result of small existing programs joining the system in mid-stream.

In order to gain an approximate idea of how well the different segments of the alcohol-abusing population are being served by the present treatment system, some comparisons were made between the characteristics of clients in treatment* and those of other populations.

The first set of comparisons was made between the distributions of sex, age, and occupation within the alcohol abuser population, as determined by the Parker Marden formula, and the same distributions among the client population.

When the Parker Marden formula** was applied to the 1970 Census for Maine, it yielded a total projection of 57,115 alcoholics and alcohol abusers; 45,354 (79.4%) of these were males and 11,761 (20.6%) were females. The client population was 81.7% male and 18.3% female. The percentage of females in the client population has fluctuated from 17% to 22% since 1974. It would thus appear that if the Parker Marden formula is accurate, women are slightly underserved in Maine. It is possible that services for women are not of appropriate quality, but there appears to be no serious State-wide shortage in their quantity.

Comparison of the distribution of age groups as derived from the Marden formula and the age groups of the client population shows that young males are significantly underrepresented in the treatment population. Table 3 shows that 5.2% of the male alcohol-abuser population are in the 15 to 19 year old age group, while only 2.2% of the client males are in that age group. The Table also shows that while 32.3% of the male alcohol abusers are in the 20 to 29 year old age group, only 15.9% of the client males are in that group.

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* Clients reported as admitted on PMTES, 1/1/77 through 6/30/77.
** Adjusted to include persons 15 to 19 years of age.

TABLE 3

Age Distribution of Alcohol Abusers (in Percents)

Age distribution derived from Parker Marden Formula			Actual distribution of clients admitted to treatment 1/1/77 - 6/30/77	
	Sex		Sex	
Age Group	M	F	M	F
15-19	5.2	4.0	2.2	4.2
20-29	32.3	11.9	15.9	11.9
30-39	18.7	35.9	26.6	24.7
40-49	20.9	33.6	24.1	32.1
50-59	16.1	8.5	18.1	19.2
60+	6.7	6.2	12.8	7.0

Elderly males are heavily overrepresented in the client population; 12.8% of the male clients are 60 years of age or older, compared to 6.7% of the male alcohol-abuser population. Males in the 30 to 39 year age bracket are also overrepresented; 26.6% to 18.7%. Males in the 40 to 49 year age group were slightly overrepresented with 24.1% of the clients and only 20.9% of the population belonging to that age group. Eighteen percent of the male clients were in the 50 to 59 year age group, which is slightly higher than the population percentage of 16.1%.

In contrast to the males, the proportion of female clients under the age of 29 is almost exactly equal to the proportion of female alcohol abusers in the population. The 30 to 39 year age group is the most seriously underserved; 24.7% of the female clients are in this group compared to 35.9% of the population. The proportion of female clients (32.1%) is slightly less than expected (33.6%) in the 40 to 49 year age group. The 50 to 59 year age group is heavily overrepresented with 19.2% of the clients in this group compared to 8.5% of the female alcohol-abuser population. Elderly women are slightly overrepresented with 7% of the client population in the 60-and-over age group compared to 6.2% of the alcohol-abuser population.

It should be noted that some of the youthful males with alcohol problems are able to receive services in OADAP-funded drug abuse treatment agencies. However, even when these alternative services are considered, it appears that youthful males are underserved in the State.

The relatively high proportions of older males and females are consistent with evidence from other sources that many of the clients presently in the treatment system are in an advanced stage of alcoholism.

The client population not only differs in age distribution from the population which would be expected using the Parker Marden formula, but also differs in the distribution of male occupations. Table 4 shows the distribution of occupations within the two groups. This Table utilizes 1975 client data since later data have not been analyzed to determine occupation by sex.

It is clear that the client population has far more non-farm laborers (47.1%) than would be expected (10.0%). The only other occupational group which is overrepresented is that of sales workers, with 5.2% of the clients in that group compared with 3.6% in the Marden group. The four white-collar occupational groups of professtional/technical, managers/administrators, sales workers, and clerical workers comprise 15.8% of the client population compared to 25.7% of the Marden group.

The distribution of occupations for both sexes in 1977 is substantially the same as that in 1975. Thus, it is highly likely that the distribution of occupations within the male client group is the same as it was in 1975. This occupational pattern is indicative of a client population drawn from the lower reaches of the social class group.

Further evidence of the lower class nature of the current population may be found by examining the income level of the clients. Clients are asked to report family income upon admission. Since 37% of all clients were living alone at admission and since some clients resided in group quarters or with friends, it was estimated that 40% of the clients reported

TABLE 4

DISTRIBUTION OF MALES IN SELECTED OCCUPATIONAL GROUPS

	Parker Marden Formula %	Male Alcohol Treatment Clients* %
Professional/Technical	6.8	5.6
Managers/Administrators	11.5	3.1
Sales Workers	3.6	5.2
Clerical	3.8	1.9
Craftsmen	26.6	22.4
Operatives Except Transport	21.4	3.6
Transport Operatives	8.0	4.6
Salaries Except Farm	10.0	47.1
Farmers	1.2	0.6
Farm Laborers and Foremen	2.1	0.2
Service Workers	5.0	1.8

*Based on 1,948 males with known occupations admitted to treatment Calendar Year 1975.

an income for themselves as unrelated individuals. A synthetic estimate of the expected client mean income based on census data* was constructed. The latest available income data indicated that income in Maine had increased by 45% from 1970 to 1974. It was conservatively estimated that it would have increased by 55% by 1977. The estimated 1977 expected client mean income was derived by increasing the mean family and mean unrelated individual incomes as given in the 1970 census by 55%. These figures were then weighted using the assumption that 40% of the clients would have reported an income for an unrelated individual, and 60% for a family. The resulting figure was $9,623. The actual reported mean income was $5,341. The actual income was only 56% of that expected. Again the client group seems to be drawn from the lower socioeconomic strata of the State's population.

The evidence that the client group comes from the lower socioeconomic strata is indicative of a client population drawn from the later stages of alcoholism. While some alcoholics may continue to maintain a high socio-economic position in the face of deteriorating performance related to alcohol use, in general, advancing alcoholism brings declining economic status.

Table 5 shows the marital status of the client population and that of the State population. The proportion of 'never married' persons is somewhat lower in the client population. This is probably due to the fact that the client population is on the average older than the general population and thus more likely to have had exposure to marriage.

It is evident that this exposure did not always produce lasting results. Only 30% of the clients were married and living with their spouses at the time of admission, compared to 62% of the general population. Nine percent of the clients were separated and 34% were divorced compared to the general population figures of 1% and 4% respectively. It is somewhat surprising to find that a lower proportion of clients were widowed since, as a group, they were older. This may be partially explained by the sex ratio of the client group. In our society females tend to outlive their mates. Eighty percent of the client group was male compared to 52% of the general population. Another factor may be that the client group tended to dissolve its marriages through divorce prior to a spouse's death thus precluding the possibility of widowhood.

It is clear that the client group is heavily weighted with divorced and separated persons. Marital dissolution is a typical result of an extended period of alcohol abuse. Again, the evidence seems to be that the current treatment system is serving clients who are in advanced stages of alcoholism.

Table 6, based on data from the CMS, indicates the relatively large number of publically intoxicated persons who have been taken into police custody. The police need an appropriate facility for these persons. The discussion in Part IV-2 shows that these persons may be receiving services, but that they are not necessarily appropriate.

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* Current population reports series P-25, No. 667 issued May, 1977 and 1970 U. S. Census of population for Maine.

TABLE 5

Marital Status

	Clients Admitted 1/1/77 - 6/30/77 %	State of Maine* %
Never Married	22	25
Married	30	62
Separated	9	1
Divorced/Annulled	34	4
Widowed	5	9
Unknown	1	-

*1970 U.S. Census data for persons 14 years old and older

TABLE 6

ALCOHOL RELATED ARRESTS CALENDAR YEAR 1977
(Includes those not formally charged)
From Uniform Crime Reporting Special Run

	Operating Under Influence	Liquor Law Violation	*Drunkenness	Disorderly Conduct
REGION I				
York	1,133	341	7	348
Cumberland	1,421	404	698	948
Sagadahoc	239	37	0	54
Lincoln	110	25	13	27
Knox	224	62	3	188
Waldo	87	15	0	52
Total	3,214	884	721	1,617
REGION II				
Oxford	182	63	0	140
Franklin	229	10	0	26
Androscoggin	492	107	5	676
Total	903	180	5	842
REGION III				
Somerset	318	83	6	145
Kennebec	613	144	45	485
Total	931	227	51	630
REGION IV				
Piscataquis	259	16	0	15
Penobscot	639	136	7	279
Hancock	294	35	1	71
Washington	179	50	5	70
Total	1,371	237	13	435
REGION V				
Aroostook	911	112	8	311
State Total	7,330	1,640	798	3,835

* Note: Although "Drunkenness" and/or "Intoxication" offenses have been removed from a criminal offense category by the Maine Legislature, the category remains in the Uniform Crime Reporting Part II offenses and is to be used administratively. Persons taken into custody and/or referred to alcohol rehabilitation or "De-Tox" centers should be scored in this category by age, sex and race.

II. Drug Abuse

This section of the Plan contains several tables which have been produced by Maine's Program Monitoring and Community Monitoring Systems. The first tables detail the characteristics of clients seeking treatment in OADAP-funded treatment programs. The next tables illustrate the services provided to drug abusers by other health and social service resources. Tables are then included which indicate the social and legal consequences of drug abuse at the community level. Finally, the last table summarizes drug abuse problems by OADAP planning regions.

Following the tables, an analysis of their content, with reference to last year's studies, is presented and a statement of their planning implications is provided.

Characteristics of Patients of Publicly Funded Drug Treatment Centers in 1977.

Admissions	Aroostook Mental Health Center	Crisis and Counseling	Day One		Full Circle	York County Counseling		Total
			Outpatient	Residential		Saco	Sanford	
Age Group								
Under 18	5	57	14	9	38	45	39	207
18 - 20	1	24	1	12	2	7	12	59
21 - 25	2	27	5	10		3	4	51
26 - 30		10	5	3	3	2		23
Over 30		13	5		1			19
TOTAL	8	131	30	34	44	57	55	359
Sex								
Male	6	88	20	24	34	35	38	245
Female	2	43	10	10	10	22	17	114
TOTAL	8	131	30	34	44	57	55	359
Last Grade of School								
0 - 9	4	52	10	11	24	23	20	143
10 - 11	2	41	8	12	17	25	23	128
12		24	7	10	3	8	8	59
Over 12	2	14	5	1		1	4	26
TOTAL	8	131	30	34	44	57	55	359
Primary Drug of Abuse								
None								
Heroin		3	2					5
Illegal Methadone								
Other Opiates		1	3					4
Alcohol			5	11	5	5	2	28
Barbiturates		15	1	3	2	1	1	23
Other Sedatives		13			2		1	16
Amphetamines	2	24	6	9	8	2	3	54
Cocaine		2		1	1			4
Marijuana	5	31	7	3	4	43	45	138
Hallucinogens	1	22	5	7	15	1	1	52
Inhalants		1			1	2	2	6
Over the counter		5				1		6
Tranquilizers		14	1		6	2		23
Other								
TOTAL	8	131	30	34	44	57	55	359

Characteristics of Patients of Publicly Funded Drug Treatment Centers in 1977.

Source: CODAP

TABLE 7
(CONTINUED)

Admissions	Aroostook Mental Health Center	Crisis and Counseling	Day One Outpatient	Day One Residential	Full Circle	York County Counseling Saco	York County Counseling Sanford	Total
Secondary Drug of Abuse								
None	1	12	1		1	8	7	30
Heroin								
Illegal Methadone		1					1	2
Other Opiates		2	1					3
Alcohol	3	29	12	8	8	41	37	138
Barbiturates		6	4	1				11
Other Sedatives		1			2		1	4
Amphetamines		12	2	8	10		4	36
Cocaine	1	3		2	1			7
Marijuana	3	40	6	8	14	8	2	81
Hallucinogens		13	3	5	6		2	29
Inhalants		2					1	3
Over the counter		1			1			2
Tranquilizers		7		2	1			10
Other		2	1					3
TOTAL	8	131	30	34	44	57	55	359
Number of Prior Treatments								
None	8	119	23	22	40	54	48	314
One		8	6	8	3	2	5	32
Two		3	1	3	1			8
Three		1		1			1	3
Four								
Five							1	1

Ten						1		1
TOTAL	8	131	30	34	44	57	55	359

TABLE 7
(CONTINUED)

Source: CODAP

Characteristics of Patients of Publicly Funded Drug Treatment Centers in 1977.

Discharges	Crisis and Counseling	Day One Outpatient	Day One Residential	Full Circle	York County Counseling Saco	York County Counseling Sanford	Total
Reason for Discharge							
Completed Treatment-No Drug	37	20	3	6	8	5	79
Completed Treatment-Some Drug	25	6		14	37	26	108
Transfer within Program		1					1
Referred Outside Program	5	2	1	5	1		14
Non Compliance	3	1	3		2		9
Left before completing treatment	46	10	25	10	22	22	135
Incarcerated	2		2				4
Death							
TOTAL	118	40	34	35	70	53	350
Average Length of Treatment in months	9.5	8.1	1.7	5.9	5.6	2.8	

(Source: CODAP Monthly Reports)

TABLE 8

Cross Tabulation
By Primary Drug at Admissions
1977 Admissions

Sex	None	Heroin	Methadone	Other Opiates	Alcohol	Barbiturates	Other Sedatives	Amphetamines	Cocaine	Marihuana	Hallucinogens	Inhalants	Over-The-Counter	Tranquilizers	Other	Total
Male		4		3	19	14	12	39	2	95	39	4	3	11		245
Female		1		1	9	9	4	15	2	43	13	2	3	12		114
TOTAL		5		4	28	23	16	54	4	138	52	6	6	23		359
Age of Admission																
Under 18				1	13	15	4	27	1	94	34	6	3	9		207
18 - 20		2			8	2	5	11		19	7		2	3		59
21 - 25		2		1	4	3	5	10	1	14	7			4		51
26 - 30		1			2	2		5	1	4	4			4		23
31 - 44				2	1	1	2	1	1	6				3		17
Over 44		—		—	—	—	—	—	—	1	—	—	1	—		2
TOTAL		5		4	28	23	16	54	4	138	52	6	6	23		359

TABLE 9

Cross Tabulation
By Primary Drug at Admissions
1977 Discharges

Reason for Discharge	None	Heroin	Methadone	Other Opiates	Alcohol	Barbi-turates	Other Sedatives	Ampheta-mines	Cocaine	Marihuana	Hallu-cinogens	Inhalants	Over-The-Counter	Tran-quilizers	Other	Total
Completed-No Drug Use	4			1	6	9	11	9	1	23	9	2	1	1	2	79
Completed-Some Drug Use			1	1	7	8	6	12		61	8		2	1	1	108
Transfer					1											1
Referred Outside					2	3	3	2		1	3					14
Non-Compliance					1		1	2		3	2					9
Left before Comp.		1		3	19	11	17	22		37	14	1	3	4	3	135
Incarcerated					1	1		1						1		4
Died	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL	4	1	1	5	37	32	38	48	1	125	36	3	6	7	6	350

TABLE 10

Admissions with Diagnoses of Drug Problems to Mental Health Institutes, 7/1/76 to 6/30/77

A.P.A. Diagnosis	Augusta Mental Health Institute	Bangor Mental Health Institute
Organic Brain Syndrome Associated with Drug or Poison Intoxication		
Male	6	10
Female	1	4
Drug Dependence		
Male	6	4
Female	0	1
	13	19

Sources: Augusta Mental Health Institute and Bangor Mental Health Institute

TABLE 11

Clients with Drug Dependence Receiving Vocational Rehabilitation Services in 1977

Year of Referral	Problem	Total Referrals	Applicants	Extended Evaluation	Ineligible	Active Caseload Status December 31, 1977						Closed		
						Written Program Development	Counseling and Guidance	Physical and Mental Restoration	Training	Ready for Employment	Service Interrupted	Rehabilitated	Program Initiated	Before Program Initiated
Prior to 1974	Major	1										1		
	Minor	1											1	
1974	Major	2							1			1		
	Minor	6					1		1	1		1	2	
1975	Major	11			2				1	1	2	2	3	
	Minor	5			1		1		1				2	
1976	Major	13			9			1	1			1		1
	Minor	6			2					1	1	1	1	
1977	Major	14	6	2	5	1								
	Minor	7	1	1	2				2					1

Source: Vocational Rehabilitation Statewide Directory, December, 1977

Source: UCR
Computer Printout

TABLE 12

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region One

Drug Offense	Age and Sex: under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
York													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana			2		6		9	1	1		1	2	22
Synthetic narcotics					1				1				2
Non-narcotic drugs	—		—	—	1	—	—	—	—	—	—	—	1
Sub-total			2	—	8	—	9	1	2	—	1	2	25
Possession:													
Opium or cocaine		1					2		1				4
Marijuana	8		50	8	19		33	3	7		2		130
Synthetic narcotics			1				1		2				4
Non-narcotic drugs	1		1				1		1				4
Sub-total	9	1	52	8	19	—	37	3	11	—	2	—	142
TOTAL ARRESTS	9	1	54	8	27		46	4	13		3	2	167
Cumberland													
Sale/Manufacturing:													
Opium or cocaine					1		1		1		3		6
Marijuana	1		8		7	1	22	4	6		5	1	55
Synthetic narcotics			1		2		2						5
Non-narcotic drugs	—	—	1	—	3	—	5	1	1	—	2	2	15
Sub-total	1	—	10	—	13	1	30	5	8	—	10	3	81
Possession:													
Opium or cocaine					2		3						5
Marijuana	11	2	68	8	54		53	4	21		7	1	229
Synthetic narcotics			3	1	1		2		3		3		13
Non-narcotic drugs	—	—	1	1	1	—	5	—	4	—	1	1	14
Sub-total	11	2	72	10	58	—	63	4	28	—	11	2	261
TOTAL ARRESTS	12	2	82	10	71	1	93	9	36	—	21	5	342

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region One (con't)

Drug Offense	Age and Sex: under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
Sagadahoc													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana					1			1					2
Synthetic narcotics			1										1
Non-narcotic drugs			1										1
Sub-total	—	—	2	—	1	—	—	1	—	—	—	—	4
Possession:													
Opium or cocaine							2						2
Marijuana *	2	1	10				3		1				17
Synthetic narcotics	1		1				1						3
Non-narcotic drugs						1							1
Sub-total	3	1	11	—	—	1	6	—	1	—	—	—	23
TOTAL ARRESTS	3	1	13	—	1	1	6	1	1	—	—	—	27
Lincoln													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana			1				2	1	2		1		7
Synthetic narcotics													
Non-narcotic drugs													
Sub-total	—	—	1	—	—	—	2	1	2	—	1	—	7
Possession:													
Opium or cocaine													
Marijuana					2		4		2		1		9
Synthetic narcotics													
Non-narcotic drugs					1								1
Sub-total	—	—	—	—	3	—	4	—	2	—	1	—	10
TOTAL ARRESTS	—	—	1	—	3	—	6	1	4	—	2	—	17

TABLE 12 (CONTINUED)

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region One (con't)

Drug Offense	Age and Sex: under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
Knox													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana							1						1
Synthetic narcotics													
Non-narcotic drugs	—	—	—	—	—	—	—	—	—	—	—	—	—
Sub-total							1						1
Possession:													
Opium or cocaine													
Marijuana			21		4		4				1		30
Synthetic narcotics													
Non-narcotic drugs	—	—	—	—	—	—	1	—	—	—	1	—	2
Sub-total	—	—	21	—	4	—	5	—	—	—	2	—	32
TOTAL ARRESTS			21		4		6				2		33
Waldo													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana	1				1		1				1		4
Synthetic narcotics													
Non-narcotic drugs	—	—	—	—	—	—	—	—	—	—	—	—	—
Sub-total	1				1		1				1		4
Possession:													
Opium or cocaine													
Marijuana			4		7		12		2		4		29
Synthetic narcotics				1									1
Non-narcotic drugs	—	—	—	—	—	—	—	—	—	—	—	—	—
Sub-total	—	—	4	1	7	—	12	—	2	—	4	—	30
TOTAL ARRESTS	1		4	1	8		13		2		5		34
TOTAL FOR REGION ONE	25	4	175	19	114	2	170	15	56	—	33	7	620

Source: UCR
Computer Printout

TABLE 12
(CONTINUED)

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region Two

Drug Offense	Age and Sex: under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
Oxford													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana			2		1		2		1				6
Synthetic narcotics													
Non-narcotic drugs													
Sub-total	—	—	2	—	1	—	2	—	1	—	—	—	6
Possession:													
Opium or cocaine					1								1
Marijuana	2	2	7	1	10		15		2		2		41
Synthetic narcotics													
Non-narcotic drugs							1						1
Sub-total	2	2	7	1	11	—	16	—	2	—	2	—	43
TOTAL ARRESTS	2	2	9	1	12	—	18	—	3	—	2	—	49
Franklin													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana					2		4	1					7
Synthetic narcotics													
Non-narcotic drugs													
Sub-total	—	—	—	—	2	—	4	1	—	—	—	—	7
Possession:													
Opium or cocaine													
Marijuana			2	1	3		6		5				17
Synthetic narcotics													
Non-narcotic drugs													
Sub-total	—	—	2	1	3	—	6	—	5	—	—	—	17
TOTAL ARRESTS	—	—	2	1	5	—	10	1	5	—	—	—	24

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

TABLE 12 (CONTINUED)

Region Two

Drug Offense	Age and Sex												Total
	under 15		15 - 17		18 - 19		20 - 24		25 - 29		30 and over		
	M	F	M	F	M	F	M	F	M	F	M	F	
Androscoggin													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana			2		2	2	1						7
Synthetic narcotics													
Non-narcotic drugs													
Sub-total	—	—	2	—	2	2	1	—	—	—	—	—	7
Possession:	—	—	—	—	—	—	—	—	—	—	—	—	
Opium or cocaine													
Marijuana	4	4	32	4	31	3	42	4	10	4	7		145
Synthetic narcotics							1		1				2
Non-narcotic drugs			1				2						3
Sub-total	4	4	33	4	31	3	45	4	11	4	7	—	150
TOTAL ARRESTS	4	4	35	4	33	5	46	4	11	4	7	—	157
TOTAL FOR REGION TWO	6	6	46	6	50	5	74	5	19	4	9	—	230

Source: UCR

TABLE 12
(CONTINUED)

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region Three

Drug Offense	Age and Sex: under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
Somerset													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana			1		4		7	1	1				14
Synthetic narcotics													
Non-narcotic drugs	1		1										2
Sub-total	1	—	2	—	4	—	7	1	1	—	—	—	16
Possession:													
Opium or cocaine													
Marijuana	3		10	1	13	4	13		5		2	1	52
Synthetic narcotics					2								2
Non-narcotic drugs	3		1		2		1						7
Sub-total	6	—	11	1	17	4	14	—	5	—	2	1	61
TOTAL ARRESTS	7	—	13	1	21	4	21	1	6	—	2	1	77
Kennebec													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana			3		2		7		1		1		14
Synthetic narcotics											1		1
Non-narcotic drugs													
Sub-total	—	—	3	—	2	—	7	—	1	—	2	—	15
Possession:													
Opium or cocaine									1		1		2
Marijuana	3		29	3	22	2	24	3	10	1	5		102
Synthetic narcotics													
Non-narcotic drugs			1				2		2	1	2		8
Sub-total	3	—	30	3	22	2	26	3	13	2	8	—	112
TOTAL ARRESTS	3	—	33	3	24	2	33	3	14	2	10	—	127
TOTAL FOR REGION THREE	10	—	46	4	45	6	54	4	20	2	12	1	204

Source: UCR
Computer Printout

TABLE 12
(CONTINUED)

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region Four

Drug Offense	Age and Sex: under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
Piscataquis													
Sale/Manufacturing:													
Opium or cocaine							1		1				2
Marijuana					1								1
Synthetic narcotics													
Non-narcotic drugs													
Sub-total	—	—	—	—	1	—	1	—	1	—	—	—	3
Possession:													
Opium or cocaine									1				1
Marijuana			3		7		6		1				17
Synthetic narcotics					2								2
Non-narcotic drugs					1	1	1						3
Sub-total	—	—	3	—	10	1	7	—	2	—	—	—	23
TOTAL ARRESTS	—	—	3	—	11	1	8	—	3	—	—	—	26
Penobscot													
Sale/Manufacturing:													
Opium or cocaine					1	1	3		5		1		11
Marijuana			1		4		15		4	1		1	26
Synthetic narcotics			1		1		3				1		6
Non-narcotic drugs			1		4	1	4	2			2		14
Sub-total	—	—	3	—	10	2	25	2	9	1	4	1	57
Possession:													
Opium or cocaine											1		1
Marijuana	7	4	35	2	27	1	37	1	6	3	3		126
Synthetic narcotics							4						4
Non-narcotic drugs					1								1
Sub-total	7	4	35	2	28	1	41	1	6	3	4	—	132
TOTAL ARRESTS	7	4	38	2	38	3	66	3	15	4	8	1	189

Source: UCR
Computer Printout

TABLE 12
(CONTINUED)

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region Four (con't)

Drug Offense	under 15 M	under 15 F	15 - 17 M	15 - 17 F	18 - 19 M	18 - 19 F	20 - 24 M	20 - 24 F	25 - 29 M	25 - 29 F	30 and over M	30 and over F	Total
Hancock							Age and Sex						
Sale/Manufacturing:													
Opium or cocaine													
Marijuana											1		1
Synthetic narcotics												1	1
Non-narcotic drugs									1				1
Sub-total	—	—	—	—	—	—	—	—	1	—	1	1	3
Possession:													
Opium or cocaine													
Marijuana	3		7	1	1								12
Synthetic narcotics				1					1		1		3
Non-narcotic drugs													
Sub-total	3	—	7	2	1	—	—	—	1	—	1	—	15
TOTAL ARRESTS	3	—	7	2	1	—	—	—	2	—	2	1	18
Washington													
Sale/Manufacturing:													
Opium or cocaine													
Marijuana													
Synthetic narcotics							1						1
Non-narcotic drugs											1		1
Sub-total	—	—	—	—	—	—	1	—	—	—	1	—	2
Possession:													
Opium or cocaine									1				1
Marijuana			14	2	22	3	46	16	33	9	13	3	161
Synthetic narcotics						1		1			1		3
Non-narcotic drugs								1			1		2
Sub-total	—	—	14	2	22	4	46	18	34	9	15	3	167
TOTAL ARRESTS	—	—	14	2	22	4	47	18	34	9	16	3	169
TOTAL FOR REGION FOUR	10	4	62	6	72	8	121	21	54	13	26	5	402

Source: UCR

TABLE 12
(CONTINUED)

Arrests for Drug Abuse Violations
by Drug Offense and Age and Sex Groups (1/1/77 to 12/31/77)
(Includes those released without having been formally charged)

Region Five

Drug Offense	Age and Sex												Total
	under 15		15 - 17		18 - 19		20 - 24		25 - 29		30 and over		
	M	F	M	F	M	F	M	F	M	F	M	F	
Aroostook													
Sale/Manufacturing:													
Opium or cocaine					1		1						2
Marijuana			1		5		8	2	1		2		19
Synthetic narcotics							2	1					3
Non-narcotic drugs							1						1
Sub-total	—	—	1	—	6	—	12	3	1	—	2	—	25
Possession:													
Opium or cocaine							1						1
Marijuana	1		17	3	50	5	64	2	18	1	10		171
Synthetic narcotics			1		2		4						7
Non-narcotic drugs			1				4		1		3		9
Sub-total	1	—	19	3	52	5	73	2	19	1	13	—	188
REGION FIVE TOTAL ARRESTS	1	—	20	3	58	5	85	5	20	1	15	—	213
GRAND TOTAL FOR STATE	52	14	349	38	339	26	504	50	169	20	95	13	1,669

TABLE 13

Drug Items Submitted to Certified Maine Laboratories

January - December, 1977

Region	County	Marijuana	LSD	PCP	Other Hallu.	Heroin	Cocaine	Misc. Narc.	Barb.	Amphet.	Positive Misc.
I	York	88			10	1	5		1	4	8
	Cumberland	25	1	14	13		2	3	2	6	25
	Sagadahoc	51		1			2			1	2
	Lincoln	21		1					1		6
	Knox	17		3							6
	Waldo	9		1							3
TOTAL FOR REGION I		211	1	20	23	1	9	3	4	11	50
II	Oxford	19		1						1	2
	Franklin	17	1	2							2
	Androscoggin	47		4			4	1		11	23
TOTAL FOR REGION II		83	1	7			4	1		12	27
III	Somerset	50		7						6	13
	Kennebec	73	2	9			3	2	1	4	33
TOTAL FOR REGION III		123	2	16			3	2	1	10	46
IV	Piscataquis	6		1	2				1		
	Penobscot	81	14	42	6		5	8	10	15	26
	Hancock	7	2	2						3	6
	Washington	10	1						1	4	3
TOTAL FOR REGION IV		104	17	45	8		5	8	12	22	35
V	Aroostook	107		6	4			1	2	4	39
TOTAL FOR STATE		628	21	94	35	1	21	15	19	59	197

SOURCE: Drug Abuse Statistical Report,
Public Health Laboratory

Source: State Police Accident Reports

TABLE 14

Number of Accidents Where the Primary or Contributing Cause is Operating Under the Influence of Drugs For Regions and Counties, by Month for 1977

Region/ County	MONTH											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	1		1	1		1		1	1	2	1	1
Cumberland	2	2	3	1	3		1	5	1	3	1	5
Sagadahoc				1	1			1			2	
Lincoln												
Knox	1			1	2		1					
Waldo				1	1	1			1			
TOTAL	4	2	4	5	7	2	2	7	3	5	4	6
REGION II												
Oxford			1								1	
Androscoggin		1	1		1		2		2			
Franklin			1				1	1	2	1		
TOTAL		1	3		1		3	1	4	1	1	
REGION III												
Somerset			2									1
Kennebec			2	1				3	3		1	1
TOTAL			4	1				3	3		1	2
REGION IV												
Piscataquis												
Penobscot	1			1	1	1	2	4	3	2		2
Hancock								2	1		1	2
Washington			1	1	1		1				2	
TOTAL	1		1	2	2	1	3	6	4	2	3	4
REGION V												
Aroostook							2					
STATE TOTAL	5	3	12	8	10	3	10	17	14	8	9	12

TABLE 15

COMMITMENTS FOR DRUG OFFENSES

TO

STATE CORRECTIONAL FACILITIES

	1975-1976	1976-1977
Maine State Prison	74	25
Maine Correctional Center	49	36
Maine Youth Center	N/A	N/A

TABLE 16

Source: Department of Education (Prel.)

Secondary School Dropout Rates

1976 - 1977

	Enrollment	Dropouts	Rates
REGION I			
York	7,978	480	6.02
Cumberland	13,564	920	6.78
Sagadahoc	2,105	115	5.46
Lincoln	1,432	96	6.70
Knox	1,778	81	4.55
Waldo	1,646	98	5.95
Total	28,503	1,790	6.28
REGION II			
Oxford	3,802	205	5.39
Franklin	1,947	58	2.97
Androscoggin	5,996	323	5.39
Total	11,745	586	4.99
REGION III			
Somerset	3,147	125	3.97
Kennebec	7,104	324	4.56
Total	10,251	449	4.38
REGION IV			
Piscataquis	922	36	3.90
Penobscot	10,003	548	5.48
Hancock	2,570	134	5.21
Washington	2,011	130	6.46
Total	15,506	848	5.47
REGION V			
Aroostook	7,664	276	3.60
State Total	73,669	3,949	5.36

Summary of Certain Activities Relating to Drug Abuse Problems by Planning Regions, 1977

TABLE 17

	Population Estimate 7/1/76*	1977 Arrests for Drug Offenses** No.	Rate per 1000 Population	Rank	1975 and 1976 Deaths due to Drug Related Causes Ø No.	Rate per 100,000 Population	Rank	Secondary School Dropouts 1976 - 1977 ØØ Enrol.	Drop Out	Rate per Enrol.	Rank	Ranking of Regions Sum	Rank
REGION I													
York	122,518	167			5			7,978	480				
Cumberland	204,442	342			10			13,564	920				
Sagadahoc	26,126	27						2,105	115				
Lincoln	23,822	17						1,432	96				
Knox	32,385	33			5			1,778	81				
Waldo	27,016	34			1			1,646	98				
TOTAL	436,308	620	1.42	3	21	4.81	2	28,503	1,790	6.3	1	6	1
REGION II													
Oxford	45,246	49			2			3,802	205				
Franklin	25,069	24			4			1,947	58				
Androscoggin	95,101	157						5,996	323				
TOTAL	165,416	230	1.39	5	6	3.63	4	11,745	586	5.0	3	12	5
REGION III													
Somerset	44,387	77			2			3,147	125				
Kennebec	102,004	127			6			7,104	324				
TOTAL	146,391	204	1.39	4	8	5.46	1	10,251	449	4.4	4	9	3
REGION IV													
Piscataquis	16,786	26						922	36				
Penobscot	135,397	189			6			10,003	548				
Hancock	39,424	18			2			2,570	134				
Washington	34,087	169			2			2,011	130				
TOTAL	225,694	402	1.78	2	10	4.43	3	15,506	848	5.5	2	7	2
REGION V													
Aroostook	97,570	213	2.18	1	0	0	5	7,664	276	3.6	5	11	4
STATE TOTAL	1,071,380	1,669	1.56		45			73,669	3,949	5.4			

* Estimate Summary Reconciled to Federal Estimates, Office of Research and Vital Records, Dept. of Human Services
** Uniform Crime Reports, Maine Department of Public Safety
Ø Listings, prepared by Division of Research and Vital Records
ØØ Preliminary, Department of Educational and Cultural Services

A. Analysis of Client Characteristics

In analyzing the characteristics of the patients admitted to treatment, it is of interest to compare them with those published in 1975 and 1976.

Admissions to the drug treatment centers in 1977 were appreciably younger than in the previous two years. The percentage of the admissions below age 18 was 45% in 1975, 39% in 1976, and 58% in 1977. The percentage of all admissions through age 25 varied from 85% in 1975, 83% in 1976 to 88% in 1977. Those with more than a high-school education ranged from 9% in 1975, 15% in 1976 to 7% in 1977, while those who had finished only grades 0 through 9 comprised 37% of the admissions in 1975, 25% in 1976, and 40% in 1977. The percentage of females admitted dropped from 48% in 1975 to 32% in 1977.

Marijuana was reported as the primary drug of abuse for 28% of those admitted in 1975, 15% in 1976, and 38% in 1977. Amphetamines were the primary drug in 19% of the admissions in 1975, 22% in 1976, and 15% in 1977. Hallucinogens varied from 9% in 1975 and 1976 to 15% in 1977 as the primary drug. Barbiturates and other sedatives varied from 17% in 1975, 29% in 1976 to 11% in 1977. As a primary drug, alcohol was reported in only 12% of the admitted cases in 1975, 6% in 1976, and 8% in 1977. However, as a secondary drug, it has been increasingly reported from 19% in 1975 to 38% in 1977. Marijuana continues to rank second as the secondary drug abused with percentages of 17% in 1975 and 1976 to 23% in 1977. The selection of the primary drug over the secondary drug may be an administrative rather than a clinical decision. More polydrug abusers are being admitted to the centers. The percentage increased from 78% in 1975 to 92% in 1977.

Those age 25 and under are abusing marijuana and hallucinogens more than those over age 25 who are more apt to abuse opiates, cocaine, and tranquilizers.

The only noticeable variation in the drugs abused by men to those abused by women is that men are more apt to abuse opiates and hallucinogens and women to abuse tranquilizers.

The characteristics of the population admitted to treatment over the last three years have varied considerably with few noticeable trends. However, in dealing with such low numbers any change shifts the percentage distribution dramatically.

It is of interest to compare the distribution of primary drugs at admission with those determined in a study of selected rural drug abuse programs in New Jersey. The order is similar with the exeption of alcohol and opiates.

	New Jersey* Rural (N=2262)	Maine Rural (N=337)
Marijuana	30.7%	40.4%
Sedatives	16.6	17.7
Amphetamines	15.8	14.2
Hallucinogens	9.5	13.7
Opiates	8.1	2.4
Alcohol	5.7	6.8
Other	5.1	1.8
Inhalants	4.5	1.8
None	2.6	---
Cocaine	1.4	1.2

The percentage of marijuana users in Maine is higher. However, Maine shares the other study observations that the majority of admissions are below 21, are likely to be enrolled in school and therefore, have less total years of schooling, and to be without prior treatment experiences.

Eighty-seven percent of the admissions are receiving their first treatment for drug abuse.

Fifty-three percent of the discharges in 1977 completed treatment as opposed to 28% in 1975. Those splitting from treatment accounted for 51% in 1975 and 39% in 1977. The average length of treatment, measured roughly, has continued to increase from 3.5 months in 1975 to 5.6 months in 1977, which may account for the increasing percentages of those completing treatment.

Those admitted for abusing alcohol, sedatives, and amphetamines are more apt to have split from treatment than those admitted for marijuana abuse, who are more likely to complete treatment. However, those who use marijuana are three times as apt to complete treatment with some drug use as none. Those abusing sedatives are more likely to give them up entirely upon completing treatment.

B. Analysis of Resources

The number of admissions to the drug treatment centers increased 11% in 1977. The two Mental Health Institutes admitted 32 who were diagnosed as having drug psychosis or dependence compared to 7 last fiscal year. The data relating to admissions to the eight Mental Health Centers are not available in the same format as in prior years, but 122 were admitted with a primary drug-related diagnosis during the last fiscal year.

Fewer persons handicapped by drug dependence were referred for vocational rehabilitation services in 1977. Of the 21 referred, seven were determined to be ineligible as of December 31 and one was closed before the program was initiated. Seventeen clients with drug dependence were

* Data from an investigation of selected rural drug abuse programs, March, 1977.

receiving vocational services as the year ended and seven were rehabilitated during the year.

C. Analysis of Community Impact

Arrests for drug offenses in 1977 totalled 1,699, an increase of 20% over 1976. Juveniles accounted for 453 or 27% of the offenses. Ninety-three (93) percent of their offenses were for possession rather than sales or manufacturing. Of the 1,090 items submitted to three Maine certified laboratories in 1977, 58% were marijuana and only 3% were narcotics. Nine (9) percent of the items were PCP in 1977 as opposed to 3% in 1976. The State Police, Division of Special Investigation, had warned, over a year ago, that PCP is available in ever-increasing amounts in Maine. The number of accidents where the cause was operating under the influence of drugs ranged from three in February to 17 in August; the monthly average was nine, down slightly from last year.

There were only half as many commitments for drug offenses to the adult correctional centers in 1977 as in 1976.

The number of deaths in Maine reported to be due to drug-related causes in 1977 is not yet available.

Ten cases of serum hepatitis were reported in Maine in 1977. An additional nine hepatitis cases were unspecified. The number of these cases has varied from 48 to 4 reported in the last three years.

The secondary school dropout rate for the school year 1976-77 increased, which may reflect disturbed youth.

Unfortunately, the tabulations of cause of death in 1977 are not yet available. The number of state-wide over the previous four years was 19 in 1973, 24 in 1974, 27 in 1975, and 19 in 1976. Because we are dealing with small numbers each year, those for 1975 and 1976 were combined to establish a more equitable variation between the planning regions.

The summary of the three indicators - arrests for drug offenses, drug-related deaths, and dropouts indicates that Region I, the southern coastal area, has the largest drug abuse problem per capita with Region IV the next most troubled area.

D. Planning Implications of the Data

It would appear that polydrug abuse continues to plague young people in Maine. Drug-free outpatient programs should be available in each area. Prevention activities should be expanded for all children under age 18 since that age group coming into treatment increased 64% over last year. Arrests for drug offenses among juveniles were up 16%. The secondary school dropout rate continues to rise in Maine, reflecting in some measure troubled youth and a typical environment for drug abuse.

PART IV

PROGRAM ACTION PLAN

PART IV: PROGRAM ACTION PLAN

1. Administrative Services

A. Planning and Coordination

1. Resource Assessment

There are no major changes projected in either OADAP's management structure or its technical support/coordination program in the coming year. The existing structure and the program are described in detail in Part I - A, Management System and Part I - C, Support System respectively. However, changes are anticipated in OADAP's planning system which will adequately develop the state and regional councils to permit the accomplishment of two important tasks. First is the development of a strong working relationship with both the Bureau of Health Planning and Development and the State Health Systems Agency. The second task is the establishment of a comprehensive, client-oriented treatment system for alcohol and drug abusers.

Currently, the role and responsibility of each regional council differs due to the relatively informal way that council relationships with OADAP have evolved. No formal process of sub-state planning has been instituted for at least two years. The work of the councils must be standardized to an extent that will provide an effective health planning system. Institution of sub-state planning processes is essential to the development and affirmation of a comprehensive treatment system which addresses client needs in each area of the state.

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment (State Advisory Council) is actively engaged in defining the elements of the ideal system and assessing the adequacy of the present system in that context. In addition to general discussion at regular council meetings, a committee of advisory council members will be meeting with greater frequency along with the OADAP staff specialists and other representatives from concerned organizations. It is expected that use of a select committee will permit greater involvement on the part of other organizations, and will also result in a much more detailed final report than would be possible if the full membership of the council were involved.

2. Goals and Objectives

OADAP's primary responsibility is for planning and coordinating the delivery of effective alcohol and drug services in Maine. We are convinced that the effectiveness of these services depends on the degree to which they address the needs of the clients who receive them. It is our policy to involve the largest possible number of interested groups and individuals while executing our basic responsibility. Such involvement provides vital information on client needs and facilitates the development of cost-effective strategies for meeting those needs.

GOAL I: Ensure effective, coordinated, efficient administration of resources and services for alcohol and drug services.

Objective (1): Expand and define the role of regional council in OADAP's planning and coordination functions.

a. Produce an outline of functions which will be carried out through council activities by January, 1979; done by grants manager.

b. Establish clear communication channels between OADAP and the councils (ongoing); done by grants manager.

c. Establish standards of council operation for evaluation of their effectiveness, May, 1979; done by grants manager.

d. Encourage the development of regional plans for integration into the State Plan, May, 1979; done by grants manager.

e. Ensure consistent application of regional review requirements for the OADAP grants process. (January-April, 1979); done by grants manager.

f. Provide funding for all regional council operations, (May, 1979).

Objective (2): Maintain a high level of activity on the part of the State Advisory Council.

a. Assist the special committee for assessment of the treatment system with its activities so as to complete a working document by fall 1978; done by alcohol program specialist, OADAP director and drug program specialist.

b. Provide guidance to the council chairman on general operating procedures and maintaining members' attendance and active involvement in council activities (ongoing); done by OADAP director.

c. Provide staff support to the Review and Comment Committee during the grant review process (January-May, 1979); done by grants manager, prevention coordinator, drug and alcohol program specialists and planner.

d. Provide staff support for all council activities as required for the purpose of recording council proceedings and researching issues for discussion and decision making (ongoing); done by OADAP director.

Objective (3): Provide requested information and assistance to the Bureau of Health Planning and Development of the State Health Systems Agency.

a. Establish a process of state plan review with the Bureau of Health Planning and Development which is to include time for public comment and revising standard format and appropriate sign-off in time for July submission, (prior to April 1, 1979); done by grants manager.

b. Establish a process to enable the review of state grant allocations of federal funds to local program activities by the Maine Health Systems Agency, (prior to January 1, 1979); done by grants manager.

c. Provide field specific input for state planning activities of both the Bureau of Health Planning and Development and the Maine Health Systems Agency, (as required); done by grants manager, prevention coordinator, alcohol and drug program specialists and planner.

d. Develop representation for alcohol and drug abuse related perspectives on both the Health Systems Council and State Health Coordinating Committees, (ongoing); done by OADAP director, grants manager and planner.

Objective (4): Produce the 1979-80 State Plan for Alcoholism and Drug Abuse Prevention.

a. Evaluate effect of changes made for this year's state plan development process and establish a time table for FY-80 plan development during July, 1978; done by OADAP staff.

b. Hold one workshop for each action plan area during fall of 1978 for the purpose of developing action plan strategies; all staff - planner will coordinate.

c. Commence needs assessment activity not later than August, 1978 for development of a more adequate Part III; planner and staff as needed.

d. Evaluate plan accomplishment monthly for inclusion in performance report utilizing current objectives for measurement data; done by OADAP director, grants manager and alcohol and drug program specialists.

e. Incorporate findings of the state planning process concerning the treatment system into all plan areas as they are developed; done by OADAP staff.

f. Produce a combined Drug and Alcohol State Plan by July 15, 1979; done by OADAP staff.

CHART 21

Planning and Coordination Cost Data

Goal

Objective 1 -	1136 man-hours direct labor	=	$ 8,486	
	6500 miles travel	=	845	
	132 man-hours support services	=	535	$130,173
	Grants to regional councils	=	119,407	
	All other	=	900	
Objective 2 -	464 man-hours direct labor	=	4,239	
	1254 miles travel	=	163	6,323
	168 man-hours support services	=	681	
	All other	=	1,150	
Objective 3 -	320 man-hours direct labor	=	2,470	
	2008 miles travel	=	261	3,938
	88 man-hours support services		357	
	All other	=	850	
Objective 4 -	2400 man-hours direct labor	=	19,145	
	20 days - consultants	=	2,500	
	6000 miles travel	=	780	
	704 man-hours support services	=	2,851	
	All other	=	6,700	31,976
			TOTAL	$172,410

B. Management Information Systems

1. Resource Assessment

The overall management information system is composed of several discrete parts. The five major components of the system are the alcohol client information system, the drug client information system, the alcohol community monitoring system, the drug community monitoring system and the fiscal management system.

During the public hearings held to solicit community input to the plan, it was suggested that the alcohol and drug client information systems be combined into a single system. It is our intention to maintain these as separate systems. The primary reason for maintaining them as separate systems is that each system is currently based on existing federal data systems. Using data systems based on the respective federally required systems greatly reduces the amount of paper work required of programs which have both state and federal funding. In order to preserve these economies, a combined system would have to contain a complete set of data elements from each of the current systems. Such a system would not reduce the data collection demands on individual programs. In addition, the process of combining the two systems in itself would not provide any additional information to OADAP. Since there seems to be no advantage to combining the systems, and since the cost of creating a combined system would be substantial, there are no plans for such combination.

NIAAA and NIDA have had preliminary discussions concerning the combination of their respective systems at the national level. If a combined national system is created, OADAP will adopt it for state use if it is judged to provide information adequate for state needs.

At this time, it is also planned to continue to maintain a separate fiscal system. The financial information provided through the NIAAA reporting system, while useful, is not consistent with state requirements for accountability.

The OADAP MIS staff consists of two professionals and one clerk. One professional is responsible for the alcohol system and one is responsible for the drug system. Both professionals have other responsibilities. The clerk is assigned full time to the alcohol system. Most of the clerk's time is spent receiving, editing, correcting, collating and transhipping MAPIS forms.

OADAP contracts with the state's central computer services to perform programming and all necessary machine processing for the MAPIS system.

The CODAP system and the community monitoring system are maintained manually.

2. Goals and Objectives

A. Alcohol System

As described in Part I - A2, Management Information Systems, the alcohol information system has undergone extensive changes in the past year. The fruits of these changes are not yet apparent. Thus, most of the objectives listed in this section will address the efforts needed to maintain the system and assess its strengths and limitations. Changes will be made if they are indicated by these ongoing assessments. However, the nature of these changes cannot yet be described.

The disruptions experienced in the information system during the past year have compounded existing feelings of dissatisfaction which accrue to any information system. Plainly put, one of the primary objectives for the forthcoming year must be to restore confidence in the capabilities of a state-run information system. The primary means of doing this consist of providing timely, accurate and useful feedback to contributing programs. Continued efforts must be made to provide program administrators with assistance in analyzing and utilizing the data.

GOAL I: Provide accurate, timely, and relevant information on program performance in order to make optimum decisions about the allocation of resources.

Objective (1): Receive MAPIS reports from every alcohol treatment program in the state.

a. Persuade the single program in the state which is not on MAPIS to join MAPIS by January 1, 1979; done by director and Alcohol Program Specialist.

b. Provide this program with technical assistance to convert from NAPIS to MAPIS, by January 30, 1979; done by research associate.

c. Continue to receive MAPIS reports from all programs currently on the system, (ongoing); done by MAPIS clerk.

d. Conduct at least one on-site visit to each reporting program during the year to maintain contact with data personnel and provide technical assistance, (ongoing); done by planner and research associate.

Objective (2): Continuously monitor MAPIS reports from each program.

a. Provide each program demonstrating exceptional performance with a written analysis of such performance within 30 days of the production of the report, (ongoing); done by planner.

b. Notify appropriate members of OADAP staff of exceptional program performance, (ongoing); done by planner.

Objective (3): Improve the dissemination of information from the MIS to users.

a. Devise a system for providing routine information to OADAP central office staff, by November 1, 1978; done by planner.

b. Develop a brief description of the types of information routinely available on the MIS to be distributed to Regional Coordinators, Regional Councils, the State Advisory Council, and central office staff by October 1, 1978; developed by planner.

c. Respond to all requests for information within 10 working days of the receipt of such requests, (ongoing); done by planner and research associate.

d. Design a report program to generate regional summaries of MAPIS data for distribution to Regional Coordinators, by November 1, 1978; done by research associate and consultant.

B. Drug System

GOAL I: Maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention, (ongoing); done by research associate.

Objective (1): Manage the Program Monitoring System (IDARP System) to collect and analyze data from treatment programs.

a. Provide technical assistance to new staff of treatment centers in preparing CODAP and NDATUS forms.

b. Continue edit and manual tabulations of monthly CODAP items from six programs to provide data to centers in time for grant preparation and for specific consideration of OADAP staff.

c. Consider a Financial Management Information System for two free standing drug treatment centers to relate staff activities to services provided and costs thereof.

Objective (2): Maintain a Community Monitoring System to assess the extent of drug problems in the various planning regions and identify resources on an annual basis, (ongoing); done by research associate.

a. Obtain, compile and analyze data from other government agencies whose activities may deal with drug abusers. For historical comparisons, continue collecting data from some agencies where data was previously obtained and expand to new areas to reinforce available data.

b. Select appropriate criteria for comparison between regions so that resources may be distributed to areas of greatest need.

CHART 22

Costs for Management Information System Objectives

ALCOHOL

Goal 1

Objective 1 -	Direct Labor	=	$ 2,276	
	Travel	=	835	$28,122
	Support Services	=	7,711	
	All other	=	17,300	
Objective 2 -	Direct Labor	=	1,646	
	Support Services	=	142	$ 1,813
	All other	=	25	
Objective 3 -	Labor	=	2,245	
	Consultants	=	200	$ 2,495
	All other	=	50	

DRUG ABUSE

Goal 1

Objective 1 -	Direct Labor	=	4,635	
	Consultants	=	2,000	
	Travel	=	105	$ 6,894
	Support Services	=	154	
	All other	=	0	
Objective 2 -	Direct Labor	=	1,795	$ 2,282
	Support Services	=	487	
			TOTAL	$41,606

2. Treatment, Rehabilitation, and Intervention*

Introduction

The existing systems of alcohol treatment and rehabilitation and drug treatment and rehabilitation in Maine had separate and distinct origins. Components of the alcohol system have been designed in response to a variety of needs evidenced by alcoholics and alcohol abusers. The Uniform Alcoholism Intoxication and Treatment Act including authorization for this office was enacted in July, 1973. When OADAP began implementing provisions of the Act, many programs were originally designed to serve the public inebriate. During the past three years, efforts have been made to expand the focus of alcohol programming to include the 95% of alcohol abusers who are not public inebriates. Intervention programs have been initiated to intercept people in the early stages of alcohol abuse and to channel them into treatment and rehabilitation programs.

On the other hand, drug treatment and rehabilitation services were developed in the early 1970's to respond to the newly acknowledged problems of people abusing illicit drugs. In fact, a majority of the clients of those programs are polydrug abusers. When feasible, alcohol intervention programs have been broadened to also serve those clients.

From the information presented in the Part III Needs Assessments section of this Plan, it is clear that the combined efforts of our systems are most responsive to people over twenty-nine who are abusing alcohol and people under twenty-five who are experiencing polydrug abuse problems. In an effort to provide appropriate services for both alcohol and drug abusers regardless of their ages, four existing providers have developed combined or joint services. In order to insure the availability of necessary services to people on a statewide basis, OADAP will prepare a comprehensive plan for the establishment of a client-oriented treatment system. That plan will contain recommendations for additions to, or changes in, the existing alcohol and drug systems to insure that clients have access to the services they require.

This section of the Plan is organized into three resource assessments and an OADAP policy statement followed by one set of goals and objectives for alcohol and drug treatment, rehabilitation and intervention services. There is one resource assessment for alcohol treatment and rehabilitation services, one for intervention services and one for drug treatment and rehabilitation services. A detailed report on the services currently offered has already been included in Part I-G, Service Delivery System. Therefore, the resource assessments focus primarily on special topics required by the Plan guidelines, client outcomes during the past year and problems encountered in the present systems.

A. Resource Assessment

1. Alcohol Treatment and Rehabilitation Services

This section begins with a general statement concerning the amounts of service rendered by type of service during the past year. This is followed by an analysis of the "chronic client syndrome," and finally, a description of some problems with each of the existing components of treatment is presented.

* See the definition of "Intervention" in the Definitions section.

The difficulties of the OADAP alcohol information system have been detailed in Part II-1B Management Information Systems. These difficulties have precluded OADAP from generating detailed information on the performance of treatment agencies during the preceding year. Information collected from the Bureau of Resource Development, which monitors Title XX contracts from licensing inspections, and from manual spot checks of data forms, indicates that calendar year 1977 was similar to the prior year in the types and amounts of services delivered.

System Outcome

Shelter components provided approximately 11,300 nights of shelter. This is a decrease from the prior year's total of 14,500. The decrease in services reflects a reduction in the number of beds in one facility to conform to licensing requirements, and a change in policy at another facility which encouraged the use of available beds for detoxification rather than shelter.

Many of the shelter clients were also referred to detoxification programs, although the primary referral source for detox programs continued to be the client himself. A total of approximately 9,900 days of detoxification service was rendered.

A large minority of detox clients were directly referred to an intermediate care (short-term rehabilitation) component. These components provided approximately 22,000 days of service.

The two halfway houses provided approximately 13,200 days of service.

The residential components, excluding shelter, maintained an average occupancy rate of 81%.

The total amount of outpatient services cannot be accurately estimated. The typical recipient of these services was described in Part III-1 Needs Assessment - Alcoholism. In reviewing the utilization patterns of the existing facilities, it became apparent that a large proportion of available residential treatment capacity was being devoted to the housing of chronic indigent inebriates, or final stage alcoholics.

These persons were not only chronically ill, they were also chronic users of services. In terms of the information system variables, these chronic clients may be described as males, who are currently unmarried and living alone, who are unemployed at admission, with an annual income of well under $2,000, and who have had an extensive history of previous treatment admissions.

These observations based on the routine output reports led to the initiation of a special analysis of the treatment admission patterns of clients admitted during the period 1/1/77 through 6/30/77.

Approximately 3,100 individuals were admitted during this 181 day period.* Of these, 110 (3.5%) received 50 or more days of residential service.

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* The coding system used to protect client identity precludes uf from being able to distinguish individuals with certainty. Therefore, all references to the number of individuals are only approximations.

An additional 45 received 40-50 days of residential service. Of those receiving 50 days or more, 50 received halfway house services. Of these 50, approximately half received additional residential services (detoxification of short-term rehabilitation) following termination from halfway house treatment.

The 110 clients with 50 or more days accounted for a total of approximately 7,780 days of non-shelter residential service out of a total of 23,327 days for all reported clients. These clients comprised 4.6% of the 2,380 individuals who received non-shelter residential services. This small group accounted for 34% of the total non-shelter residential days of service rendered.

A small group of clients had 6 or more admissions in the six-month period (other than shelter), but did not stay more than 5 days for any one admission.

This analysis of admissions indicates that there is a relatively small group of chronic clients who appear to be using residential services as temporary housing or refuges from crisis situations, but who do not receive any long-term benefits from their treatment. The implications of this pattern of use for both the chronic clients themselves and the rest of the clients (and potential clients) in the treatment system are discussed in the section on system problems below. The problems are presented according to the existing component of care in which they have arisen.

Community-based-Outreach Programs

Many programs provide an outreach component primarily by locating outpatient components in outlying communities. The staff at these locations have a dual role of counselor and community educator. In addition, information efforts on behalf of the program are provided to the community.

Outreach efforts are presented in an uncoordinated manner, causing one or two components of care to be promoted while other components exist which might be more appropriate to fulfill some clients needs.

Shelter Components

Shelter components are provided on a limited basis within all regions with the exception of Region V. The available beds are located within urban areas. Some problems with the shelter components center around their physical unattractiveness, and their inadequate capacity. Other problems arise over the philosophy of shelter programs and their inability to cope with severely disturbed clients.

Although all shelter components have passed fire and safety inspections under the OADAP licensure process (shelter components are inspected when they are located in the same physical plant as other licensed components), some concern has been expressed to OADAP about the physical appearance of certain shelters.

Individuals have voiced concern over the possible exploitation of the shelter components by clients, stating that the shelters perpetuate the illness instead of addressing the illness because of the ease with which the final stage alcoholic goes in and out of the component.

Periodically, the demand for shelter beds in the urban areas exceeds the supply. This causes some final stage alcoholics to be exposed to the harsh Maine weather.

Available shelter components are used by a few individuals within the state who are falling between available alcohol and mental health services. Individuals who are identified by the alcohol facilities as experiencing mental illness and who are drinking and/or abusing medication to cope with their illness usually display behavior during or after withdrawal (through detoxification) which the shelters are not equipped to address. The presence of alcohol use makes the mental health facilities reluctant to accept the client even when the individual has received those services before and has been diagnosed as experiencing mental illness. Unfortunately, this situation causes the shelter to involve law enforcement agencies when acceptance by a mental health facility might be more appropriate.

Detoxification

There are seven detoxification components in the State of Maine.

Six detoxification components are located within the same physical plant as other components. Three detoxification components are located within the same physical plant as shelter components that are used by final stage alcoholics. This situation limits usage of the detoxification component to the final stage population because of the reluctance of early and middle stage alcoholics (especially women) to mix with this population. Thus, even if the total number of detoxification beds were adequate, as a practical matter, many of them are not available for use by a large segment of the alcohol-abusing population.

Short-Term Rehabilitation (Intermediate Care)

The social setting short-term rehabilitation programs (ranging from 14 to 30 days) are not eligible for third party payment. The facilities are funded by state or federal monies, self-pay or Title XX funds. The Title XX financial eligibility criteria plus the need to provide services in accordance with the Uniform Intoxication and Treatment Act have caused these facilities to be heavily used by late and final stage alcoholics. This is the alcoholic population least able to be helped by a short-term component. The resulting multiple admission pattern of these clients not only lowers staff morale, but also prevents the admission of earlier stage clients. This occurs in two ways.

First, beds are tied up by inappropriate clients. Secondly, programs acquire a reputation for serving certain clients which discourages referral agencies and individuals who are seeking help from using their services.

The presence of large numbers of late and final stage alcoholics creates additional problems. In many cases, the late and final stage alcoholic - because of the extent of his illness - is unemployed or unemployable, which severely limits his ability to pay for services. Therefore, the hope of supporting short-term rehabilitation programs on a self-pay basis is unrealistic.

The early and middle stage alcoholic would be reluctant to enter an identifiable social setting alcoholism component because of the sensitivity to the stigma of alcoholism in the community.

Even if this stigma could be overcome, these persons would still face the problem of paying for services. Government funds are inadequate to provide services to everyone who requires them. It does not appear that free-standing rehabilitation facilities will be eligible for private third-party payments in the near future. One solution to this problem is to initiate hospital care components.

Hospital based programs by themselves cannot resolve all the problems. One hospital based short-term rehabilitation program encounters many of the same problems faced by free-standing facilities. It is faced with the necessity of allowing inappropriate admissions. Even though its services are reimbursable, many clients do not have private third-party coverage. Consequently, a large portion of the program is Title XX funded. Reliance on the funding mechanism increases the pressure to admit low income late and final stage alcoholics. Thus the two problems of inappropriate admissions and inadequate funding are closely interrelated.

The problems created by inappropriate admissions can in large part be attributed to the lack of appropriate alternative resources for the late and final stage alcoholics. Given the choice between providing these persons with inappropriate treatment, or with no treatment at all, service providers are choosing to provide treatment. OADAP thinks that a long-term housing component would meet the needs of the final stage alcoholic. Such a component would concomitantly reduce the pressures and problems faced by treatment providers.

Long-Term Rehabilitation (Intermediate Care-Halfway House)

Two long-term rehabilitation programs exist within the State of Maine. The programs differ in funding, admissions criteria, type of clients served and programs.

One halfway house has a medical component, serves a significant number of final stage alcoholics and is seen to be quite flexible in admissions criteria. The other program serves the late stage alcoholic, has restricted acceptance criteria, and offers a vocational and social adjustment program.

Both programs are partially funded by Vocational Rehabilitation, have full counseling staffs and provide six to eight months of rehabilitation.

Assessment of the medical and vocational and social adjustment programs should be made to evaluate their effect on the total program. The assessment would determine if either or both elements ought to be in both halfway houses. Each program should assess a client's continuing need for treatment at the end of a ninety day period to allow these programs to provide services to as many clients as possible.

Outpatient Counseling

New intervention programs (such as DEEP) are expected to increase outpatient caseloads. Since quality of treatment may suffer if caseloads become too heavy, consideration has to be given to additional outpatient counselors.

Aftercare

Several types of aftercare exist within the state from eyeball to eyeball contact, to contact through the use of telephone.

OADAP accepts the philosophy that aftercare should be provided according to identified client need. Many clients require personal contact for aftercare services. Such services are expensive.

Since aftercare is provided after treatment and rehabilitation, payment for the services is not included in the funds provided for treatment and rehabilitation services.

Financing the aftercare component remains a problem for OADAP. Aftercare, by definition, follows treatment and rehabilitation, but is still the responsibility of treatment and rehabilitation providers.

An assessment of aftercare needs and funding available to provide for the needs must be accomplished to resolve the problem.

Long-Term Housing

No long-term housing components exist within the State of Maine causing the final stage alcoholic to use all other existing components inappropriately.

Final stage alcoholics use shelter on a nightly basis and detoxification for ten days when necessary because of severe physical or psychological difficulties. Referral to short and long-term rehabilitation does take place, but OADAP recognizes that referral to these components may be inappropriate or premature. On the other hand, if the final stage alcoholic is not referred to these components, he is placed in the situation of getting a substandard room or returning to the street environment.

All the above options are seen as providing a risk to the client and in some cases, the components as well. When referral is made to a rehabilitation program, the client is led to a false hope of recovery only to return again to a room or the street after an attempt at recovery.

Time has to be allowed for the final stage alcoholic to recover and decide on the appropriateness of further treatment. The short and long-term rehabilitation components are limited in what they are able to accomplish with the final stage alcoholic. In addition, as mentioned above, his presence effects the quality and acceptability of the program provided to other clients not experiencing the same degree of illness.

Component Personnel (CETA Funded)

A significant number of personnel staffing the present components of care, treatment, and rehabilitation have been funded by the Comprehensive Employment and Training Act (CETA) to provide services for a growing client caseload. CETA positions are only funded for a limited time period. When CETA funding is discontinued, agencies must either seek new funding or undergo staff reductions.

Native American Population

The regional councils, state advisory council and OADAP agreed with the philosophy of the Native American community that given the differences in cultures, provision of Indian services by Indian people would be more conducive to recovery of the Native American alcoholic.

A state-wide assessment of need done through an NIAAA grant indicated alcoholism in epidemic proportions among all Native Americans living on and off reservations.

Lack of sufficient funding, exacerbated by grant cutbacks, has prevented the Native Americans from providing or purchasing, when appropriate, services to significantly address their drug and alcohol problems.

Youth Services

A great deal of concern has been expressed about the youthful alcohol abuser, drug abuser and alcoholic. A sufficient quantity of services for youthful abusers does not exist within the State of Maine. There is little agreement on the proper type and location of facility, programming or services that should be developed to address the alcohol problems of Maine youth.

Elderly

No programs exist specifically for elderly alcohol or drug abusers in Maine. An assessment needs to be made, with the cooperation of agencies for the elderly, to define need. In addition, some existing programs which are serving Maine's elderly, could be further educated about the specific needs of elderly drug and alcohol abusers.

2. Intervention Services

A description of the problems encountered in delivering intervention services is provided below for each existing service.

Court Counseling Program (Diversion Services)

The Update to the Maine State Plan on Alcohol Abuse and Alcoholism (March 1, 1977) contained objectives for providing Court Counselors to work within the District and Superior Courts to "screen, refer and track" alcohol abusers and alcoholics who appear in the judicial system as a result of alcohol related offenses. The need to place counselors within the juvenile court was also expressed. The legislature did not appropriate funds to implement the programs.* The need to provide intervention and diversion for this population is essentially unmet.

Two identifiable court counselors do work with some District Courts in Regions I and III. The remainder of the regions do not have formalized court programs.

Employee Assistance Programs

The "Update" also contains an objective to provide three additional occupational program consultants. Not only did a lack of funds prevent the creation of these additional positions, but also the loss of the NIAAA Staffing Grant in Region IV led to the elimination of an existing OPC.

Convincing private industries to initiate EAPs is a long and arduous process. Management and unions alike must be convinced to lay aside feelings of competition and conflict, and join together to support a common effort. The long and sometimes delicate process of negotiating policies is complicated by the presence of high turnover of personnel within the firms.

Another far too common barrier to the establishment of an EAP is the presence of alcohol problems among the top management personnel of the firms. It is difficult to gain commitment from a manager when he himself feels stigmatized and threatened by his own illness.

Despite these adversities, progress is still possible. Current positive prospects include one company and one association comprising a number of companies which have shown interest and are now in the initial planning stage of developing EAPs.

Another positive note is that the Occupational Program Consultants Association of Maine (OPCAM) is now a reality; however, it is new with a low profile at present. The present consultant hopes this organization will become a magnet attracting funds from many sources. It is a non-profit organization outside state and federal control. The objectives are program development and implementation on a private basis.

The ideal occupational program consultant program in Maine would include an OPC for each of the five regions in the state. These OPCs would develop policies unique to the needs of individual firms, and would schedule orientation sessions to the policy for supervisors and union officials in these firms.

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* The impact of the failure of LD 857 (Appendix K-LD 857) to become law is discussed in Part II - 2, Treatment, Rehabilitation, and Intervention.

Ideally, there would be a standardized procedure for documenting poor job performance in all work systems, standardized fee schedules for client diagnosis and treatment, and a determination of insurance coverage. A well developed EAP would provide information about the program through an in-house bulletin or memo. Information would also be distributed to the worker's families through mailings or telephone contacts. Ideally, also, the program would be self-supporting with each OPC generating enough fees from interested firms to free the sponsoring agency from dependency on government funding.

Driver's Education and Evaluation Program

New legislation was implemented expanding the OUI program to encompass single and multiple offenders. As the program identifies more offenders who require treatment and refers them to treatment, counselor overload will prevent the existing outpatient components from providing quality services.

OADAP recognizes that increased funding is necessary to provide additional outpatient services personnel.

3. Drug Treatment and Rehabilitation Services

The largest single factor which determines OADAP treatment priorities is the potential utilization of individual drug abuse services on a state-wide basis. This potential for each documented drug of abuse is measured by the prevalence of problems related to that drug which are revealed in the indicator studies OADAP conducts annually. The staffs at existing drug treatment programs, the Veterans Administration Hospital, community mental health centers and selected community hospitals are periodically consulted to obtain information about the number of requests made for the following specific drug abuse services: detoxification, methadone maintenance, residential treatment and outpatient treatment. At this date, drug problems in Maine continue to result from the widespread abuse of a variety of legally and illegally obtained substances, often including alcohol. The number of reported problems related to the abuse of opiates or synthetic narcotics remains small. As in the past, the choice of a particular drug seems to depend on what is easily available at any given time.

After consideration of this first factor, OADAP examines the geographical distribution of reported drug-related problems and requests for service in order to determine both the appropriate levels and the specific locations at which treatment and rehabilitation services should be provided. At the present time, OADAP continues to insure the availability of residential services on a state-wide basis by maintaining one residential treatment facility in the state's largest city. Outpatient treatment services are provided in smaller cities and towns throughout the state by means of service programs with satellite offices. Intervention services with strong referral links to the treatment programs are available in several rural areas. Because of the anticipated low utilization rate for detoxification or methadone maintenance services, no formal programs incorporating those services have been established in Maine. OADAP recognizes the need of individuals for such services and provides access to the services by referral within the New England Region. Specific hospitals continue to provide detoxification services on a case by case basis.*

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* A summary of the modalities, capacities and locations of drug treatment programs in the state is contained in Chart 23 which follows here.

CHART 23

DRUG TREATMENT AND REHABILITATION SERVICES

Program Name	Environment/ Modality	Location of Offices	Static Capacities* Budgeted 1977-78	Anticipated 1978-79
Day One (Drug Rehabilitation, Inc.	Drug-free Residential	Portland	8	9
	Drug-free Outpatient	Portland	5	14
Aroostook Mental Health Center	Drug-free Residential	Limestone	Variable	Variable
	Drug-free Outpatient	Presque Isle, Caribou, Fort Fairfield, Van Buren, Madawaska, Fort Kent, Houlton	5	5
Crisis & Counseling (Rap & Rescue, Inc.)	Drug-free Outpatient	Augusta, Waterville, Skowhegan	90	90
Full Circle (Bath-Brunswick Mental Health Center, Inc.)	Drug-free Outpatient	Brunswick, Bath, Lincoln County	30	35
YCCS Substance Abuse Component (York County Counseling Services, Inc.)	Drug-free Outpatient	Saco, Sanford	35	35
		TOTALS	173	188

* Number of clients in treatment at any point in time.

The information provided in the Part III - Needs Assessment section of this Plan indicates that the clients of drug treatment programs are typically between the ages of fifteen and twenty-five. They are twice as likely to be male as female and, in nine out of ten cases, are abusing more than one drug. A discussion of client outcome for both residential and outpatient treatment follows.

During the past year, a total of forty-five clients received residential treatment services in Maine. Of the thirty-five clients discharged last year, 8.8% successfully completed treatment. The length of stay in treatment for all residential clients averaged 1.7 months. It should, however, be noted that, since the employment of a new director at the residential program in November, 1977, the average length of stay has increased to 3.6 months and several residents are now progressing through the latter treatment phases of the program.

A total of four hundred and ninety-one clients was served by the state's five outpatient treatment programs, with 58.3% of those who were discharged during the past year successfully completing treatment. The length of stay for clients averaged 6.4 months.

The major problems encountered in the current drug treatment system can be classified in three categories. First are the problems created by the absence of a particular type of service in a geographical area where the need for that service has been demonstrated. Currently, the problems in this category include: the lack of outpatient treatment services in Regions II and IV and the need for drug treatment in correctional institutions. The second category of problems is presented by the need for particular services where the demonstrated need is not large or widespread enough to justify establishment of a program. The needs for drug detoxification services for methadone maintenance services, and for drug treatment among the elderly are problems in this category. The last category of problems is presented by existing needs for service which have not been adequately assessed. These problems include: the need for additional residential drug treatment services for youth and the need for residential services specifically designed for primary drug abusers over 25 years of age.

Cooperation with the Criminal Justice System

With the conclusion of the Criminal Justice System Treatment Project in the county jails and adult correctional institutions in April, 1978, most of OADAP's direct support for drug treatment within the criminal justice system has ended. As indicated in Part I-G, Service Delivery System, services will continue to be available in selected correctional institutions through grants from the Maine Criminal Justice Planning and Assistance Agency to community-based programs. OADAP will continue to support the efforts of two drug treatment programs to provide counseling for residents at the Maine Youth Center who are from the program's catchment areas. The majority of the funds OADAP has available for drug treatment are NIDA funds. The restrictions placed on their use for serving the incarcerated prevent our development of the treatment programs required in correctional settings. Instead, OADAP continued to develop its planning relationship with the Maine Criminal Justice Planning and Assistance Agency to encourage and assist their efforts to provide alcohol and drug programming in the criminal justice system. Although that relationship is established by formal agreement (Appendix O, Memo of Agreement), the relatively

small size of Maine government allows us to pursue it on an informal basis. Grant review, state plan development and data retrieval are three specific areas in which OADAP and MCJPAA have cooperated during the past year.

OADAP's cooperation with law enforcement agencies, the Department of Mental Health and Corrections and judicial officials has occurred at the state level through invitations to participate in state plan development. It has also occurred atthe sub-state level through OADAP sponsorship of intervention services, through efforts initiated by community-based drug programs to provide training or to develop financial support and through the cooperation of regional alcohol and drug councils with regional criminal justice organizations.

B. Goals and Objectives

During January of 1978, in order to provide information required by the Maine Health Systems Agency, OADAP sought a way of evaluating the present treatment components available for alcoholics in the State of Maine. In addition, OADAP wanted to develop a means for identifying additional needed components to address the needs of all alcoholics within the state. Consequently, selected OADAP staff met for a week to develop an overall assessment strategy.

During the planning session, the OADAP staff recognized that the only criterion which should be used for evaluating available services and for determining the need for additional services was how well each component serves the clients' physical, psychological and social needs. When the types of components available are compared with the needs of clients, the need for additional components in each existing service area* of Maine may become apparent.

OADAP recognizes that a client-oriented approach to treatment and rehabilitation is the optimum one for drug abusers and problem drinkers as well as alcoholics.

OADAP has therefore decided to fully develop a comprehensive client-oriented treatment system to meet the defined needs of alcohol and drug abusers in Maine.

During the process of plan preparation, an outline of the needs for both alcohol and drug abusers was incorporated in a position paper on treatment, rehabilitation and intervention which was then sent to more than 400 groups and individuals. The position paper asked for comments on and additions to the outlines, but only a few responses were forthcoming.

OADAP has confidence in the accuracy of its outline of the needs of alcohol abusers based on the previous experience with a variety of services and clients. However, since drug treatment to date has been primarily directed at a youthful population of polydrug abusers, OADAP is seeking assistance in clearly defining the overall needs for drug treatment in Maine. Since that assistance was not generated by the position paper, we must devise a method to define those needs that can be used while we are refining our perspectives on the needs already identified for alcohol abusers.

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* The State of Maine is divided into five regions. Each region is regarded as the service area, making services available within a reasonable distance.

The goals and objectives in this section focus on maintaining existing services while developing a comprehensive plan for a client-oriented treatment and rehabilitation system. But first, for the purpose of illustration, a summary is presented of the physical, psychological and social needs of alcohol abusers which was initially produced by the planning session referred to above.

Alcoholism is regarded as a progressive illness (disease) with symptoms visible to one degree or another as the illness progresses. OADAP has partially* identified the symptoms of the problem drinker (alcohol abuser) and alcoholic. OADAP has identified the treatment needs of problem drinkers and alcoholics as indicated by their physical, psychological and social symptoms.

The licensing and certificate of approval regulations with which OADAP regulates the residential and nonresidential alcoholism and drug abuse care, treatment and rehabilitation programs, require that each client be assessed upon entering treatment. (Chapter 3 § 29 - Appendix D, Licensing Regulations). These regulations establish the mechanism through which the client's need for a particular component of service is identified.

OADAP has identified five general categories in which the problem drinker or alcoholic may be classified. In order to stay away from professional jargon because of the need for understanding by a variety of individuals, the categories are simply called stages of alcoholism. The general stages and the physical, psychological, and social factors used to determine the stage and in turn identify the correct component of service are as follows.*

Problem Drinkers**

Problem drinkers are those individuals who have adopted a life style with drinking habits that are not conducive to good health and personal growth. Usually such individuals associate with others in our society who have established and promote*** the same life style allowing for encouragement to maintain the established drinking habits.

This individual's drinking may periodically interfere with his/her life through conflicts with individuals not in agreement with the life style, charges and convictions for operating under the influence of intoxicating liquor, disagreement or conflict with family members and financial difficulties brought on by excessive expenditure of funds to purchase beverages for self and others. Physical addiction or identifiable psychological dependence are absent.

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*OADAP purposely did not go into great detail in the description of symptoms to allow for input from others to reflect how the general field views the stages. Stages appear in diagram form for simplification in Appendix P.

**The problem drinker is frequently an experimenter with drugs other than alcohol, using the type of drugs most available within the peer group. The experimental drug abuser experiences many of the same social effects as the problem drinker.

***Promotion of frequent drinking and the accompanying life style is prevalent amongst youths and young adults.

Physical effects are those usually brought on by excessive drinking - the hangover in some cases. Psychologically the individual must resolve those problems which are created by those who disagree with the drinking habits or life style. Additionally, problems brought on by alcohol-affected behavior, must be addressed.

The absence of physical addiction or identifiable psychological dependence allows the individual to be aided through intervention, confrontation, information and education. The information and education are usually based on the physical, psychological and social effects of alcohol abuse.

Outpatient counseling may be used but is usually not needed to aid the individual in changing drinking habits or life style provided the individual is open to the information and education provided.

Community education through community-oriented prevention programs can be of great assistance to the problem drinker by discouraging peer acceptance of the drinking habits and behavior.

Early Stage

In the early stage, alcoholics begin to experience observable physical harms as a result of their drinking habits. Alcohol related injuries are common within this stage as well as later stages. Alcohol related injuries cause the alcoholic to come into contact with the medical profession within emergency rooms or in private practice, but usually the alcoholism is undetected and unconfronted. Tolerance to alcohol is increased in the early stage alcoholic.

Alcoholics experience this and the middle stage (next explained) especially the woman alcoholic may consult physicians with complaints of depression, anxiety, etc. which leads to medication prescription and polyaddiction through abuse of medication. When consulting the physician, the alcoholic will not admit to or is not aware of the extent to which he/she is drinking. Swapping addictions, other drugs to alcohol or alcohol to other drugs, is not uncommon for the early and middle stages.

In the early stage the individual becomes psychologically dependent on, as well as physically addicted to, alcohol. The psychological dependence is evident because of the individual's need to drink or take drugs to relieve or escape from stressful situations.

Socially, the individual avoids activities that are not alcohol-oriented, and may be experiencing minor family, job or social problems because of alcohol effected behavior.* The alcoholic in this stage continues to receive a substantial amount of peer support for his or her drinking habits.

*The woman alcoholic will experience the same family, job or social problem, but will be protected or hidden. The youthful drinker's behavior can appear to be part of immaturity.

The crucial difference between the problem drinker and the early stage alcoholic is that the alcoholic is experiencing physical addiction and psychological dependence. In addition, the alcoholic experiences a greater degree of personal, familial and social harm.

The degree of harm, dependence and addiction indicates the need for intervention and formalized counseling for the alcoholic and family members plus education on alcoholism within society. Counseling can be adequately provided through an outpatient component.* Alcohol related injuries or severe psychological problems dictate an inpatient component.

Middle Stage

The middle stage alcoholic is identified as an individual who experiences minimal physical impairment, is physically addicted and has a decreasing tolerance to the drug.

Psychologically the individual is dependent, denies having a problem or addiction and is demonstrating an inability to cope with problems that are causing or are being caused by alcoholism.** Socially the individual is experiencing more severe harms evidenced by meaningful relationships becoming unstable and declining peer group status which creates feelings of loneliness and hostility. The individual tries to conform to dominant social values because of his/her sensitivity to peer and community expectations.

The middle stage alcoholic is usually employed but is demonstrating a declining job performance. White and blue collar employees exhibit the same behavior, but are tolerated in their current position or transferred to less crucial positions enabling them to continue employment and progression of the illness.

*Alcoholics Anonymous is recognized as being successful with any stage of alcoholism. In addition, Alanon and Alateen are regarded as successful in working with the alcoholic's spouse and family members, including children.

**The woman alcoholic is usually experiencing a more severe degree of psychological problems because of the female life style and expectations placed on her by our society. The stigma of alcoholism is worse for a woman than for a man. The stigma creates a need for the family to encourage her to deny her addiction. A failing to address it causes more serious physical and psychological harms. A need to address the physical and psychic pain encourages the woman to seek relief from her addiction through the use of prescribed medication which is often abused.

Youth's physical and psychological symptoms appear to result from immaturity allowing them to progress to and through the stages of alcoholism within a fraction of the time taken by their adult counterparts.

Alcohol related behavior may cause youth to appear within our judicial system. They usually receive probation at first. However, if alcohol/drug problems remain unaddressed, sentences to the youth penal system follow.

The woman alcoholic who is not in the labor force is experiencing problems of maintaining the household according to family members' expectations. She may place herself in a situation where a man or a group of men will support her drinking habits or life style. Drug abuse is common within this chosen life style.

The individual may be experiencing legal problems as a result of alcohol related financial problems, OUI charges, marital problems or changes resulting from alcohol affected behavior.

The components of care appropriate for the middle stage alcoholic consist of intervention through outreach programs; ambulatory, social setting (emergency care), or medical detoxification as determined through physical evaluation; outpatient counseling for the alcoholic and where appropriate, family members. Outpatient counseling is regarded as appropriate if family, community, and employer support is adequate and conducive enough to sobriety to allow the alcoholic to remain in his environment during treatment and rehabilitation. It is mandatory in Maine that outpatient counseling be followed by aftercare.

Assessment of the middle stage alcoholics' surroundings and psychological state is crucial in determining the appropriate component of care. Where the external support system is questionable or non-existent, referral to short-term rehabilitation (intermediate care) in a residential setting is appropriate. Consideration has to be given to the degree to which the individual acknowledges the illness for appropriate referral for treatment and rehabilitation. Where the alcoholic minimizes or denies the illness, short-term rehabilitation will serve to allow the alcoholic time to be helped by reducing or eliminating the denial.

Late Stage

On the physical level, the late stage alcoholic experiences frequent withdrawal symptoms, and has other alcohol related health problems including possible malnutrition due to poor eating habits.

Psychologically the individual is experiencing guilt, anxiety, hostility, distrust, etc. which necessitates creating alibis for drinking and the resulting behavior.

Socially the individual maintains few personal relationships because of alcohol affected behavior. Typically, relationships are restricted to individuals or groups displaying the same life style which revolves around the excessive use of alcohol and many times other drugs.

If the late stage alcoholic is able to maintain employment, it is usually at a level of underemployment because of excessive use of alcohol. The individual has marketable skills but usually is found to be undependable. Quitting because of the fear of being terminated or actual termination because of unacceptable job performance and absenteeism is not uncommon for this group.

Any life goals established before or during the illness are set aside or forgotten with the rationalization that they are unimportant or unattainable. The individual accepts dominant social values but is unable to adhere to them because of alcohol affected behavior. Recurrent legal problems exist because of uncontrollable behavior causing appearances in the judicial system or, in some cases, penal system depending on frequency of appearances or nature of offense committed.

The woman alcoholic experiencing the late stage of alcoholism has usually lost any support from her family or peers. If she had been married she is almost certainly divorced.* As a result she may be forced to appeal to welfare because of unemployability caused by lack of a marketable skill or by inability to find substitute care for her children. Hiding her addiction is necessary because of the stigma attached to alcoholism in women.

The woman alcoholic may rely heavily on prescribed medication to allow her to cope with problems that have been created by alcohol and/or drug abuse creating a multi-addiction.

The components identified as necessary for proper treatment and rehabilitation are those that address the immediate need of the person followed by a supportive environment created by the rehabilitation components.

Components identified as necessary for treatment and rehabilitation for late stage alcoholism are outreach (primarily for the woman alcoholic), intervention, diversion, detoxification as determined by physical evaluation, short-term rehabilitation,** long-term rehabilitation (halfway house), outpatient care, and aftercare. Long-term rehabilitation (halfway house) is necessary to supply the supportive environment which substitutes for meaningful relationships and allows the alcoholic to recover in an atmosphere conducive to sobriety.

Outpatient counseling should follow long-term rehabilitation to allow the individual continued support while making adjustments to employment, new personal relationships and re-entering the community. Continued counseling should be available for personal and emotional problems.

Aftercare follows outpatient care to allow continued contact with the treatment and rehabilitation system and re-entry if necessary.

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*Within our society the woman alcoholic experiences a much higher divorce rate than the male.

**Many late stage alcoholics need the confrontation and education available in short-term rehabilitation programs to lessen denial and help them to be ready for employment when entering the long-term program.

Final Stage*

Physically the individual is experiencing severe alcohol related health problems accompanied by organic deterioration.

Psychologically the person is experiencing emotional disorganization and ethical deterioration. This is evident in the observed life style.

Socially the individual is transient and lacks personal relationships. The final stage alcoholic does form superficial relationships with those with whom he drinks. They usually travel in pairs and drink in groups within a specific locale in urban areas that allows continuance of the addiction. The life goals of the individual are nonexistent. He lives a life style of day-to-day survival created by the degree of addiction.

The individuals within this stage alone or collectively create discontent within society because of their financial irresponsibility. Society recognizes the physical deterioration or physical disability, resulting from many events, has created income through pensions or disability payments for the final stage alcoholic. The income is usually used to perpetuate the illness with little or none spent on providing the person's basic needs. As a result, the individual seeks to live within the care, treatment and rehabilitation system, leaving the system only for a few days at a time when money is available until discomfort or physical problems dictate the acceptance of detoxification. After detoxification, other components of treatment and rehabilitation may be accepted if made available. Because of the severity of the illness, acceptance is usually based more on the personal hopes of the client or staff than on a favorable prognosis of recovery.

Components of care necessary to provide proper treatment and rehabilitation to fulfill the needs of the final stage alcoholic are detoxification, social setting (emergency care) or medical as determined by physical evaluation. Physical evaluation and restoration are necessary.

The psychological condition of the individual dictates an extended period of time to allow for lessening the effects of the addiction before counseling of any type would be effective.

A supportive environment which supplies the basic necessities of life is needed for an extended period of time before the final stage alcoholic is able to make a decision on the acceptability of further treatment and rehabilitation attempts. If the decision is that no further rehabilitation is wanted, the component must serve as a living facility for the alcoholic.

Overnight shelter should be available for those alcoholics who will only periodically accept detoxification or will not accept long-term housing.

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*There are few women alcoholics in this stage of the illness. This may be due to premature death as a result of alcohol related health problems or suicide, or permanent placement in programs providing custodial care removing her from the source of her addiction.

Comprehensive Client-Oriented Treatment System

The client-oriented treatment system philosophy adopted by OADAP allows for the identification of components of care to develop a comprehensive treatment system.

The components identified from the assessment of need dictated by physical, psychological and social symptoms of the illness are outreach, (with the provision for intervention and diversion), aftercare (mandatory in Maine), detoxification (ambulatory, social setting, or medical), outpatient counseling, short-term rehabilitation, long-term rehabilitation, long-term housing, and shelter.

During the identification of needs, special emphasis was placed on the need for proper identification of symptoms and need to refer to the appropriate component of care. OADAP realizes the need for a visible, accessible, available screening and referral component to allow optimum success of the client-oriented treatment system.

The screening and referral center and all components of care, treatment and rehabilitation must be readily available and geographically accessible to the alcoholic and others they serve. Therefore, OADAP identifies the need for some components of care to be duplicated within each of the regional planning areas.

Hospital Based Components

A hospital based treatment system offers many advantages over other types of treatment systems. First of all, hospital based programs offer a means to reduce the stigma of alcoholism treatment. This is an important consideration if early and middle stage alcoholics are to be attracted to treatment.

Qualitative data available to OADAP indicate that the early and middle stage alcoholics are usually reluctant to accept treatment for the illness of alcoholism. These stages of alcoholism are experienced by individuals who are conscious of the stigma of the illness* of alcoholism as it exists within their family, community, and society. Treatment services sponsored by an accepted community based health care agency, such as a hospital, are far more likely to be acceptable to such persons than those offered by a free standing alcoholism specific treatment program.

The hospital is regarded as the community health provider. The physicians who make up the hospital staff are usually the first professional to come in contact with a person entering or experiencing the illness of alcoholism. The emergency room treats many alcoholics because of symptoms of alcoholism or alcohol related injuries. In addition, it has been found that alcoholics make up a significant percentage of the census of a hospital on any given day. Since hospitals are already in contact with a great many alcoholics, they offer an ideal location for outreach, intervention, and short-term rehabilitation programs.

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*The woman alcoholic in the early and middle stages is especially conscious of the stigma connected to the illness because of society's lack of tolerance of the intoxicated woman.

The hospital also offers certain organizational advantages. The hospital is regarded as an agency which has the staff and capability to offer the fiscal, programmatic, and managerial skills to administer alcohol programs.

Establishing alcohol programs within the hospital provides the potential for third party payments including medicare, medicaid and other resources to pay for services.

Hospitals are already accessible to many of Maine's citizens. Their 24-hour coverage provides availability of services. Both these features are necessary for the screening and referral program required to enable the Comprehensive Client-Oriented Treatment System to provide optimum care, treatment and rehabilitation services. Therefore, OADAP has adopted a philosophy of a hospital care treatment system by identifying the hospital as the primary provider of the appropriate components of alcoholism services.

The philosophy has been partially actualized in some regions where hospitals and hospital-based programs currently provide short-term rehabilitation, outpatient counseling, aftercare, detoxification, and some outreach programs.

In summary, the existing system was developed in response to isolated local needs and crises. It is currently beset with a multitude of interrelated problems. During the coming year OADAP intends to maintain at least the current level of services. We will also begin the task of restructuring the system to address the needs and problems identified above. The initial direction of this restructuring has been pointed out. The coming year of planning will refine and polish this initial direction into a more effective comprehensive client-oriented treatment system.

GOAL I: Maintain the availability of effective treatment, rehabilitation and intervention services for alcohol and drug abusers.

Objective (1): Provide alcohol treatment and rehabilitation services at the existing capacity.

Objective (2): Provide drug and alcohol intervention services through the DEEP program, court counseling program and employee assistance programs.

Objective (3): Provide residential drug treatment and rehabilitation services through 9 drug-free slots at an average utilization of 90% to serve a total of 35 clients.

Objective (4): Provide outpatient drug treatment and rehabilitation services through 179 drug-free slots at an average utilisation of 90% to serve a total of 500 clients.

Accomplishment of each of the objectives above requires the completion of these general activities:

a. Allocate funds through the OADAP grant process for service provision, July 1, 1978; done by alcohol program specialist, drug program specialist and grants manager.

b. Deliver technical assistance on request or as a result of program evaluation to insure the quality of services provided; done by APS, DPS, when required.

Objective (5): Assist in the establishment of an additional hospital-based, 16-bed treatment program in Region II.

a. Provide technical assistance to the Regional Coordinator, July-December, 1978; done by APS.

b. Provide technical assistance to the staff of St. Mary's Hospital, July-December, 1978; done by APS.

GOAL II: Produce a plan for a comprehensive, client-oriented treatment system for alcohol and drug abusers in Maine which is supported by key groups and individuals, who are personally and professionally concerned with the needs of alcohol and drug abusers.

Objective (1): Clearly define the physical, psychological and social needs of alcohol and drug abusers and design components of care which meet those needs.

a. Work with a selected committee of direct service providers, detail the outline of needs already completed and design each component of care needed, July 15, 1978; done by APS, DPS.

b. Secure client affirmation of the physical, psychological and social needs identified and the components of care designed, July 30, 1978; done by APS, DPS.

Objective (2): Determine, on a region-by-region basis, what components of care, outreach, and intervention must exist to serve alcohol and drug abusers.

a. Request that each regional council: 1) assess the client population, including special populations, in its region to determine types and numbers of clients requiring service and 2) identify which components of care are needed to serve those clients, July, 1978; done by APS, DPS.

b. After reviewing the results of each regional planning effort, recommend adjustments in, and/or additions to, the existing service systems in each region that are necessary to establish a comprehensive treatment system, August 1, 1978; done by APS, DPS.

Objective (3): Obtain recommendations from the State Advisory Council on the establishment of a comprehensive treatment system.

a. Present recommendations resulting from the regional planning efforts to the Planning Subcommittee of the Council, August 1, 1978; done by APS, DPS.

b. Provide staff assistance to the Subcommittee to insure the development of a plan which contains recommendations detailing the components of care required on a state-wide basis, August, 1978; done by APS, DPS.

Objective (4): Pursue the funds necessary for accomplishing the planned changes and additions in the existing systems.

a. Prepare an itemized budget of the funds needed, September 1, 1978; done by APS, DPS and GM.

b. Present sections of the plan and accompanying financial information to potential funding sources, September, 1978-June 30, 1979; done by APS, DPS.

Objective (5): Obtain broad-based support for the plan produced by the process described above.

a. Prepare the plan in a format for distribution, September 15, 1978; done by APS, DPS.

b. Present the plan to interested groups and individuals, answering questions and clarifying the recommendations included, September 15, 1978-June 30, 1979; done by APS, DPS.

c. Publicize the major recommendations in the plan to the general population of Maine, September 15, 1978-June 30, 1979; done by OADAP staff.

CHART 24

Costs for Treatment, Rehabilitation, and Intervention Objectives

Goal 1				
Objective 1 -	200 hours direct labor	= $	1,722	
	Travel	=	500	
	80 hours support services	=	324	$1,989,761
	Grants and contracts to programs	=	1,987,215	
Objective 2 -	OPC, 1,904 hours direct labor	=	12,871	
	Court counseling & State EAP, 5,712 hours direct labor	=	41,778	$ 192,232
	DEEP program budget	=	133,583	
	All other	=	4,000	
Objective 3 -	80 hours direct labor	=	598	
	Travel	=	150	
	20 hours support services	=	81	$ 68,829
	Contract to program	=	68,000	
Objective 4 -	320 hours direct labor	=	2,390	
	Travel	=	400	
	80 hours support services	=	324	$ 162,062
	Grants and contracts to programs	=	158,948	
Objective 5 -	100 hours direct labor	=	861	
	Travel	=	150	$ 1,092
	20 hours support services	=	81	
Goal 2				
Objective 1 -	220 hours direct labor	=	1,769	
	Travel	=	200	$ 2,050
	20 hours support services	=	81	
Objective 2 -	240 hours direct labor	=	1,929	
	Travel	=	200	$ 2,210
	20 hours support services	=	81	
Objective 3 -	60 hours direct labor	=	1,190	
	10 hours support services	=	41	$ 1,231
Objective 4 -	330 hours direct labor	=	2,630	
	Travel	=	100	$ 3,216
	120 hours support services	=	486	
Objective 5 -	480 hours direct labor	=	3,950	
	Travel	=	500	$ 4,936
	120 hours support services	=	486	
			TOTAL	$2,427,619*

* Includes $52,500 in Title XX administrative fees.

3. Quality Assurance and Evaluation

A. Resource Assessment

1. Quality Assurance

The Board of Registration of Substance Abuse Counselors, which is an independent body under the general aegis of the Department of Business Regulation, has begun to function to create a means of assessing the competence of substance abuse counselors.

The licensing and certificate of approval process, as described in Part I-G, is a major tool for assuring program quality.

Primary responsibility for the licensing and approval process rests with the alcohol program specialist. He is responsible for coordinating the overall process as well as participating in the actual inspections. The OADAP drug program specialist, grants manager, and planner also participate in on-site inspections. Where required, a nurse consultant is contracted to participate in site visits.

A small part of the cost of licensing and approval inspections is paid for by the licensing fee. The rest comes from OADAP's administrative budget.

The licensing process is a viable one which has brought about improvements in several areas of service delivery. However, it is recognized that there are several flaws in the process as it currently exists. Revisions of the regulations have been completed by the OADAP licensing inspection team. Further revisions in the regulations, the scoring system and the inspection process itself are necessary. Once these revisions have been completed, they must be presented during public hearings and formally initiated.

Objectives relating to the revision of the licensing process have been included in this section. However, their achievement at this stage is problematical due to the demands of other activities.

The design and implementation of the new Client-Oriented Treatment System has a high priority. This project will require substantial amounts of the Alcohol and Drug Specialists' time. Both these persons are essential to the licensing revision process. It is expected that most of their efforts in the area of licensing will be directed towards maintaining the current schedule of inspections.

Setting forth these objectives amounts to pointing out a gap in the services available from OADAP to programs and clients within the state.

2. Evaluation

Two professional staff persons and one clerk have evaluation activities as part of their primary job responsibilities. The professional staff members also have additional functional responsibilities in planning, licensing, information system management, and needs assessment.

The efforts of these two are primarily focused on evaluating the overall effectiveness of OADAP's alcohol and drug service delivery structure, and the effectiveness of individual external service delivery programs. Their efforts in this area are supplemented by input from the alcohol and drug program specialists.

Evaluation of OADAP's internal functioning and overall fiscal policies is conducted by the Grants Manager.

Data collection, processing and analysis must compete with client services for funds.

OADAP grant guidelines and licensing regulations mandate that service agencies perform self evaluations. OADAP provides technical assistance and data upon request to assist agencies in these evaluations.

B. Goals and Objectives

1. Quality Assurance

GOAL I: Ensure that programs conform to at least minimum standards designed to protect the health, the safety, and the legal and civil rights (indluding the right to the best available treatment) of clients in treatment.

Objective (1): Revise the licensing and approval regulations to improve their clarity, their protection of client rights, and to strengthen their concern with programmatic issues by September 15, 1978.

a. Resume scheduled meetings of licensing team members to discuss revisions of the regulations, (August - October, 1978); done by licensing team members.

b. Complete proposed revisions by July 1, 1979; done by licensing team members, research analyst and OADAP director.

c. Hold public hearings concerning proposed revisions on or before July 15, 1979; conducted by alcohol program specialist, drug program specialist.

d. Promulgate revised regulations by September 15, 1979; promulgated by OADAP director.

Objective (2): Explore alternative methods of conducting the licensing process which will both reduce the total cost of the process and improve its credibility.

Objective (3): Continue to carry out the provisions of the licensing and approval regulations.

a. Inspect all programs applying for a license or certificate of approval within 30 days of the receipt of an application; done by licensing team members.

b. Examine all individual applicants requiring such examination for DEEP approval within 10 days of receipt of application; done by alcohol program specialist.

c. Respond promptly to any written requests for investigation of program activities made by clients or community members; investigations conducted by alcohol program specialist, drug program specialist, director and research analyst.

2. Evaluation

Concomitant data collection objectives have been described in Part IV-1B, Management Information Systems.

GOAL I: Assess the effectiveness and efficiency with which the overall alcohol prevention, treatment and rehabilitation effort has achieved its goals and objectives.

Objective (1): Maintain the community monitoring system; done by planner.

Objective (2): Devise a format for comparing the new MAPIS data with PMTES data from prior years in order to assess system changes by December 1, 1978; done by planner.

GOAL II: Assess the performance of individual grantee agencies.

Objective (1): Work with the Bureau of Resource Development to develop a unified evaluation procedure for assessing the quality of Title XX funded alcoholism programs; done by planner, director, alcohol program specialist and grants manager.

a. Develop by July 15, 1978 a common policy statement concerning the unified system.

b. Develop by September 15, 1978 a common pool of identified information needs.

c. Devise by September 30, 1978 mechanisms for collecting the necessary information within the framework of existing data systems.

d. Produce by January 1, 1979 a report on the activities of funded programs.

Objective (2): Develop, in conjunction with the Maine Association of Alcoholism Program Directors, performance standards for programs; done by planner, alcohol program specialist, director and research associate.

a. Develop program cost standards by December 31, 1978.

MAPIS will provide integrated information on costs and services for all alcoholism programs for the first time. It also ensures that receipts and expenses will be recorded and reported in a uniform manner. This information will enable OADAP to construct a cost schedule indicating cost of services by type of service across all programs, and within each program. This will provide a much more powerful tool for assessing the relative efficiency of programs than is now available. This assessment will enable OADAP to establish upper limits for the costs of each type of service within different settings. Programs can then be monitored for their ability to deliver services within these cost limits.

b. Develop standards for measures of effort by December 31, 1978, such as occupancy rates and quantity of service delivered.

The cost and performance standards will be developed in conjunction with the treatment programs. Once developed, the standards will be disseminated to the programs. Each program will then be able to monitor its own performance with regard to the standards.

Objective (3): Integrate licensing reports into the overall evaluation of programs; done by planner, alcohol program specialist.

GOAL III: Utilize the results of evaluation studies to improve the quality of performance.

Objective (1): Make technical assistance available to programs demonstrating substandard performance on the MIS reports, (ongoing); done by appropriate staff members as determined by nature of required assistance.

Objective (2): Prepare a report for next year's state plan on the overall performance of the treatment system, (March 2 - March 31, 1979); done by planner, grants manager and alcohol program specialist.

CHART 25

COSTS FOR QUALITY ASSURANCE OBJECTIVES

GOAL I

Objective 1 -	Labor	= $1,193	
	Support	= 85	$1,428
	All other	= 150	
Objective 2 -	Labor	= 281	281
Objective 3 -	Labor	= 10,164	
	Support	= 855	14,197
	Travel	= 1,350	
	Consultants	= 400	
		TOTAL	$15,906

CHART 26

COSTS FOR EVALUATION OBJECTIVES

GOAL 1			
Objective 1 -	Labor	= $1,245	
	Support	= 122	$1,917
	All other	= 550	
Objective 2 -	Labor	= 187	187
GOAL 2			
Objective 1 -	Labor	=$1,581	$1,581
Objective 2 -	Labor	= 3,312	
	Support	=	$3,462
	All other	= 150	
Objective 3 -	Labor	= 131	$ 131
GOAL 3			
Objective 1 -	Labor	=$1,094	
	Travel	= 400	$1,494
Objective 2 -	Labor	=$1,022	$1,022
		TOTAL	$9,794

4. Prevention and Education

A. Resource Assessment

The State of Maine has one professional and one-third clerical staff to plan, coordinate and in some cases, provide services in drug abuse prevention. OADAP has made grants to six agencies which are either partially or totally prevention oriented.

Partial support for those and other prevention projects has also come from LEAA, NCA, NIAAA, NIDA, State Department of Education and the State of Maine Library. The total dollar commitment for these prevention projects in Maine is less than $250,000 from all sources. Most of these prevention projects are aimed at youth and much of the youth effort has been directed toward schools. There are about 245,000 youths in schools. The prevention projects, funded by OADAP, have been in 24 of the schools this year. In addition, films, pamphlets and one period lectures have been used in many of the other schools. The DIAL Alcohol and Jackson Junior High series have been used 117 times in the public schools this year. They were also on Instructional T.V. and viewed by a known school population of 1,456 students. A drug prevention project of some kind therefore has been in almost all of the 132 public schools.

A community-wide alcohol prevention project was piloted within a small community this year. This project used the media, a task force, the development of a slide show and many presentations to increase community awareness of the role of alcohol in community life. A limited evaluation indicated that awareness was increased. We plan to build on this community-wide model.

Projected funding will be at a lower level than in the current year. OADAP will be funding about $113,000 worth of prevention projects, unless additional funds are obtained. This compares to $170,000 in 1977-78.

Many communities in the state have performed surveys to determine the people's perspective of all types of problem areas. Each survey has resulted in alcohol and drug problems as the second or third priority of the people. The schools are being confronted with what seem to be more serious problems. Alcohol and drugs are reported to be both more used and used at earlier ages. The magnitude of use and abuse in schools is not well documented, but the numbers of pamphlets, films and posters being requested, as well as the number of programs sought by schools, is increasing.

OADAP has established a policy statement on drug prevention which has been commended and accepted by many groups of Maine people when they responded to position papers sent out to over 400 individuals and agencies. One part of this statement, which is very significant, is the acceptance of a unified prevention effort between alcohol and all other drugs.

The policy statement is: "Drug Abuse Prevention is that activity which helps people to make responsible decisions about the use of drugs, including the drug alcohol. This activity strives to reduce the potential for harm resulting from the abusive use of drugs. (Prevention is primarily directed toward individuals who are not yet experiencing serious harmful effects resulting from the abusive use of drugs.)"

OADAP's commitment to prevention is firm, though not as financially substantial as the office would like it to be. An effort to secure more funding for prevention activities will be continued this year.

Another thrust and policy decision at OADAP in this programmatic element is to develop the intense community-wide approach. OADAP must maintain some state-wide prevention efforts, but serious efforts will be made to constrain the proliferation of projects which sap OADAP's energy. A few communities will be chosen in which extensive efforts will be applied. This policy is based on the belief that the less intense efforts have not accomplished satisfactory results. OADAP needs and wants to be able to have measurable results, and the intensive community-wide effort is believed to be better suited for this. The community approach also has the backing of many Maine people. A majority of the state legislature is supportive of this approach. The Maine Municipal Association, representing most of the towns of Maine, also endorses it.

B. Goals and Objectives

GOAL I: Alcohol and other drug abuse prevention activities will be coordinated as a single unit.

Objective (1): Publicize policy throughout the year.

a. Media coverage to begin by August 15th; the prevention coordinator is responsible for this.

b. Written statement to people in the field by August 1st sent by prevention coordinator.

Objective (2): Designate an OADAP staff person to be in charge of all drug abuse prevention activities by July 15th.

a. OADAP Director to designate the current alcohol abuse prevention coordinator to be the prevention coordinator for all drug abuse.

b. Evaluate performance of one person in charge of all drug abuse by February 28, 1979; by OADAP Director.

Objective (3): Apply this policy to training that is given throughout the year.

a. Apply to prevention training programs to be overseen by OADAP training specialist.

b. Integrate it into other alcohol and drug abuse training programs all year; done by OADAP training specialist.

c. Develop a specific training session for prevention personnel which addresses this policy by August 15, 1978; done by training specialist and prevention coordinator.

GOAL II: Develop a needs assessment which will be more valuable for identifying prevention priorities.

Objective (1): Develop a compositeof all available materials which give indications of drug abuse by December 15th; done by OADAP statistician and prevention coordinator.

a. Contact schools, police departments, Maine Municipal Association, University of Maine and others for appropriate surveys and information they have by October 15, 1978; done by OADAP prevention coordinator and statistician.

b. Analyze drug treatment data and other statistics OADAP has collected by October 15, 1978; done by prevention coordinator and statistician.

Objective (2): Determine what else is necessary for a good prevention needs assessment and develop, where possible, means of collecting this material by November 15, 1978; done by statistician of OADAP.

a. Get assistance from appropriate OADAP staff and others to decide on what new information could be obtained by October 30, 1978; process led by prevention coordinator.

b. Design a way to obtain it and get it by November 15, 1978; done by OADAP prevention coordinator.

Objective (3): Prioritize the results, January 1, 1979.

a. Present results to OADAP staff meeting and ask for help in prioritization by December 15, 1978; done by prevention coordinator.

b. Send out information to those in the field and ask help to prioritize list by December 15, 1978; done by prevention coordinator.

c. Publish results with specific priorities as selected, as a result of the input by January 1, 1979; done by prevention coordinator.

GOAL III: Develop training and other means of help for persons working in prevention, which will acquaint them with other people in the field and the current trends.

Objective (1): Plan, hold and evaluate a one-day workshop of people involved in prevention by October 15, 1978; organized by prevention coordinator.

a. Invite all who work part-time or full-time to 1) meet one another, 2) discuss their projects and 3) investigate new directions by August 15, 1978.

b. Request technical assistance from Regional Support Center in designing the day by August 1, 1978.

c. Hold day long workshop by September 30, 1978.

d. Evaluate the workshop by October 15, 1978.

Objective (2): Develop communication links between prevention personnel by October 30, 1978; supervised by prevention coordinator.

a. Seek advice by questionnaire from field personnel as to what would be helpful to them in their work, by October 30, 1978.

b. Find means to meet their needs by December 1, 1978.

Objective (3): Plan follow-up training through Project Pyramid and others by March 30, 1979; directed by training specialist and prevention coordinator.

a. Ask Project Pyramid, Regional Support Center, State Dept. of Education and others for help in designing training by November 15, 1978.

b. Develop and execute plans by March 30, 1979.

c. Evaluate training, May 1st.

GOAL IV: Develop and deliver broad prevention effort for Maine people of all ages.

Objective (1): Develop philosophy and possible strategies for prevention efforts which will be directed toward Maine people of all ages (not just youth); conducted by prevention coordinator.

a. Discuss these needs at OADAP staff meetings throughout the year.

b. Continue developing these ideas with OADAP prevention sub-committee throughout the year.

c. Discuss these ideas at training sessions for prevention personnel throughout the year.

Objective (2): Develop ways to present this philosophy to the general public throughout the year; guided by prevention coordinator.

a. Develop media coverage throughout the year.

b. Develop public meetings or workshops throughout regional councils and state advisory council throughout the year.

c. Encourage prevention personnel to emphasize this philosophy throughout the year.

Objective (3): Target three communities and run intense broad based prevention activities by May 30, 1979; coordinated by prevention coordinator.

a. Select communities by September 30, 1978.

b. Develop funding mechanism by October 30, 1978.

c. Complete projects between October 30th and May 30, 1979.

c. Evaluate projects by June 30, 1979.

GOAL V: Raise the level of commitment to drug abuse prevention efforts in Maine.

Objective (1): Seek support from State Legislature for drug abuse prevention by February 1, 1979; coordinated by OADAP legal consultant.

a. Seek legislative leadership of this cause, October 30, 1978.

b. Support that leadership by December 15, 1978.

Objective (2): Seek federal support for drug abuse prevention in Maine; done by prevention coordinator.

a. Write proposals where appropriate during the year.

b. Assist NIDA and NIAAA in ways that will help them provide states with leadership and resources in prevention throughout the year.

Objective (3): Obtain line item for prevention in OADAP budget for fiscal grant period 1979-80, by January 30, 1979; guided by prevention coordinator.

a. Develop support among prevention personnel throughout the year.

b. Present this concept at OADAP staff meetings by November 30, 1978.

GOAL VI: Continue prevention efforts which currently include state-wide media presentations, a speaker's bureau, and distribution of pamphlets.

Objective (1): Provide films for use in various locations all year.

a. Send out films as requested - 3 per week; done by secretary.

b. Evaluate new films and purchase as appropriate - 3 per year; done by prevention coordinator.

c. Seek out films not owned by OADAP, but occasionally requested. A secretary will assist in obtaining these films for those who request them.

Objective (2): Provide literature for filling requests all year.

a. Respond to needs for pamphlets - 6,000 per year; done by secretary.

b. Supply posters upon request - 500 per year; done by secretary.

c. Evaluate pamphlets and posters for stock all year; done by prevention coordinator.

Objective (3): Coordinate the prevention presentations throughout the state for the year.

a. Relate speaking requests to Regional Planning Coordinators as they come in to prevention coordinator. Regional Planning Coordinators will get speakers.

b. Offer training to potential speakers in one day courses in each region, possibly designed by the Regional Support Center and organized by prevention coordinator by October 30, 1978.

Objective (4): Provide media presentations and media spots throughout the year.

a. Encourage and assist people in the field to take part in media presentations and get drug spots on radio and T.V.; done by prevention coordinator throughout the year.

Objective (5): Provide research material on request from OADAP library or through NIAAA and NIDA clearing houses or other resources throughout the year.

a. Prevention coordinator will, as time allows, research specific requests which are made by people in Maine throughout the year.

b. Prevention coordinator will refer research requests he can't meet on to others in OADAP, NIAAA or NIDA, as requests come in.

Objective (6): Continue to support agencies which propose to do worthwhile prevention projects.

a. Through state-wide grant process, seek to continue six good prevention projects totalling $90,000.

b. Assist agencies in filling out funding requests to the federal government and others.

CHART 27

Prevention and Education Cost Data

Goal 1

Objective 1 -	30 hours direct labor	= $	268	
	20 hours support services	=	78	$ 446
	All other	=	100	
Objective 2 -	30 hours direct labor	=	268	
	10 hours support services	=	39	357
	all other	=	50	
Objective 3 -	40 hours direct labor	=	358	
	24 hours consultant's time plus room, board, & travel	=	675	
	300 miles of travel & tolls	=	49	1,438
	40 hours support services	=	156	
	all other	=	200	

Goal 2

Objective 1 -	50 hours direct labor	=	447	
	100 miles travel plus tolls	=	18	
	20 hours support services	=	78	593
	all other	=	50	
Objective 2 -	40 hours direct labor	=	358	
	40 hours consultant's time plus room, board, & travel	=	1,290	
	100 miles travel plus tolls	=	18	2,222
	40 hours support services	=	156	
	all other	=	400	
Objective 3 -	20 hours direct labor	=	179	
	20 hours support services	=	78	457
	all other	=	200	

Goal 3

Objective 1 -	80 hours direct labor	=	715	
	16 hours consultant's time plus room, board, & travel	=	383	
	300 miles travel plus tolls	=	49	1,325
	20 hours support services	=	78	
	all other	=	100	
Objective 2 -	40 hours direct labor	=	358	
	300 miles travel plus tolls	=	49	
	40 hours support services	=	156	813
	all other	=	250	
Objective 3 -	160 hours direct labor	=	1,430	
	300 miles travel plus tolls	=	49	
	40 hours support services	=	156	
	40 hours consultant's time plus room, board, & travel	=	1,000	2,835
	all other	=	200	

Goal 4

Objective 1 -	80 hours direct labor	=	$ 715	
	300 miles travel plus tolls	=	49	$ 853
	10 hours support services	=	39	
	all other	=	50	
Objective 2 -	200 hours direct labor	=	1,788	
	500 miles travel plus tolls, room and board	=	230	2,474
	40 hours support services	=	156	
	all other	=	300	
Objective 3 -	300 hours direct labor	=	2,682	
	500 miles travel plus tolls, room and board	=	240	42,200
		=	39,000*	
	20 hours support services	=	78	
	all other	=	200	

Goal 5

Objective 1 -	160 hours direct labor	=	1,430	
	100 miles travel plus tolls	=	18	1,576
	20 hours support services	=	78	
	all other	=	50	
Objective 2 -	200 hours direct labor	=	1,788	
	air travel	=	500	2,650
	80 hours support services	=	312	
	all other	=	50	
Objective 3 -	20 hours direct labor	=	179	210
	8 hours support services	=	31	

Goal 6

Objective 1 -	100 hours direct labor	=	894	
	400 hours support services	=	1,560	3,954
	all other	=	1,500	
Objective 2 -	80 hours direct labor	=	715	
	160 hours support services	=	624	2,339
	all other	=	1,000	
Objective 3 -	80 hours direct labor	=	715	
	20 hours support services	=	78	
	500 miles travel plus tolls, room and board	=	217	1,526
	all other	=	200	
	16 hours consultant's time plus room, board & travel	=	316	

Objective 4 -	40 hours direct labor	=	358	
	200 miles travel plus tolls	=	36	706
	16 hours support services	=	62	
	all other	=	250	
Objective 5 -	60 hours direct labor	=	534	
	16 hours support services	=	62	796
	all other	=	200	
Objective 6 -	100 hours direct labor	=	894	
	20 hours support services	=	78	113,760
	all other	=	112,788**	
			TOTAL	$182,734

* This is to be funding for the community-wide prevention project. OADAP has applied for a contract from NIDA which will help make this objective possible, if it is funded.

** The following is the breakdown of this item:

YWCA Intervention - $10,600
YWCA Drug Education - $16,000
Full Circle - $10,648
Aroostook County
  Youth Services Program - $22,000
Community School - $18,000
Mid-Coast Mental Health
  Youth Services Project - $11,540
Project Atrium - $8,500
Channel 1 - $500
York County Counseling Services - $15,000

Total - $112,788

5. Manpower and Training

A. Resource Assessment

1. Manpower

Funds have not been available to conduct a comprehensive manpower survey of Maine's drug and alcohol service delivery system. Therefore, the assessment presented here is based on informal observations and experience in dealing with specific problems that have arisen. The observations and experiences differ significantly between alcohol programs and drug abuse programs, so separate discussions are provided.

The direct service staff of individual alcohol programs in Maine can generally be characterized as a mix of recovering alcoholics and non-recovering people. Many of the recovering alcoholics, when originally hired, do not possess formal degrees or extensive counseling experience. The non-recovering people more often have degrees or counseling experience, but rarely do they have both. In fact, a person's degree may be in a field unrelated to counseling or alcoholism. In the case of administrative staffs however, an increasing number of people possess degrees and relevant experience when they are recruited for their position.

The situation described above implies that previously qualified direct service staff people are not readily available for employment in alcohol programs in Maine and means that a shortage of the necessary skills exists among direct service staff people when they are hired.

In response to this problem, some programs have instituted in-service training programs to develop necessary skills. The University of Maine, through the Chemical Addiction Counseling Program at Bangor Community College, provides opportunities to prepare for employment in the alcohol field. That program offers academic courses and practicum experiences which culminate in an Associate of Arts degree. However, these two approaches have not been sufficient to eliminate the problem. OADAP has also worked with the Facility Directors Association to establish a wage and salary scale for workers in alcohol programs. The scale is intended to address existing inequities in salary levels between programs. However, until funds are available to adequately implement the scale, those inequities continue to account for problems in hiring and retaining qualified personnel.

In the case of drug programs in Maine, available manpower resources seem to meet the demand for service in existing programs. The total number of administrative, counseling, prevention and ancillary staff people remains small. A majority of people working in each of those career areas possess advanced degrees and previous work experience related to that area. At the same time, staff vacancies are filled with relative ease and speed by new people who have comparable qualifications. Training is required for these people at advanced levels to insure continuing quality of care and the retention of competent staff members.

II. Training

During the past three years OADAP has developed an integrated approach to alcohol and drug abuse training which recognizes two responsibilities for the provision of training. Those are:

a. a primary responsibility to provide training to workers in alcohol and drug abuse agencies, including OADAP, for the purposes of imparting information and developing skills.

b. a secondary responsibility to help provide training for the same purposes to people working with alcohol and drug abusers outside of those programs.

OADAP has been directly involved with a variety of resources in conducting or securing training for the first population identified above. The major resources have been: the Eastern Area Alcohol Education and Training Program (EAAETP); the National Council on Alcohol Education (NCAE), the University of Maine, the Title XX Training System, the Northeast Regional Support Center (NRSC) and the State Training Support Program (STSP).

The funds available through the STSP contract have provided the major impetus for OADAP training efforts directed at workers in alcohol and drug agencies. That contract has resulted in the development of a state-wide system for drug and alcohol training which comprises six distinct elements. A brief report on Maine's status with respect to each element follows:

Needs Assessment - Formal assessments of training needs have been performed for the job categories of counselor and administrator and priority training needs have subsequently been identified for both of those categories. Also, specific training needs have been identified from responses received to a position paper on training which was used to develop this Plan. Summaries of the information collected from the assessments are included as Appendix Q, (Training Needs Assessments).

A plan is being formulated for updating needs assessments on an annual basis and for conducting initial assessments in additional job categories.

Priority Establishment - In addition to establishing training priorities within individual job categories, OADAP has also outlined basic assumptions about training and established system-wide priorities for its activities related to training. The Training Advisory Committee to OADAP reviews those priorities on an annual basis and makes recommendations on necessary or desirable revisions. More detailed information on the current priorities is included in the policy statement which precedes the training goals and objectives presented in this section.

Resource Identification - OADAP originally published a directory of drug and alcohol training resources in Maine. Since then, the Title XX Training System has published a more comprehensive listing of human and material resources, which we utilize. Additionally, we maintain a file of current training opportunities for use by interested individuals and agencies.

Training Design/Delivery - Limited staff resources have prevented the original design of training courses. This has led to the use of established training packages and courses with appropriate modifications for the needs of the training audience. However, we have piloted several models of training delivery and evaluated their effectiveness. Our experience has convinced us that three alternative delivery models are required to address the variety of needs presented by alcohol and drug workers. Those alternatives are: centralized training events, regional training courses and selective purchase of training opportunities for individual needs.

Evaluation - OADAP has insured that each course delivered under its sponsorship has included a formal evaluation component. The results of those evaluations have been used to structure subsequent training events. We are now investigating the establishment of standardized evaluations for each model of training delivery listed above. Such evaluations would include both formal and informal components.

Credentialing - The Maine legislature has enacted a law establishing a nine-member Board of Registration of Substance Abuse Counselors. The Board was appointed by the Governor in January, 1977, and has been meeting to organize and secure staff assistance. Before the registration process begins, certain sections of the legislation require additional definition and additional criteria for registration including a competency examination, must be developed.

In addition to the training events which have been directly sponsored by OADAP using STSP and other funds, OADAP has purchased individual training opportunities for drug and alcohol program workers. Opportunities have been made available either through the inclusion of training funds in program line item budgets or through direct purchase from the agency sponsoring the training. During the past year, agencies other than OADAP which have sponsored training relevant to alcohol and drug workers include: the New England Institute of Alcohol Studies (NEIAS), the Rutgers School of Alcohol Studies, the Counseling Center, the University of Maine, the Title XX Training System, the Maine Mental Health Training Program and York County Counseling Services.

To date, OADAP training efforts directed at people who work with alcohol and drug abusers outside of alcohol and drug programs have largely occurred within the context of OADAP-funded grants. Several community-based agencies which receive OADAP funds have designed program activities to train local groups and individuals on alcohol and drug issues. Such activities are commonly directed toward educators, law enforcement officials, correctional institution personnel and employees of other human service agencies. In 1976, an attempt was made to obtain legislated funds from a tax on alcoholic beverages, a portion of which would have been used by OADAP to purchase training for judges and physicians. The tax proposal's failure has meant that those important training needs have not yet been addressed.

It is clear, given OADAP's manpower resources, that our agency cannot actually sponsor a sufficient number of training opportunities to meet all needs for alcohol and drug abuse training in Maine. The adequacy of available training opportunities in the state has not been tested because we do not have financial resources sufficient to purchase the required training for even drug and alcohol workers. A particular problem which has been identified in our treatment system consisting largely of small, widely dispersed programs, is the need to provide substitute coverage when employees attend training. Funds are not currently available to pay for such coverage. The special training needs of people working in related fields have so far been addressed only in a sporadic manner.

B. Goals and Objectives

The goals and objectives presented here reflect OADAP's basic assumptions about the role of training in the service delivery system and OADAP's priorities for training-related activities. The basic assumptions are:

A. There are five major reasons to conduct training for staff who work in alcohol and drug abuse agencies that provide direct services:

1) to guarantee high quality effective services to clients;

2) to prevent staff "burn-out" which contributes to the difficulty and the expense of delivering effective services;

3) to insure the minimum level of staff competency which will be required by third-party payers;

4) to train staff people as trainers who can, in turn, train other employees of the substance abuse treatment system or employees of related systems; and

5) to provide career development opportunities for employees, especially non-degreed employees.

B. There are two major reasons to conduct training for people who work outside substance abuse programs:

1) to ensure earlier, appropriate referrals of substance abusers to services designed to assist them, and

2) to promote successful reintegration of former substance abusers into social, home, and work environments.

C. The impact of any training activity on the actual delivery of services is in direct relationship to the amount of administrative involvement secured from the programs whose staff members are being trained.

D. Field involvement in OADAP decisions related to training is essential to the maximum utilization and effectiveness of training opportunities.

E. A six-element training system model, including needs assessment, resource identification, priority establishment, training design/delivery, evaluation, and credentialing, is a reasonable one for establishment of an alcohol and drug abuse training system in Maine.

F. The choice of components to be included in each element, especially the element training design/delivery, must depend on factors which characterize the service delivery system in Maine.

OADAP's general priorities for training are indicated above as a. and b. in the first paragraph of the training resource assessment. Skill development training for those employees of alcohol and drug programs who work directly with clients is OADAP's first priority under the responsibility assumed in A-1.

The major focus of that skill development training is provided by the priority training needs identified for counselors (Appendix Q, (Training Needs).

Finally, OADAP places a high priority on the coordination of training it sponsors with other human services training offered in Maine. The relatively small size of our training population and the lack of concentrated fiscal or human resources combine to make such coordination essential.

GOAL I: Provide training for employees of alcohol and drug programs to maximize the quality and effectiveness of direct services to clients.

Objective (1): Conduct required needs assessments for alcohol/drug workers.

a. Establish a method and schedule for annual update of training needs assessments for alcohol/drug counselors, administrators and prevention workers (Training Specialist (TS) with Training Advisory Committee; October, 2978).

b. Update training needs assessments for counselors and administrators (TS; January, 1979).

c. Conduct an initial assessment of prevention workers (TS; January, 1979).

d. Identify additional career areas for which needs assessments are required (TS; October, 1978).

Objective (2): Establish OADAP priorities for training of drug and alcohol workers.

a. Review needs assessment data in cooperation with the Training Advisory Committee to OADAP (TS; as the data are collected).

b. Prepare decisions on priorities in a format suitable for distribution to alcohol and drug abuse programs (October, 1978).

Objective (3): Identify and catalogue personnel and material resources for training alcohol/drug workers.

a. Secure copies of training resource directories, course schedules and calendars from federal, state and regional levels (TS; continuing).

b. Maintain a central file of training events and seminars in the OADAP office (TS; continuing).

c. Establish a list of interested alcohol/drug workers which indicates their specific training needs. Match incoming announcements against the list contacting appropriate workers (TS; continuing).

Objective (4): Ensure delivery of training programs and events for alcohol/drug workers.

a. Sponsor three centralized training events to impart information or introduce specific skills (TS; June, 1979).

b. Sponsor five regional or local training programs to develop basic skills (TS; June, 1979).

c. Review individual requests for specific training opportunities, selecting appropriate ones for funding (TS; continuing).

Objective (5): Evaluate training programs sponsored by OADAP and training opportunities purchased by OADAP for alcohol/drug workers.

a. Establish formal evaluation criteria and informal evaluation procedures, applying them to each event sponsored or purchased (TS; October, 1978).

b. Review evaluation results for future planning purposes (TS and the Training Advisory Committee; on a quarterly basis).

Objective (6): Encourage the implementation of the legislatively established registration process to credential alcohol/drug workers.

a. Provide consultation and assistance to the Board of Registration of State Advisory Council (TS; as requested).

b. Monitor the relationship between training opportunities offered and the requirements established for the Board of Registration (TS; continuing).

GOAL II: Assist in the provision of training to workers outside alcohol and drug programs who encounter alcohol and drug abusers.

Objective (1): Invite other workers to participate in OADAP-sponsored training as it is appropriate (TS; as appropriate).

Objective (2): Provide technical assistance to agencies or individuals designing or delivering training on alcoholism and drug abuse (TS; as requested).

Objective (3): Identify training needs of special populations related to alcoholism and drug abuse.

Objective (4): Assess possibilities for securing additional funds to provide training which meets the needs identified in Objective 3.

GOAL III: Secure involvement of interested groups and individuals in the delivery of alcohol and drug training.

Objective (1): Select training delivery models which are supported by program administrators (TS; September, 1978).

Objective (2): Maintain a Training Advisory Committee to OADAP to ensure field involvement decisions related to training (TS; continuing).

Objective (3): Coordinate training delivery with courses offered by other training agencies whenever possible (TS; whenever possible).

CHART 28

Manpower and Training Cost Data

Goal 1

Objective 1 -	7 weeks labor	= $2,170	
	Travel	= 312	$2,838
	2 weeks clerical	= 356	
Objective 2 -	3 weeks labor	= $ 930	
	2 weeks clerical	= 356	1,286
Objective 3 -	6 weeks labor	= $1,860	
	5 weeks clerical	= 890	2,750
Objective 4 -	12 weeks labor	= $3,720	
	Travel	= 416	
	6 weeks clerical	= 1,068	20,704
	Direct Trng. Costs	= 15,500	
Objective 5 -	5 weeks labor	= $1,550	
	Travel	= 104	2,010
	2 weeks clerical	= 356	
Objective 6 -	4 weeks labor	= $1,240	
	Travel	= 104	$ 1,522
	1 week clerical	= 178	

Goal 2

Objective 1 -	1 week labor	= $ 310	
	1 week clerical	= 178	$ 488
Objective 2 -	2 weeks labor	= $ 620	
	Travel	= 208	$ 1,006
	1 week clerical	= 178	
Objective 3 -	2 weeks labor	= $ 620	$ 620
Objective 4 -	2 weeks labor	= $ 620	
	1 week clerical	= 178	$ 798

Goal 3

Objective 1 -	2 weeks labor	= $ 620	$ 620
Objective 2 -	2 weeks labor	= $ 620	
	Travel	= 208	$ 1,362
	3 weeks clerical	= 534	
Objective 3 -	2 weeks labor	= $ 670	
	1 week clerical	= 178	$ 798
		TOTAL	$36,802

6. Summary of Financial Support

A. State Appropriations and Financial Summary

The information required to complete this form is not available at this time. The fiscal year for Maine ends on June 30 and preliminary fiscal summaries will not be published until early August. When the appropriate information becomes available it will be forwarded to NIDA.

B. Expenditure Report

This report is voluntary and as such will not be prepared for submission in this Plan.

C. Expenditure Projection Summary

Table 18 shows all sources of income for State FY'79 and the associated expenditure projection by functional area.

TABLE 18

State Agency Expenditure Projection by Functional Area and Resource

Source	Total	ADMINISTRATIVE SERVICES			Treatment Rehabilitation & Intervention	Quality Assurance & Evaluation	Prevention & Education	Manpower & Training	Direct Office Overhead
		Administration	Planning & Coordination	Management Information System					
State Appropriation	1,060,000	39,596	19,884	24,000	887,412	17,765	34,019	0	37,324
NIAAA Formula	305,067	27,733	120,456	15,910	2,299	4,688	29,010	0	104,971*
NIAAA Uniform Act Incentive	211,013	0	0	0	211,013	0	0	0	0
NIDA 409	183,092	17,826	29,177	1,696	27,252	917	81,648	0	24,576
State-wide Services Contract	109,060	0	0	0	109,060	0	0	0	0
State Training Support Program	38,000	0	0	0	0	0	342	37,658	0
State Prevention Coordinator Program	40,608	0	2,893	0	0	0	37,715	0	0
Tetra Cycline	7,000	0	0	0	7,000	0	0	0	0
Title XX	1,050,000	52,500	0	0	997,500	0	0	0	0
Other	147,900	13,417	0	0	133,583	900	0	0	0
Total FY '79	3,151,740	151,072	172,410	41,606	2,375,119	24,270	182,734	37,658	166,871*

*Includes $55,947 of unallocated formula grant dollars. This is primarily support services and material costs which have not been included in specific activities.

PART V

ASSURANCES

Assurances

The following assurances are and have been in effect from prior year submissions:

a. Nondiscrimination
b. Accessibility
c. Maintenance of effort
d. Funds
e. Records retention
f. Conflict of interest
g. Civil rights
h. Rehabilitation
i. Sex discrimination
j. Drug abuse
k. Alcoholism

Governor's Review

Exhibit A is the Governor's comment concerning the review and approval of this state plan.

State Health Coordinating Council Review

The Bureau of Health Planning and Development is currently conducting its review activity conjointly with the State Health Coordinating Council. The final outcome of that review process will be forwarded as soon as documentation becomes available.

A-95 Review

This plan has been submitted for A-95 during the week of June 19, 1978. The final outcome of that review process will be forwarded as soon as documentation becomes available.

Proof of Publication

The following legal notice appeared in newspapers having general circulation throughout the State during late June and early July, 1978:

Legal Notice

The 1978 State Plan for comprehensive services relating to drug and alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs in Maine as provided for by federal legislation has been compiled. Upon approval of this plan, federal fiscal year 1978 funds in the amount of $488,159 will be allocated to the State for the development and implementation of these programs.

The State Plan addresses itself to such issues as expansion and modification of existing services and facilities.

A copy of the State Plan is available for examination at the Office of Alcoholism and Drug Abuse Prevention, 32 Winthrop Street, Augusta, Maine, 04330.

EXHIBIT A

STATE OF MAINE

Inter-Departmental Memorandum

Date March 24, 1978

To David Smith, Commissioner — Dept. Human Services

From Gov. James B. Longley — Dept. Executive

Subject Two Grant Applications - Office of Alcoholism and Drug Abuse Prevention

This office has received two grant approval requests from the Office of Alcoholism and Drug Abuse Prevention. The first is a State Plan Formula Grant of $488,163 to enable the State to coordinate its alcoholism and drug abuse prevention programs; the second is for $211,013 to supplement State alcoholism funds which are used to improve treatment services to public inebriates.

Inasmuch as these two grants comprise the basic funding sources of treatment services in the areas of alcoholism and drug abuse, I do hereby announce my support for the program.

JBL:mas

James B Longley

PART VI

DEFINITIONS

DEFINITIONS

Aftercare: The process of providing continued contact, after discharge from treatment, which supports and increases the gains made in the treatment process.

Alcohol Abuser: A generic term which refers to all persons who use alcohol to the extent that it interferes with their social or economic functioning or their physical or psychological health.

Alternatives: Those activities or projects established to direct or redirect people's harmful or potentially harmful drug activities toward positive behaviors.

Drug: Any chemical that modifies the function of living tissues, resulting in physiological or behavioral change.

Education: The process of training and developing knowledge, skills, and abilities in order to broaden understanding or modify perception. Education may lead to deeper comprehension of issues and finally, to altered behavior.

Emergency Care: A network of services that provides immediate diagnosis and care for acute alcohol or drug related problems, as well as appropriate referrals for continuing care after emergency treatment.

Information: Factual presentation. Not intended to change a person's attitudes. Material simply given to increase knowledge which may help people to obtain what they feel they need or want.

Inpatient Care: The process of providing 24-hour supervised care in a hospital or other suitably equipped medical setting for acute or chronic physical, emotional, and/or psychological problems associated with alcohol or drug abuse and/or alcoholism.

Intermediate Care: The process of providing substance abuse treatment services in a full (24-hour) residential therapy setting, or a partial (less than 24 hours) residential therapy setting.

Intervention: The process of interrupting people in the early stages of alcohol or drug abuse and providing referral services to appropriate treatment services. Intervention in the context of the criminal justice system is called 'diversion.'

Outreach: The process of reaching into a community systematically to identify persons in need of services, alerting them and their families to the availability of and location of needed services, and enabling persons to enter and accept the service delivery system.

Outpatient Care: The process of providing nonresidential diagnostic and substance abuse treatment services on both a scheduled and nonscheduled basis.

Prevention: That activity which helps people to make responsible decisions about the use of drugs, including the drug alcohol. This activity strives to reduce the potential for harm resulting from the abusive use of drugs. Prevention is primarily directed toward individuals who are not yet experiencing serious harmful effects resulting from the abusive use of drugs.

Shelter: The process of providing food, lodging, sanitation, and clothing to protect and maintain life, and motivating recipients to seek further treatment.

Substance Abuse Facility: Any establishment, organization, or institution - public or private - which offers or purports to offer, maintain, or operate one or more facilities for the diagnosis, care, treatment, or rehabilitation of two or more non-related individuals who are suffering physically, emotionally, or psychologically from the abuse of alcohol and/or other drugs of abuse, and which includes as part of its treatment a requirement that the persons physically reside on the premises.

A. Public Facility: A substance abuse facility operating under the direction and control of OADAP or providing treatment through a contract with OADAP, or any facility funded in whole or in part by municipal, state, or federal funds.

B. Private Facility: A substance abuse facility which is sponsored by an individual, firm, or corporation and which is not a public treatment facility.

APPENDICES

Appendix A

ENABLING LEGISLATION

APPROVED

JUN 28 '73

BY GOVERNOR

CHAPTER

566

PUBLIC LAWS

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-THREE

S. P. 635 — L. D. 2008

AN ACT Reconstituting and More Effectively Coordinating the Maine Commission on Drug Abuse and the Division of Alcoholism and Providing an Alternative Sentencing for Violators of Drug Laws.

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

Sec. 1. R. S., T. 22, Subtitle 4, Part 3, additional. Subtitle 4 of Title 22 of the Revised Statutes is amended by adding a new Part 3 to read as follows:

PART 3

DRUG ABUSE

CHAPTER 1601

ALCOHOLISM, INTOXICATION AND DRUG ABUSE PREVENTION, TREATMENT AND REHABILITATION

SUBCHAPTER I

GENERAL PROVISIONS

§ 7101. Short title

This Part may be cited as the 1973 Alcoholism and Drug Abuse Act.

§ 7102. Declaration of objectives

1. The serious problem of drug abuse, including the use of alcohol which results in chronic intoxication or alcoholism, must be confronted with the immediate objective of significantly reducing the incidence of such abuse in the State within the shortest possible period of time.

2. In order to efficiently and effectively accomplish this objective, it is essential to adopt an integrated approach to the problem and to focus all the varied resources of the State on developing a comprehensive range of drug abuse prevention and treatment services, conducted by one administrative unit.

3. It is, therefore, the objective of this Act to establish one office to coordinate the planning and operation of drug abuse services, including those related to the abuse of alcohol, and excepting those relating to the prevention of drug traffic, and to provide support and guidance to individuals, public and private organizations and especially local governments, in their drug abuse prevention activities.

§ 7103. Definitions

As used in this Act, unless the context otherwise indicates, the following words shall have the following meanings.

1. Administrative activities. "Administrative activities" means an activity related to guidelines, criteria, regulations, requirements or procedures for operations related to drug abuse prevention.

2. Agreement. "Agreement" means a legally binding document between 2 parties including such documents as are commonly referred to as accepted proposal, contract, grant, joint or cooperative agreement, or purchase of services.

3. 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.

4. Approved treatment facility. "Approved treatment facility" means a public or private nonprofit agency meeting the standards promulgated by the office pursuant to section 7115, subsection 1, and approved under section 7115, subsection 3 and licensed pursuant to section 5-A or pursuant to other applicable provisions of Maine law. An approved public treatment facility is a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under section 7114, subsection 6.

5. Commissioner. "Commissioner" means the Commissioner of Health and Welfare.

6. Department. "Department" means the Department of Health and Welfare.

7. Dependency related drug. "Dependency related drug" means alcohol or any substance controlled under chapter 551, subchapter II, and chapters 557 and 558.

8. Director. "Director" means the Director, Office of Alcohol and Drug Abuse Prevention.

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 section 7103, subsection 18 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 7123.

14. Incapacitated by alcohol. "Incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his 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 Alcoholism and Drug Abuse Prevention in the department established under section 7104.

18. 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.

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

20. 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.

21. 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 20.

SUBCHAPTER II

ORGANIZATION

§ 7104. Office of Alcoholism and Drug Abuse Prevention

There is created within the Bureau of Rehabilitation of the Department of Health and Welfare the Office of Alcoholism and Drug Abuse Prevention. The office shall be under the immediate and full supervision of the Director, Bureau of Rehabilitation. The office shall be the sole agency of State Government responsible for administration of this chapter. It shall be a separate, distinct administrative unit, which shall not be in any way integrated as a part or function of any other administrative unit of the department.

The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the Division of Alcoholism Services heretofore

fore established in the Department shall, by this Act and implementation of it, be reconstituted and unified into a single administrative unit, functioning as an integrated agency of State Government.

§ 7105. Director

The Office of Alcoholism and Drug Abuse Prevention shall be administered by a director, who shall be appointed, subject to the Personnel Law, under the classified service by the commissioner after consultation with the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. The director shall be a person qualified by training and experience with drug abuse, or alcoholism and intoxication, or who has had 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. He shall be immediately and fully responsible to the Manager, Office of Resource Development and shall not be indirectly responsible to any other official of the department.

The director shall serve full time in a position that is separate from and not in any way integrated with another position in the department. He shall not concurrently hold another title and shall perform duties solely germane to the powers and duties of the office as provided for in this chapter.

The director shall possess full authority and responsibility for administering all the powers and duties of the office provided in section 7106, except as otherwise provided by statute. He shall, with the advice of the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, assume and discharge all responsibilities vested in the office. He shall not in any case assign to another unit of the department which is not responsible to him any powers and duties granted to the office by statute, or by rules, regulations or procedures adopted pursuant to this chapter. He shall make full use of existing support services available in State Government to assist with carrying out the responsibilities set by this chapter.

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

§ 7106. Powers and duties

The office shall establish in accord with the purposes and intent of this chapter, and with the advice of the council and the cooperation of the coordinating committee, the overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic, which are conducted or supported in the State of Maine. In order to carry out the above, the office shall have the power and duty to:

1. Encourage and assist development of more effective, more coordinated, more efficient administration of resources and services available for drug abuse prevention;

2. Develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention. The information shall be available for use by the people of Maine, the political subdivisions, public and private nonprofit agencies and the State. Educational materials shall be prepared, published and disseminated. Objective devices and research methodologies shall be continuously developed. Uniform methods of keeping statistical information shall be specified for use by public and private agencies, or-

ganizations and individuals. Existing sources of information shall be used to the fullest extent possible, while maintaining confidentiality safeguards of state and federal law. Information may be requested and shall be received from any state government or public or private agency. To the extent feasible, information shall maintain compatibility with federal information sharing standards.

Functions of the drug information system shall include, but not be limited to:

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

B. Collecting, maintaining and disseminating such knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention as will enable the office to fulfill its responsibilities;

C. Determining through a detailed survey the extent of the drug abuse problem, and the needs and priorities for the prevention of drug abuse and drug dependence in the state and political subdivisions. Included shall be a survey of health facilities needed to provide services for drug abuse and drug dependence, especially alcoholics and intoxicated persons;

D. 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;

E. Conducting a continuous evaluation of the impact, quality and value of drug abuse prevention facilities, programs and services; including their administrative adequacy and capacity. Activities operated by or with the assistance of the State and Federal Governments shall be evaluated. Included shall be alcohol and drug abuse prevention and treatment services as authorized by this and so much of the several Acts and amendments to them enacted by the People of the State of Maine, and those authorized by the United States Acts and amendments to them as relate to drug abuse prevention:

(1) The Drug Abuse Office and Treatment Act of 1972 (P. L. 92-255);

(2) The Community Mental Health Centers Act (42 USC 2688);

(3) The Public Health Service Act (42 USC);

(4) The Vocational Rehabilitation Act;

(5) The Social Security Act;

(6) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P. L. 91-616) and similar Acts.

3. Assist, with the advice of the council and cooperation of the coordinating committee, the Legislature and executive branches and Judicial Council of State Government, especially the Governor, commissioner, and Bureau of the Budget, to coordinate all state government efforts dealing with drug abuse prevention and control, including alcoholism, by:

A. Submitting to each branch of State Government no later than September 1st of each year an annual report covering its activities for the immedi-

ate past fiscal year and future plans, including recommendations for changes in state and federal laws, and including reports of the council and coordinating committee;

B. Reviewing all proposed legislation, fiscal activities, plans, policies and other administrative functions relating to drug abuse prevention activities made by or requested of all state agencies. The office shall have the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and commissioner shall be advisory; and which in the case of other state agencies shall be binding. Such findings, comments and recommendations shall specify what modification in proposals or actions shall be taken to make proposed legislation, fiscal activities and administrative activities consistent with such policies and priorities;

C. Making recommendations to the respective branches of State Government concerning prevention of drug traffic and shall consult with and be consulted by all responsible state agencies regarding the policies, priorities and objectives of functions to prevent drug traffic.

4. Prepare and administer a comprehensive state plan mutually developed by the office, council and coordinating committee, relating to all drug abuse prevention and treatment of alcoholics and intoxicated persons and control of drug abuse. The comprehensive state plan shall be implemented for the purpose of coordinating all drug abuse prevention activities and of assuring compliance with applicable state and federal laws and regulation and with the state plan relating to drug abuse prevention. Implementation of this duty shall mean that the office shall have the authority to supervise through a review process the preparation and administration of any portion of any state plan relating to drug abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government to obtain federal funding under federal legislation. Such state plans, or portions thereof, shall include, but not be limited to, all state plans dealing with education, employment and vocational services, medical, rehabilitation, social services, welfare, drug abuse prevention and treatment of alcoholism and intoxicated persons.

The office shall advise the commissioner and Governor on preparation of and provisions to be included relating to drug abuse prevention and relating to alcoholism and intoxicated persons. Such state plans shall provide for methods of administration which will supplement, compliment and broaden related state plans, including, but not limited to, those developed under the U. S. Public Health Service Act, section 314 (2);

5. Plan, establish and maintain necessary or desirable prevention or treatment programs for individuals or groups of individuals, except that the office and its staff, whether assigned to the office or to operating units, may provide direct service only to a drug dependent individual or groups of such individuals, whose drug dependency is related to alcohol. The office may use the full range of its powers and duties to serve any drug dependent person through indirect services provided for by agreements;

6. Function as the organizational unit of Maine State Government with sole responsibility for conducting and coordinating, with the advice of the council and the cooperation of the coordinating committee, state programs and activities authorized by this chapter, and by the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970, as amended, and by the Drug Abuse Office and Treatment Act of 1972, as amended; and other programs or Acts of the State of Maine or United States related to drug abuse prevention which are not the specific responsibility of another state agency under federal or state law.

The Office is designated as the single agency of Maine State government solely responsible for administering the state plans required by those Acts;

7. Help communities mobilize their resources to deal with drug abuse. The office shall provide, or coordinate the provision of information, technical assistance and consultation to state, regional and local governments; and to public and private nonprofit agencies, institutions, organizations and individuals. The help shall be for the purpose of encouraging, developing and assisting with the initiation, establishment and administration of any plans, programs or services to prevent drug abuse.

Included in this duty is authority to coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in drug abuse prevention, especially alcoholism and treatment of alcoholics and intoxicated persons. The support and assistance of interested persons in the community, particularly recovered alcoholics and abusers of drugs, shall be utilized to encourage alcoholics and drug abusers voluntarily to undergo treatment;

8. Seek and receive funds from Federal Government and private sources to further its activities. Included in this function is authority to solicit, accept, administer, disburse and coordinate for the State in accordance with the intent, objectives and purposes of this chapter; and within any limitation which may apply from the sources of such funds, the efforts to obtain and the use of any funds from any source to treat alcoholism or prevent drug abuse. Any gift of money or property made by will or otherwise, and any grant or other funds appropriated, services or property available from the Federal Government, the State or any political subdivision thereof and from all other sources, public or private, may be accepted and administered. The office may do all things necessary to cooperate with the Federal Government or any of its agencies in making application for any funds. Included in this duty is authority to coordinate the disbursement of all state funds, or funds administered through agencies of State Government, appropriated or made available for drug abuse prevention. No fund transaction, including encumbrance or disbursement, shall be made for drug abuse prevention without approval of the office;

9. Enter into agreements necessary or incidental to the performance of its duties. Included is the power to make agreements with qualified community, regional and state level, private nonprofit and public agencies, organizations and individuals in this and other states to develop or provide drug abuse prevention and treatment facilities, programs and services. Such agreements may include provisions to pay for such prevention or treatment rendered or furnished to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or person in need of assistance due to use of a dependency related drug. Such contracts shall be executed only with agencies that meet the standards for treatment promulgated by the office under section 7115, subsection 1, and approved under section 7115, subsection 3, and licensed pursuant to section 5-A or other applicable provisions of law. The office may engage expert advisors and assistants who may serve without compensation, or to the extent funds may be available by appropriation, grant, gift or allocation from a state department, the office may pay for such expert advisors or assistants;

10. Prepare, adopt, amend, rescind and administer policies, priorities, procedures, rules and regulations to govern its affairs and the development and operation of facilities, programs and services. The office may adopt rules to carry out the powers and duties conducted under the authority in accordance with the purpose and objectives of this Act. It shall especially adopt such rules and regulations as may be necessary to define contractual terms, conditions of agreements and all other rules as are necessary for the proper administration of this chapter. Such adoption, amendment and rescission shall be made as provided under Title 5, chapters 307 to 375, Administrative Code;

11. 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 un-

der section 7115, subsection 1, and licensed pursuant to section 5-A 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. It shall fix and collect the fees for such 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;

12. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons and persons who abuse or are dependent on drugs. Assist in the development of, and cooperation with, alcoholic education and treatment programs for employees of state and local governments and businesses and industries in the State. Convene and conduct conferences of public and private nonprofit organizations concerned with the development and operation of drug abuse prevention programs. Included shall be the power to encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons who abuse or are dependent on drugs and to provide them with adequate and appropriate treatment. Also included is the power to encourage all health and disability insurance programs to include alcoholism as a covered illness;

13. Foster, develop, organize, conduct or provide for the conduct of training programs for all persons in the field of treating alcoholics and intoxicated persons and drug abusers;

14. Coordinate activities and cooperate with drug abuse prevention programs in this and other states for the common advancement of drug abuse prevention and alcoholism progra

15. Establish and maintain a principal office at the department's general headquarters, and such other offices within the State as it may deem necessary;

16. Do other acts and exercise such other powers necessary or convenient to execute and carry out the purposes and authority expressly granted in this chapter.

SUBCHAPTER III

ADVISORY COUNCIL

§ 7107. Maine Council on Alcohol and Drug Abuse Prevention and Treatment

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, hereinafter in this chapter referred to as the "council," is created. The council may appoint from its membership subcommittees relating to particular problem areas or to other matters, provided that by January 1, 1975 the council shall function as an integrated committee. 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. The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the advisory councils on alcoholism heretofore established in the department and by section 1352, as amended, shall, by this Act and implementation of it, be reconstituted and unified into a single unit.

§ 7108. Membership

The council shall consist of no more than 17 members who, excepting members representing the Legislature, shall be appointed by the Governor

with the advice and consent of the Executive Council. To be qualified to serve, members shall have education, training, experience, knowledge, expertise and interest in drug abuse prevention and training. Members shall be residents of different geographical areas of the State, who reflect experiential diversity and concern for drug abuse prevention and treatment in the State.

They shall be selected from outstanding people in the fields of education, health, law, law enforcement, manpower, medicine, science, social sciences and related areas. Members shall 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.

Membership shall include representatives of nongovernmental organizations or groups and of public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. At least 2 members of the council shall be current members of the Legislature, consisting of one member from the House of Representatives appointed by the Speaker of the House to serve at his pleasure and one member from the Senate appointed by the President of the Senate to serve at his pleasure. Two of the private citizen members shall be between the ages of 16 and 21. At least 3 members shall be persons recovered from alcoholism, chronic intoxication, drug abuse or drug dependence. At least 3 members shall 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. Membership may also include, but not be limited to, representatives of professions such as law, law enforcement, medicine, pharmacy and teaching.

Members shall be appointed for a term of 3 years, except that of the members first appointed, 5 shall be appointed for a term of 3 years, 5 shall be appointed for a term of 2 years and 5 shall be appointed for a term of one year, as designated by the Governor at the time of appointment; except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term, and except that members who are members of the current Legislature and who are appointed by the President of the Senate or the Speaker of the House shall serve at their pleasure. Any vacancy in the council shall not affect its powers, but shall be filled in the same manner by which the original appointment was made.

Members shall be eligible for reappointment for not more than one consecutive term and may serve after the expiration of their term 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 reason for the termination of each appointment shall be communicated to each member so 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 chairman. An official, employee, consultant or any other individual employed, retained or otherwise compensated by or representative of the Executive Branch of the Government of the State of Maine shall not be a member of the council; but shall assist the council if so requested. The director of the office or his representative shall attend all meetings of the council.

The Governor shall designate the chairman from among the members appointed to the council. The council may elect such other officers from its members as it deems appropriate.

§ 7109. Meetings, compensation, quorum

The council shall meet at the call of the chairman or at the call of ¼ of the members appointed and currently holding office. The council shall meet at least 5 times a year and at least once every 3 months. The council shall

keep minutes of all meetings, including a list of people in attendance. Minutes of all meetings shall be sent forthwith to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

Members of the council shall serve without compensation, but they may be reimbursed on the same basis as employees of state departments for the actual travel and other necessary expenses incurred in the performance of their duties.

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.

§ 7110. Powers and duties

The council, in cooperation with the office and coordinating committee, shall have the power and duty to:

1. Advise, consult and assist the Executive and Legislative Branches of the State Government and the Judicial Council, especially the Governor, on activities of State Government related to drug abuse prevention and treatment, 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 or coordinating committee, such 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 shall not be delegated any administrative authority or responsibility.

2. Serve as an advocate on alcoholism and drug abuse prevention and treatment, 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 Maine State Government. It shall be a spokesman on behalf of drug abuse prevention to the director, commissioner, Governor, Legislature, public at large and National Government;

3. Serve as the advisory council on behalf of the State of Maine to the state agency 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 such other Acts of the United States as may heretofore or hereafter be enacted. The council shall advise regarding state and federal plans, policies, programs and other activities relating to the drug abuse and drug dependence in Maine. The council shall submit their recommendations and comments on the state plan, and any revisions thereof, and reports to federal or state agencies. Statements at variance or in addition to those of the office or the coordination committee 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. Serve, through a subcommittee of the council consisting of 5 persons including the chairman and 4 other members appointed by the chairman with the advice and consent of the Governor, as the review committee on behalf of the State of Maine responsible for analysis and recommendation to the director concerning the acceptability of proposals requesting award of state administered grant funds for drug abuse prevention and treatment under the United States Comprehensive Alcohol Abuse and Alcoholism Prevention,

Treatment and Rehabilitation Act of 1970 and the United States Drug Abuse Office and Treatment Act of 1972, and in order to insure coordination and prevent duplication of services shall review and comment on, under its own initiative or at the request of any state or federal department or agency, any application from any agency or organization within the State to a state or federal department or agency for financial assistance related to meeting the needs of people who abuse or are dependent on drugs;

5. Review and evaluate on a continuing basis, in cooperation with the office, for the purpose of determining the value and impact on the lives of people who abuse or are dependent on drugs, 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;

6. Inform the public in cooperation with the office, 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 elsewhere in the State or Nation, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports;

7. Provide public forums, including the conduct of public hearings, sponsorship of conferences, workshops and other such meetings to obtain information about, discuss and publicize the need of and solutions to drug abuse and drug dependence. The council may hold a state-wide conference, regional conferences and meetings;

8. Administer in accordance with current fiscal and accounting regulations of the State, and in accordance with the philosophy, objectives and authority of this Act, any funds appropriated for expenditure by the council or any grants or gifts which may become available, accepted and received by the council; and make, to be included in the annual report of the office, an annual report to the director, commissioner, Governor and Legislature not later than September 1st of each year concerning its work, recommendations and interests of the previous fiscal year and future plans; and shall make such interim reports as it deems advisable.

SUBCHAPTER IV

COOPERATING STATE AGENCIES, PROGRAMS AND TREATMENT

§ 7111. State Government Coordinating Committee

1. The State Government Drug Abuse Coordinating Committee is established. It shall, in cooperation with the advisory council and office, recommend policy to be established and implemented by state government agencies. It shall assist with the coordination of, and exchange of information on, all drug abuse prevention and control activities of the State of Maine. It shall act as a permanent liaison among the branches of Maine State Government and their agencies engaged in or expected to engage in activities affecting drug abuse or drug dependent people. The committee shall assist the Legislative and Executive Branches and Judicial Council in formulating and implementing a comprehensive plan, mutually developed by the advisory council, coordinating committee and office for prevention and control of drug abuse and drug dependence, especially treatment of alcoholics and intoxicated persons. The office shall provide any ordinary administrative and financial assistance to the coordinating committee as may be reasonably required from time to time to carry out its activities. Reasonable and proper expenses of the committee shall be paid from currently available state or federal funds. The committee shall meet at least twice annually at the call of the commissioner, who shall be its chairman.

2. In exercising its coordinating functions, the committee shall assure that:

A. The appropriate agencies of State Government shall provide all necessary career, educational, employment, health, judicial, law enforcement, legal, medical, penal, psychiatric, psychological, rehabilitative, social, treatment and vocational services for drug abusers and drug dependent persons and for prevention and control of drug abuse and drug dependency without unnecessary duplication of services;

B. The agencies of the several branches of State Government cooperate in the use of facilities and in the treatment of drug abuses and drug dependent persons;

C. All agencies of State Government shall adopt policies to control use of drugs, prevent drug abuse and to treat drug abusers and drug dependent persons, especially alcoholics and intoxicated persons in a manner consistent with the policy of this chapter;

D. Minutes of all meetings shall be sent to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

3. The committee membership shall consist of not more than 17 members, who shall include, but not be limited to, the following members, who shall serve ex officio, or their designated representatives:

The Attorney General;

The Chief Justice, as Chairman of the Judicial Council;

The Director of Law Enforcement Planning and Assistance;

The Director, Office of Alcohol and Drug Abuse Prevention;

The Commissioner of Educational and Cultural Services;

The Commissioner of Health and Welfare;

The Commissioner of Manpower Affairs;

The Commissioner of Mental Health and Corrections;

The Commissioner of Public Safety;

The Commissioner of Transportation;

The Governor;

The President of the Maine Senate;

The Speaker of the Maine House of Representatives;

The State Youth Coordinator;

and other appropriate officials.

§ 7112. State agencies to cooperate

State agencies proposing to develop, establish, conduct or administer drug abuse prevention programs or to assist with such programs as covered by this chapter shall, prior to carrying out such actions, consult with the office to obtain the approval of the office to conduct such action.

All agencies of State Government shall advise the office of their proposed fiscal activities, especially budget requests and expenditures, concurrently

with their submission to the Budget Office or to the Governor. All agencies of State Government, concurrent with submission to that agency's approval authority, shall advise the office of proposed legislation, fiscal activities and administrative activities relating to drug abuse prevention. No such action shall be taken related to drug abuse prevention without approval of the office. State agencies shall, in the implementation of their activities, keep the office fully informed of their progress and of any proposed changes in fiscal matters and policy.

State agencies shall cooperate fully with the office and council in carrying out this chapter. The office and council are authorized to request such personnel, financial assistance, facilities and data as will assist the office and council to fulfill its powers and duties.

The office shall cooperate with the Department of Mental Health and Corrections and all institutions under its control in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons and for people who abuse or are dependent on drugs in or on parole from penal or special treatment institutions.

The office shall cooperate with the Department of Public Safety and the Department of Transportation in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of drugs or intoxicating liquor.

The office shall coordinate all drug abuse education, information and training programs conducted within the State through cooperation with the Department of Educational and Cultural Services, school administrative districts, municipal schools, police departments, courts and other public and private agencies, organizations and individuals. Such coordination may assist with: Establishing educational programs for the prevention of alcoholism and drug abuse; treatment and rehabilitation of alcoholics, intoxicated persons and persons dependent upon or abusing drugs; training in the prevention, treatment and rehabilitation of such persons; and with preparation of curriculum materials thereon for use in all levels of educational programs.

§ 7113. State drug abuse strategy

Immediately upon the day this Act becomes effective, the Governor shall direct the development of a comprehensive, coordinated long-term state strategy for all drug abuse prevention functions and all drug traffic prevention functions conducted, sponsored or supported by any agency of State Government. The strategy shall be initially promulgated by the Governor no later than January 1, 1975.

To develop the strategy, the office, council and coordinating committee shall mutually participate to achieve its preparation. The strategy shall be subject to review and written comment by those state officials participating in its preparation.

The strategy shall contain:

1. An analysis of the nature, character and extent of the drug abuse problem in Maine, including examination of the interrelationships between various approaches to solving the drug abuse problem and their potential for interacting both positively and negatively with one another;

2. A comprehensive plan, with respect to both drug abuse prevention functions and drug traffic prevention functions, which shall specify the objectives of the strategy and how all available resources, funds, programs, services and facilities authorized under relevant law should be used; and

3. An analysis and evaluation of the major programs conducted, expenditures made, results achieved, plans developed and problems encountered in

the operation and coordination of the various drug abuse prevention functions and drug traffic prevention functions.

The strategy shall be reviewed, revised as necessary and promulgated as revised from time to time as the Governor deems appropriate, but not less often than once every 2 years.

§ 7114. Comprehensive program on alcoholism and drug abuse

1. A comprehensive and coordinated program of drug abuse prevention and treatment, especially of alcoholics and intoxicated persons, is established. Nothing in subsequent sections shall be interpreted as preventing the establishment of additional drug abuse prevention and treatment programs, including programs which the office considers necessary or desirable for intoxicated persons and alcoholics.

2. The program shall include:

A. Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

B. Inpatient treatment;

C. Intermediate treatment; and

D. Outpatient and followup treatment.

3. The office shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 7117 to 7120. Treatment may not be provided at a correctional institution, except for inmates.

4. The office shall maintain, supervise and control all facilities operated by it subject to policies of the department. The administrator of each facility shall make an annual report of its activities to the director in the form and manner the director specifies.

5. All appropriate public and private resources shall be coordinated with and utilized in the program, if possible.

6. The office may contract for the use of any facility as an approved public treatment facility, if the director, subject to the policies of the department, considers this to be an effective and economical course to follow.

§ 7115. Standards for public and private alcohol or drug abuse treatment facilities; enforcement procedures; penalties

1. The department shall establish standards for approved treatment facilities, 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 department for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

2. The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

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

4. Each approved public and private treatment facility shall file with the department on request data, statistics, schedules and information the department 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 thereof, shall be removed from the list of approved treatment facilities.

5. The District Court may restrain any violation of this section, review any denial, restriction or revocation of approval and grant other relief required to enforce its provisions.

6. The department may at reasonable times enter and inspect and examine the books and accounts of any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this Act.

§ 7116. Acceptance for treatment of alcoholics and intoxicated persons; rules

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

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

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

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

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

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

5. 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.

§ 7117. Voluntary treatment of alcoholics

1. 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, he, a parent, a legal guardian or other legal representative may make the application.

2. Subject to rules adopted by the director, 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 director, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

3. If a patient receiving inpatient care leaves an approved public treatment facility, he 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. 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 his transportation to another facility or to his home. If he has no home, he shall be assisted in obtaining shelter. If he 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.

§ 7118. Treatment and services for intoxicated persons and persons incapacitated by alcohol

1. 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 he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility or other health facility by the police or the emergency service patrol.

2. A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available, he 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 him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

3. A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician forthwith. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

4. A person, who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility once he is no longer incapacitated by alcohol, or if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under section 7119. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

5. 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 to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

6. If a patient is admitted to an approved public treatment facility, his 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, his request shall be respected.

7. 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 therefor.

8. 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.

§ 7119. Emergency commitment of an incapacitated or intoxicated person

1. 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. 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 he has examined the person sought 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. 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 to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection 5.

4. 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. When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he 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 7120 has been filed within the 5 days and the adminstrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

6. 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.

§ 7120. Involuntary commitment of alcoholics or incapacitated persons

1. A person may be committed to the custody of the office by the District Court upon the petition of his 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 that he has threatened, attempted or inflicted physical harm on another and that 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. 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, his next of kin other than the petitioner, a parent or his legal guardian, the administrator in charge of the approved public treatment facility to which he 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. 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 his presence is likely to be injurious to him; in this event, the court shall appoint a guardian ad litem to represent him 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, he shall be given an opportunity to be examined by a court-appointed licensed physician. If he 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 him to the division for a period of not more than 5 days for purposes of a diagnostic examination.

4. 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 for him and the treatment is likely to be beneficial.

5. 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, he shall be discharged automatically, unless the office before expiration of the period obtains a court order for his 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 because he is 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. 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 because he is 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. 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, his next of kin other than the petitioner the original petitioner under subsection 1, if different from the petitioner for recommitment, one of his parents or his legal guardian and any other person

the court believes advisable. At the hearing the court shall proceed as provided in subsection 3.

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

9. 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 he 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 he 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, that 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. The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of any proceedings relating to his commitment and recommitment and have counsel appointed by the court or provided by the court, if he 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 for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his 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. If a private or public treatment facility agrees with the request of a competent patient or his parent, sibling, adult child or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

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

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

§ 7121. Records

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

2. 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.

§ 7122. Visitation and communication of patients

1. 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. 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. 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 his property.

§ 7123. Emergency service patrol; establishment; rules

1. 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 to 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. The director shall adopt rules for the establishment, training and conduct of emergency service patrols.

§ 7124. Payment for treatment; financial ability of patients

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

2. A patient in an approved 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 office for cost of maintenance and treatment of the patient therein in accordance with rates established.

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

Sec. 2. R. S., T. 5, § 2301, sub-§ 1, ¶ I, additional. Subsection 1 of section 2301 of Title 5 of the Revised Statutes, as amended, is further amended by adding a new paragraph I to read as follows:

I. Approved treatment facilities as defined in Title 22, section 7103.

Sec. 3. R. S., T. 5, c. 317, repealed. Chapter 317 of Title 5 of the Revised Statutes, as enacted by chapter 370 of the public laws of 1971, is repealed.

Sec. 4. R. S., T. 22, §§ 1351 and 1352, repealed. Sections 1351 and 1352 of Title 22 of the Revised Statutes are repealed.

Sec. 5. R. S., T. 34, § 1631, sub-§§ 5 and 5-A, additional. Section 1631 of Title 34 of the Revised Statutes, as amended, is further amended by adding 2 new subsections 5 and 5-A to read as follows:

5. Sentence to drug abuse treatment facility. In any case in which the offense relates to violation of any statutes concerning controlled or illegal

drugs or the sale or possession of drugs or narcotics, the court may impose sentence and place the person on probation. The court may require as a condition of probation that such person shall participate in, as a resident or nonresident, programs at an approved treatment facility as defined under Title 22, chapter 1601, provided the Office of Alcohol and Drug Abuse Prevention certifies to the court that such approved treatment facilities, personnel and programs are available and in compliance with all state licensing and certification laws, standards, rules and regulations.

Any person so sentenced to probation shall be required to participate in programs at the facility for a period not to exceed the period of probation ordered by the court. The professional staff of the facility may determine that the person's participation in treatment should be terminated. The supervisor or professional staff of the treatment facility may make such a determination when in their judgment the person:

A. Has successfully completed treatment or will derive no further significant benefits from such participation, or both, or

B. Will adversely affect the treatment of other participants by his continued participation, or

C. Has not conducted himself in accordance with the provisions of his sentence or probation.

When the professional staff of the treatment facility determines that the person's participation should be terminated, the supervisor of the treatment facility or the probation officer shall make a report to the court, which may thereupon make such provision with respect to the person's probation as the court deems appropriate.

5-A. Definition. For purposes of this section, "drug abuser" shall mean any person convicted of any violation of any statutes relating to controlled or illegal drugs.

Sec. 6. Transitional provisions.

1. Effect of transfer of powers, duties and functions. The Office of Alcoholism and Drug Abuse Prevention of the Department of Health and Welfare shall be the successor in every way to the powers, duties and functions of the former Division of Alcoholism Services and the former Maine Commission on Drug Abuse, or any of their administrative units, except as otherwise provided in this Act. The Director, Office of Alcoholism and Drug Abuse Prevention shall be the successor in every way to the responsibilities of the former Executive Director, Maine Commission on Drug Abuse and the former Director, Division of Alcoholism Services.

2. Rules, regulations and procedures. All existing regulations in effect, in operation or promulgated in or by the Maine Commission on Drug Abuse and the Division of Alcoholism, or in or by any administrative units or officer thereof, are hereby declared in effect and shall continue in effect until rescinded, revised or amended by the proper authority.

3. Contracts, agreements, compacts. All existing contracts, agreements and compacts currently in effect in the Maine Commission on Drug Abuse and the Division of Alcoholism shall continue in effect.

4. Personnel. Any positions authorized and allocated subject to the Personnel Law, to the former Maine Commission on Drug Abuse and the former Division on Alcoholism are transferred to the Office of Alcoholism and Drug Abuse Prevention and may continue to be authorized to the office. Initial appointments to such positions vacant as of the effective date of this Act shall be made on an open competitive basis. Any employee and official of such former agencies subject to the Personnel Law on the effective date

of this Act may be transferred to the office and continue their employment after the effective date of this Act, without interruption of their state service, unless personnel positions or such office is terminated or abolished or method of appointment or employment is altered or changed by the provisions of this Act. Any positions in the unclassified service allotted to the Maine Commission on Drug Abuse are abolished. The office and title of Executive Director, Maine Commission on Drug Abuse and of Director, Division of Alcoholism are abolished.

5. Records, property and equipment. All records, property and equipment previously belonging to or allocated for the use of the Division of Alcoholism or the Maine Commission on Drug Abuse shall become on the effective day of this Act, part of the property of the Office of Drug Abuse and Prevention, Department of Health and Welfare.

6. Conflicts. All acts or parts of acts and rules inconsistent with this Act are repealed or amended to conform hereto.

7. Funds and equipment transferred. Notwithstanding the Revised Statutes, Title 5, section 1585, all accrued expenditures, assets, liabilities, balances of appropriations, transfers, revenues or other available funds in any account, or subdivision of an account, of any agency to be reallocated to another administrative unit as a result of this Act, shall be transferred to the proper place in an account for the office, by the State Controller, upon recommendation of the department head, the State Budget Officer and upon approval by the Governor and Executive Council. A proper accounting shall be made by activity within the account.

8. Effective date. This Act shall become effective October 1, 1973 in the event the Legislature adjourns on or before July 1, 1973 or otherwise shall become effective January 1, 1974.

IN HOUSE OF REPRESENTATIVES,.....1973

Read twice and passed to be enacted.

.....*Speaker*

IN SENATE,.....1973

Read twice and passed to be enacted.

.....*President*

Approved.....1973

.....*Governor*

Appendix B

52 Winthrop Street
Augusta, Maine 04330

Tel: 207-289-2781

OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

GRANT GUIDELINES

I. General:

A. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, make, by allotment, Federal Funds available to this State under a formula grant basis. The State Administrator may provide a portion of these funds to: State, regional and local public and private non-profit agencies and organizations for participation in programs under these Acts. In addition, some State funds are made available for the same purposes.

B. Almost any type of project activity may be fundable, provided that the activity is based upon:

1. the Alcoholism State Plan or Drug Abuse State Plan.

2. the development of new or innovative programs to fill gaps in existing services or to expand the reach of existing services.

3. the ultimate integration of services and resources of all State, regional, and local public and private agencies assisting alcohol or drug abusers, or high-risk persons as defined in the Drug Abuse State Plan, and the Alcoholism State Plan.

C. The use of Federal/State funds must not result in a decrease in the effort of providing local alcohol or drug abuse prevention services. To the extent feasible, this program is designed to stimulate an increase in local effort.

D. The major thrusts of the grant program are for the delivery of services, and ongoing planning and coordination of all alcohol and drug abuse prevention, treatment and rehabilitation efforts.

E. OADAP may fund up to 75% of a proposed alcoholism or drug abuse project subject to the availability of funds.

II. Program Guidelines:

A. Project design, identification and justification are basically the same as those in developing any other type of funding proposal.

B. The project documentation features shall include the following specific information where applicable:

1. Statement of Need: In this part, identify in detail the problem which this project is intended to address. Accurate problem definition is essential. The problem as described here must be specifically related to the activities or effort proposed. Describe the problem in a manner which offers the potential to observe and measure its dimensions before, during and after the project activity.

As a minimum this item should:

a. Describe the nature and scope of the problem addressed in this application.

b. Provide supporting facts and figures which describe the existence of this problem and a summary of your analysis of the implications of this information.

c. Describe the underlying causes of the problem.

d. Provide a clear description of the impact or effect of the problem on other agencies or groups.

2. Goals and Objectives:
This section is vital to the application. It should clearly and concisely present the goal statement and measurable objectives for the project. In other words, this section should describe precisely what the project will achieve and/or demonstrate. The goal statement and measurable objectives presented in this section should be directly related to the statement of the problem so that the project can be monitored and/or evaluated in terms of its ability to resolve the problem identified.

a) Specify a goal statement for the project. The goal statement should clearly communicate the intended result of the project as of the end of the grant period. The goal statement identifies, before the project starts, what must happen or be achieved in order for the project to be considered a success. The goal statement must be precise enough so that a person could, on the basis of project records and data, determine if the project goal has been achieved.

Below is one method for writing a precise goal statement:

(1) Identify the terminal (end) behavior or condition which will be accepted as evidence that the project has achieved its goal.

(2) Try to further define the desired behavior or condition by describing the important limits or circumstances under which the behavior and/or conditions will be expected to occur.

(3) If possible, specify the criteria of acceptable performance and/or results by defining the minimum acceptable functioning level of the project.

NOTE: Complex projects may have more than one goal statement.

b. Identify implementation objectives for the project. Implementation objectives reflect major activities necessary to begin the project. They should be stated in the order in which they will happen. Describe how completion of each activity will be documented.

c. Identify performance objectives for the project. Performance objectives indicate major activities necessary to conduct the project as planned. Each performance objective should incorporate, where applicable, specific behavior, the method or procedures to be followed, time specifications and how achievement of the objective will be documented. Performance objectives should answer the questions 1) Who? 2) What? 3) Where? 4) When? 5 How? 6) Under what conditions? 7) To what level of acceptance? 8) As documented by what?

If this is a continuation of a previously funded project then the prior year's goals and objectives must be indicated along with a statement of the progress made toward achieving each specific goal or objective.

3. Project Description: Describe physical requirements for the project to be funded. List the types of clients to be served and describe the services to be delivered. Provide a list of project personnel requirements with job descriptions and special training and education requirements. Explain how this project will be made available to the specific client groups and identify sources of referral to and from your project. Indicate the relationship of each project activity to the goals and objectives. If this is a Single Purpose request, then describe only that purpose and indicate the impact on your program of not funding the request.

4. Project Budget: The budget should be prepared listing the total expense for each line item and identifying the OADAP share of the line. It will be assumed that this budget may be applied evenly for each quarter of the grant year unless otherwise noted in the grant request.

5. Line Item Costs Justification: You must show the basis of cost for each major category line in the budget. This may be done by showing the process used to arrive at the line expense total. If an estimate is used from a supplier or contractor then give the name of the firm and/or person from which the estimate was obtained.

6. Summary of Project Personnel: List each position or job title relative to the grant activity. State the number of persons who will hold each position or job title and the number of hours to be spent weekly on the project for each position. Show the total salary expense for that position or job title.

A breakdown of fringe benefit costs should also be provided. The maximum fringe benefit ceiling allowed by the state should not be exceeded.

7. Sources of Income: All sources of income must be listed (including "in kind" services). Show contract dates and indicate the amount represented by each source. If this is a continuation of a previously funded proposal then show the increase or decrease from the previous budget.

8. Future Project Funding: Describe the steps that your agency plans to take concerning funding for this project for at least one year following the requested termination date of this grant. Identify sources of funding and indicate the proportion of the project that each source is expected to support. If this is a continuation of current activity request, then describe the progress which has been made during the previous funding period toward achieving funding goals.

9. Evidence of Community Support:

   a. List any inter-agency agreements which concern this project, and indicate in what ways they have been utilized, and how they will be used during the requested grant period.

   b. Describe the involvement that the local community has had in developing this project. What attempts will be made to solicit local community support during the project period?

   c. Provide evidence of community support if possible in the form of unsolicited endorsement letters from community leaders, municipal officials, legislative representatives, former clients (with the client's written permission only!), and other concerned citizens.

10. Assurance of Compliance with the Department of Health, Education and Welfare Regulation under Title VI of the Civil Rights Act of 1964: A signed and properly filled in copy of the illustrated affidavit must be included with the grant application. See Figure 11 - 1.

11. Applicant Certification and Governing Authority review: The applicant must certify that the application is complete and accurate and that they have read and will abide by these grant guidelines. The application must be reviewed and approved by the governing authority of the agency prior to submission to OADAP. A statement of approval must be signed by the principal board officer.

12. Delivery of Services: Use of OADAP funds for support of services is designed to fill gaps in the existing service structure in the State and for expansion of services for persons not now receiving services.

13. Proposal Submission: Grant proposals for OADAP funds will be submitted

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

_____ (hereinafter called the "Sponsoring Agency")
(Sponsoring Agency)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Sponsoring Agency by the Department, this assurance shall obligate the Sponsoring Agency, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Sponsoring Agency for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Sponsoring Agency for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Sponsoring Agency by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Sponsoring Agency recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Sponsoring Agency, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Sponsoring Agency.

Dated _____

_____
(Chief Administrator of Sponsoring Agency)

By _____
(Project Director, if different)

to OADAP regional planning and coordinating agencies. Regional review and comment data and OADAP recommendations will then be submitted to OADAP's State Advisory Council for final review and comment. OADAP will then make a final decision as to the disposition of the proposal.

14. Evidence will be submitted that the grant request has been comprehensively planned and that appropriate local and regional agencies coordination has been fully accomplished.

15. The applicant will comply with all the provisions of these guidelines and procedures.

16. Methods of Administration: The public or private agency submitting the project proposal assures that:

a) Funds paid to the agency under this plan will be used to make a significant contribution toward improving the quality, scope and extent of alcohol and/or drug abuse treatment, rehabilitation or prevention services.

b) Funds paid will be further used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available for the purposes for which these funds are provided and will not supplant local funds.

c) There will be applicant/agency participation in the cost of carrying out the project at the rate of at least 25% of the project costs.

d) Methods and procedures for properly charging project costs will be established and maintained. Fiscal procedures will be adequately described in writing and made available to OADAP on request.

e) In accordance with Title VI of the Civil Rights Law of 1964 (42 U.S.C. 200d et. seq.) and the regulation issued thereunder by the U.S. Department of Health, Education, and Welfare (45 DFR Part 80) no individual shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under the project submitted.

f) All information as to personal facts and circumstances obtained by the agencies or other private nonprofit agencies, groups or organizations, to whom funds are paid by the State, will be held confidential and will not be divulged without the individual's consent in accordance with current federal regulations except as necessary to provide services to him. Each project proponent agency will establish adequate procedures to carry out this provision and to adequately protect the rights of persons with respect to whom confidential information is held.

g) Applicants for projects shall be in compliance with the U.S. Department of Health, Education, and Welfare policy concerning Human Rights: Copies of HEW Regulations concerning Human Rights are maintained for reference purposes by OADAP at 32 Winthrop Street, Augusta.

h) The project or facility to be provided funds will furnish a community service, and that consideration will be given to the involvement of residents of the community in management and operation of the project, or if applicable, the facility.

i) The project or the facility will furnish services to all persons in need of such services regardless of ability to pay.

j) All portions and services of the project, and if applicable, of the entire facility of which, or in connection with which, OADAP funds are sought, will be made available without discrimination on account of sex and creed and no professionally qualified person will be discriminated against on account of sex and creed with respect to the privilege of professional practice in the facility.

k) Resumés detailing the professional qualifications of project staff and key operating personnel, responsible for the operation of service projects or facilities funded under these guidelines will be provided upon request by OADAP.

l) The grantee understands that all service projects funded will normally be scheduled for termination on June 30. Projects scheduled for a time length of more than 12 months will only be considered for funding by the single state agency for a specific year. In the event of multi-year project proponents the successive fiscal year funding or continuing projects will be dependent upon Federal/State funding levels and annual approval of OADAP. At the present time there are no provisions for extended time length projects.

No obligations made before the starting or after the termination date may be charged to a grant.

Such projects when submitted will be considered for funding subject to these conditions:

..... The annual availability of Federal/State funds
..... Relative success or failure of the project
..... Annual approval of the project by OADAP

m) Any major change in the scope of the project (policy, objectives or goals) for funded projects must receive prior written approval of the single state agency responsible for administration of the program. Personnel changes must be reported to OADAP within 5 working days of their occurence.

Permissible changes in the approved project shall be limited to minor changes in methodology, approach, or other aspects that would expedite achievement of the project's objectives as long as the original objectives are not changed. Such changes

may not result in increasing the cost of the project to OADAP. Whenever the grantee, or program director, is uncertain as to whether any change complies with the above provision, the question shall be referred to the OADAP for resolution.

n. Expenditures will follow the major budgetary categories established in the application. Prior written approval of the grantor is required for the transfer of funds between established budget categories when the amount exceeds 5% of the total grant. Requests for rebudgeting will be submitted to the Director of OADAP outlining the justification for rebudgeting.

o. The budget categories between which funds are to be transferred will be clearly defined with full justification.

p. Subgranting is not allowable. The grantee may not, in whole or part, delegate or transfer responsibility for the use of project funds to any other institution, organization, or person.

q. Accounting of project funds provided will be in accord with grantee standard accounting practices, based upon generally accepted principles, consistently applied, regardless of the source of these funds. Itemization of all supporting records of fund expenditures must be recorded in sufficient detail to show the exact nature of the expenditures. Where personnel costs apply to two or more activities or projects, such costs involved will be appropriately prorated and explained.

r. The retention of essential records is required. Project accounting records are considered to be essential. Records required for retention include all original receipt and expenditure documents that support and substantiate charges to project activity. All recipients of project funds are required to maintain accounting records, as follows:

(1) Records may be destroyed three years after the end of the budget period if audit, by or on behalf, of the state agency has occurred by that time.

(2) If audit, by or on behalf of the state agency, has not occurred by that time, the records must be retained until audit or until five years following the end of the budget period, whichever is earlier.

(3) In all cases an overriding requirement exists to retain records until resolution of any audit questions relating to individual grants.

(4) Project records are subject to inspection and audit by state and federal representatives:

(a) To verify financial transactions and determine whether funds were used in accordance with applicable laws, regulations, and procedures;

(b) To ascertain whether policies, plans, and procedures are being followed;

(c) To provide management with objective and systematic appraisals of financial and administrative controls and information as to whether operations are carried out effectively, efficiently and economically; and

(d) To determine reliability of financial records and reports.

ε) The audit activity is not intended to review technical aspects of the conduct of the project. The audit is performed in accordance with generally accepted auditing practices in determining that there is a proper accounting for and use of grant funds. If the grantee fails to appeal a proposed audit disallowance within 30 days of receipt of written notification, the disallowance becomes final.

t) Obligations, commitments, encumbrances, or expenditures normally will be made within the budget period indicated on the agreement. (The agreement is a document which will be tendered to grantees upon acceptance of their project application). Project funds may not be used to reimburse obligations, commitments or expenditures made prior to the beginning date of an initial grant for a new or renewal project.

u) Title to equipment purchased with grant funds is vested in the grantee and the equipment must be accounted for during and after the end of the project period. The state agency reserves the right to determine final disposition of equipment.

w) Upon termination of the project, grant, or agreement for any reason, funds issued to the grantee and not expended or obligated will be returned to the grantor.

17. The following guidelines apply to specific budget items:

a) Bonus Payments: Not allowable.

b) Consultant Services: Allowable, subject to the following restrictions:

(1) Consultant fees may not be paid to a State or to a U.S. Government employee.

(2) Consultant fees may be paid to an employee of the grantee institution only under unusual circumstances and with prior approval of the OADAP.

The grantee agency policy prevails as to determination of consultant fees. In the absence of agency policy any questions concerning appropriateness of consultant fees should be referred to the OADAP.

c) Contingency Funds or Reserves: Not allowable.

d) Depreciation or Use Allowance: Not allowable for real or personal property (buildings or equipment).

e) Dues: Not allowable except when incurred because membership in professional organizations or societies is required to obtain publications necessary to the project.

f) Entertainment: Not allowable for costs of amusements, social activities, entertainment, or incidental costs related thereto.

g) Equipment: Allowable; however, prior OADAP approval is required for:

(1) any item of equipment costing in excess of $1,000;
(2) printing equipment;
(3) audio-visual equipment; and
(4) equipment for offices, conference rooms, and similar facilities.

Equipment may be rented but not purchased from grant related funds in support of conferences.

For purposes of charging project grant funds, the cost of a single unit or piece of equipment includes necessary accessories, duty, excise, and sales taxes (unless the institution is exempt from such taxes). If the institutional policy provides that charges for transportation, protective-in-transit insurance, and installation are a part of the cost of equipment, such charges must be included in the equipment costs if they are to be charged to OADAP funds. Whenever possible, equipment purchases will be made within the first quarter of the grant period.

h) Equipment Maintenance and Repairs: Allowable on equipment used specifically on the OADAP supported project.

i) Equipment Rental: Allowable provided the equipment is not owned by the grantee. Rental charges to the project must be made in conformance with grantee policies and in the same manner that similar charges are made to any account.

j) Fringe Benefits: Allowable for employer's share to the extent that such payments are made under formally established and consistently applied institution policies, uniformly charged as a direct cost on an actual rather than an estimated basis, and charged in proportion to salary charged to the project (exceptions may be granted on a case for spacific circumstances by OADAP). The employee's share is part of the gross salary and included therein. Not allowable for trainees.

k) Honorarium: Not allowable. An honorarium is considered a payment or reward whenever the primary intent is to confer distinction on, or to symbolize respect, esteem, or admiration for the recipient. A consultant fee, on the other hand, is compensation for services rendered and is allowable.

other liability insurance to cover personnel directly connected with the project. Not allowable for premiums on government owned equipment.

m) Land: Not allowable for purchase costs.

n) Leave: Allowable when earned on the project which the grant is supporting and prorated in accordance with the salary charged to the project. Not allowable for trainees.

o) Meals: Allowable for persons receiving service or when an agency or program customarily provides for meals to employees working beyond the normal workday, or as a part of the salary arrangement.

p) Publication Costs: Allowable subject to prior approval for cost of publishing books, monographs, pamphlets, etc., describing project activities, however, an acknowledgement of support must be made through use of the following or comparable footnote*:

> *This project was supported by Grant No._____awarded by the State of Maine Office of Alcoholism and Drug Abuse Prevention.

q) Recruitment Costs: Allowable for full-time employment on OADAP supported projects, including the charges for want ads, transportation for an interview, and other costs, if payment of such costs is normally made by the grantee regardless of the source of funds. Allowable are costs of descriptive brochures or other costs directly related to the recruitment of trainees. Not allowable are payments to prospective trainees for transportation, per diem, or other related recruiting costs. Now allowable, also, are moving expenses of employees.

r) Rental of Space: Allowable when charges are made in conformance with grantee policies and in the same manner that similar charges are made to any account. Expenses for the alteration of rented facilities will be detailed as a cost item (other). Full cost particulars will be provided and justified for such expenses.

s) Salaries and Wages: Allowable for time or effort spent on a supported project. Rate must be consistent with salaries paid from grantee funds. Salary and wage rates must be in conformity with those permitted by the grantee's wage and salary scales and policies.

t) Supplies: Allowable.

u) Taxes: Allowable only for those taxes which a grantee is required to pay in connection with employment, services, travel, renting, or purchasing for a project.

v) Travel: Allowable for domestic travel when such travel is essential to the successful conduct of the project being supported including attendance at National or Regional Meetings (prior approval necessary unless authorized in the form of approved application). Travel on grant funds may be allowed for those persons listed in

the application who are holding staff positions at least 50% of full time in the conduct of the project (others with prior written approval). Prior approval is required for such travel if the total required for travel exceeds the amount approved by the OADAP. Not allowable for foreign travel. Less than first class air travel must be used when available. Mileage cost and expenses relating to the travel will be applied in accordance with the grantee's policy. State of Maine Travel regulations must be followed when a grantee has no established policy.

w) Tuition and Related Costs: Allowable with prior OADAP approval when specialized training is required for the project. Other tuition costs are not allowable unless treated consistently as a fringe benefit.

x) Indirect Costs: Indirect costs of a project are those not readily identified with the project itself but nevertheless incurred by a grantee - as in the operation and maintenance of building or in the payment of utilities costs or administrative salaries - for the joint benefit of the project activity and of other objectives. These costs must be clearly identified in the project application.

y) Bank Interest: Whenever possible, the total grant or major portion of the grant award should be deposited in an interest bearing account. The amount received should be reported in the financial report to OADAP and may be used to reduce project related expenses incurred over and above the grant amount. Remaining interest funds not utilized for program expenditures under the grant will be returned to OADAP upon expiration of the grant period.

z) Accreditation of Agency: Costs associated with agency accreditation by recognized National Organizations (JCAH etc.) are allowable, with prior OADAP approval.

18. Reports on Project Accomplishments and Evaluation:

Where Regional Coordinators exist, projects will be assigned to them for continuing consultation. Where they do not exist, consultation will be provided by central office OADAP staff. Program Directors may relate progress or problems either verbally or preferably in writing at any time during the project.

In addition, there are five written reports required to be furnished to OADAP central office and regional coordinators, where they exist.

a) Quarterly Evaluation Progress Report - (1 copy Regional Coordinator, 1 copy OADAP central office.) This report is a narrative report of the Project activities; it will include success or failure assessments based upon criteria in the original grant application. Problems with goal attainment will also be described in this report.

b) Report of Expenditures - (1 copy Regional Coordinator and 1 copy OADAP central office.) This report will be submitted either monthly or quarterly as deemed by OADAP (sample form attached, see Figure II - 2).

BY OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

Agency Reporting: _____

For Month/Quarter Ending: _____ Grant Number _____

Project Total: $_____ Grant Period _____

PART I - MONTHLY/QUARTERLY EXPENDITURES AND OBLIGATIONS:

	Cash expenditures this month or quarter	Unliquidated Obligations*
1. Personnel Services	$_____	$_____
2. Consultant Services	$_____	$_____
3. Travel	$_____	$_____
4. Rent of Quarters	$_____	$_____
5. Consumable Supplies	$_____	$_____
6. Equipment	$_____	$_____
7. Insurance	$_____	$_____
8. Other	$_____	$_____
9. Totals	$_____	$_____

PART II - GRANT SUMMARY:

	This month or quarter	Project to date
1. Funds available:		
a. Beginning adjusted cash balance	$_____	$_____
b. Cash received during this period	$_____	$_____
c. Total funds available	$_____	$_____
2. Cash expenditures (Part 1, line 9)	$_____	$_____
3. Cash balance (1 c, less 2)	$_____	$_____
4. Adjustments (explain on reverse side)	$_____	$_____
5. Adjusted cash balance (3 (+ or -) 4)		$_____

I hereby certify that this report is complete and accurate and that the expenditures and obligations have been made solely for the purposes set forth in the application for this grant.

Date: _____ Signed: _____

_____
Typed name and title

PART III - OADAP QUARTERLY EVALUATION PROGRESS REPORT:

This report is a narrative report of project activities. It is to include success or failure assessments based upon criteria in your original grant application. Problems with goal attainment will also be described in this report.

MAIL: 1 copy to appropriate Regional Coordinator, and 1 copy to OADAP, 32 Winthrop Street, Augusta, Maine 04330, no later than 15 days after the reporting period.

*Unliquidated obligations are defined as the unpaid balances of formal purchase orders and contracts at the end of the period covered by this report.

c) Client Reports - (1 copy to OADAP central office). These reports on individual clients will be submitted when services to the client are terminated or as may be required by OADAP.

d) Final Report - (1 copy to Regional Coordinator, 1 copy to OADAP central office). This report will be submitted within 30 days after the end of the project period. It will consist of a review of the project's activities and accomplishments during the entire project period and a final evaluation of the extent to which the project achieved its objectives.

e) Final Financial Status Report - (2 copies OADAP central office). This report must be submitted within 30 days after the end of the grant project period. (Use the quarterly financial report form illustrated in Figure II - 2.)

III. Grantee Responsibility:

A. Grant requirements - The grantee, when applying for a project grant, agrees to administer any grant awarded by the State in accordance with governing State and Federal regulations and policies in effect at the time the award is made. The grantee further agrees to assume responsibility for fiscal administration, public information, program management, integration of services with local public and private agencies, and will comply with the Provisions of Human Rights and Civil Rights.

B. Coordination - In order to effectively promote integration of projects in the community and regional system of services, and in order to provide integration of service care provided to client group, the grantee must:

.....coordinate with appropriate local, regional and state organizations and agencies.

.....secure letters of endorsement from these organizations, agencies, and others who will participate in proposal. Such letters must be specific in scope and serve as a project commitment.

IV. Submission and Review of Grant Application:

A. Complete the project application forms and the project description and forward them to the appropriate Regional Coordinator.

Region I

Ralph Kilgore
Lafayette Towne House
638 Congress Street
Portland, Maine 04101
Tel: 775-6553

Region III

Ed Moffitt
OADAP
32 Winthrop Street
Augusta, Maine 04330
Tel: 289-2781 - 872-2365

Region V

James B. Sabine
Aroostook Mental Health Ctr.
97 Military Street
Houlton, Maine 04730
Tel: 532-6523

Region II

John Coffey
Western Regional Council
179 Lisbon Street
Lewiston, Maine 04240
Tel: 783-9151 Ext. 244

Region IV

Linwood K. Oakes, Sr.
Bangor Health Facility
103 Texas Avenue
Bangor, Maine 04401
Tel: 947-6367

B. The process described in Figure IV - 1 normally takes ninety days to complete. In cases of extreme urgency at the regional coordinator's option, the Regional Review and Comment Committee review and regional council approval may be bypassed. The State Review and Comment Committee review and the State Advisory Council approval may be bypassed at the option of the OADAP Director to facilitate urgent requests.

V. Amendments to Grants:

A. Grants may be amended upon receipt of a written request for amendment by the OADAP Director. The request should be submitted to the appropriate regional coordinator and must contain the following information:

1) Grant number to which the amendment will apply.

2) Type of amendment requested (i.e. change in grant period date, budget revision, personnel change, new objective, etc.)

3) Justification for the amendment in the form of statistical data, impact on program, accounting information, alternatives which have been examined, etc.

4) Specific wording to be used in the amendment.

5) Date amendment should take effect.

6) Signatures of project director, chief administrator of sponsoring agency and principal board officer. (The signature of the principal board officer will include a statement that the governing authority has reviewed and approved the amendment).

VI. Termination/Suspension and Appeal of Grants:

A. Normal Termination: Grants administered by OADAP will normally be effective for a period of 12 months or less. All grants, unless otherwise amended will cease to be effective on the stated termination date. At that time no further expenditures may be charged to the grant except for those in which the obligation to expend was incurred during the grant period. A final financial report must be forwarded within thirty days of the grant termination date.

B. Termination for Cause: OADAP may terminate a grant in whole or in part any time before the date of completion if it has been determined that the grantee has failed in a material way to comply with the terms and conditions of the grant. OADAP will promptly notify the grantee in writing, stating the reasons for the termination and the effective date. Payments to grantees or recovery of funds by the State shall be made in accordance with the legal rights and liabilities of both parties. Termination for cause is appealable.

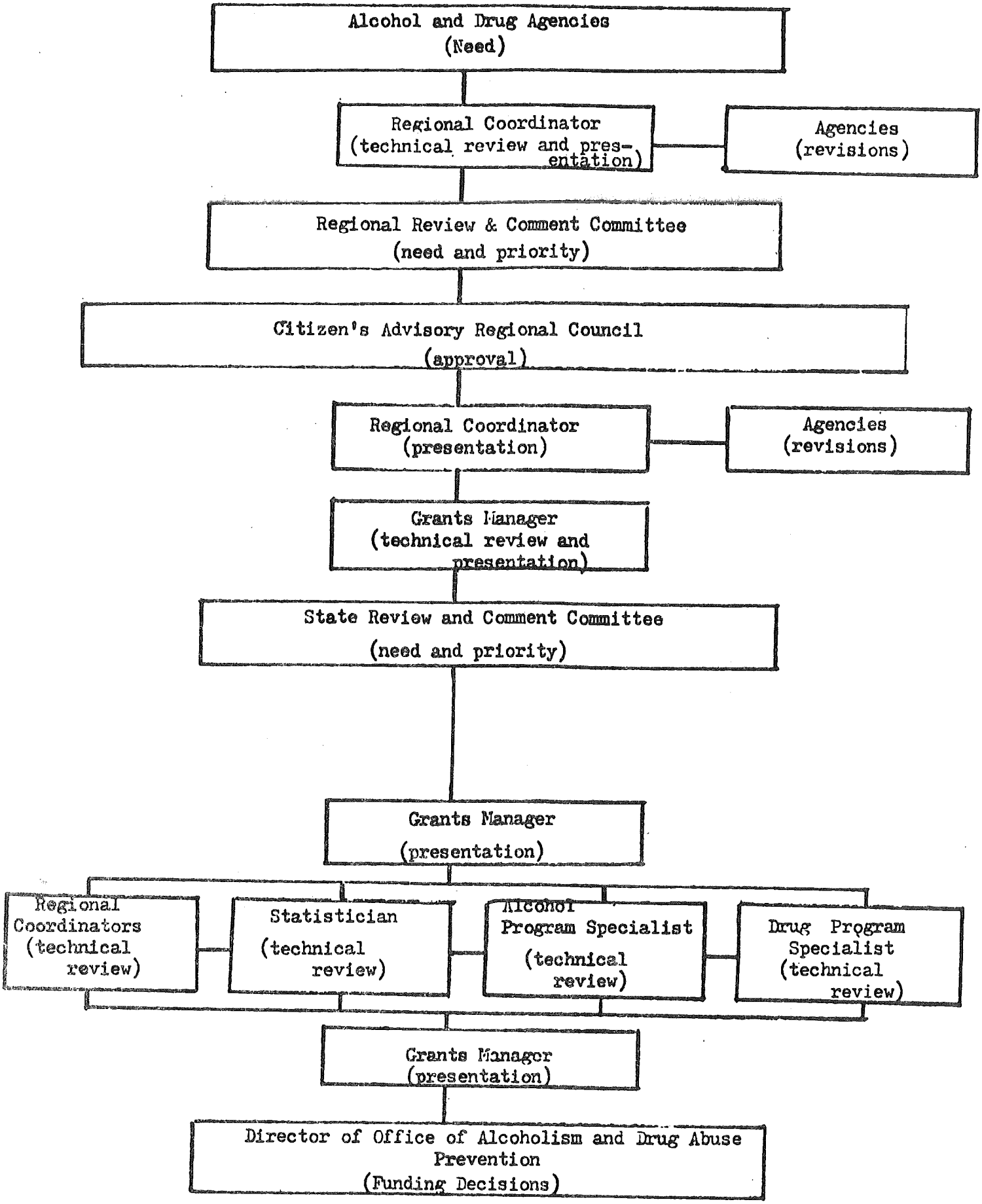
Alcohol and Drug Agencies
(Need)
Regional Coordinator
(technical review and presentation)
Agencies
(revisions)
Regional Review & Comment Committee
(need and priority)
Citizen's Advisory Regional Council
(approval)
Regional Coordinator
(presentation)
Agencies
(revisions)
Grants Manager
(technical review and presentation)
State Review and Comment Committee
(need and priority)
Grants Manager
(presentation)
Regional Coordinators
(technical review)
Statistician
(technical review)
Alcohol Program Specialist
(technical review)
Drug Program Specialist
(technical review)
Grants Manager
(presentation)
Director of Office of Alcoholism and Drug Abuse Prevention
(Funding Decisions)

Figure IV - 1

C. Termination on Other Grounds: Except as provided above under Termination for Cause, OADAP grants may be terminated in whole or in part only as follows:

1) By OADAP with the consent of the grantee, in which case the two parties shall agree on the termination conditions, including the effective date and, in the case of partial terminations, the portion to be terminated.

2) By the grantee, upon written notification to OADAP setting forth the reasons for such termination, the effective date, and, in the case of partial terminations, the portions to be terminated.

When a grant is terminated, the grantee shall not incur new obligations for the terminated portion after the effective date of the termination and shall cancel as many outstanding obligations as possible. OADAP shall allow full credit to the grantee for the State share of noncancellable obligations properly incurred by the grantee prior to termination.

D. Withholding of Support: OADAP may withhold the payment of grant funds within a previously approved project period for justifiable reasons. Such reasons may include one or more of the following:

1) The grantee is delinquent in submitting required reports.

2) Adequate funds are not available to support the project.

3) The grantee fails to show satisfactory progress in achieving the objectives of the project or otherwise fails to meet the terms and conditions of the award.

4) The grantee's management practices fail to provide adequate stewardship of OADAP funds.

5) Any other reason that would indicate that continued funding would not be in the best interests of the State of Maine.

E. Suspension: When a grantee has materially failed to comply with the terms and conditions of a grant, OADAP may, after reasonable notice to the grantee, suspend the grant. No obligations incurred by the grantee during the period of suspension shall be allowable under the suspended grant; however, OADAP may at its discretion allow necessary and proper costs that the grantee could not reasonably avoid during the period of suspension, provided that such costs would otherwise be allowable. Suspensions shall remain in effect until the grantee has taken corrective action to the satisfaction of OADAP, or has given assurances satisfactory to OADAP that corrective action will be taken, or until OADAP terminates the grant.

F. Appeals: Terminations and suspensions of grants by OADAP are subject to appeal. The appeal must be submitted to OADAP within 10 working days of the notification of termination or suspension date. Each appeal will be considered for acceptance by the OADAP Director on an individual case basis.

OFFICE OF ALCOHOLISM & DRUG ABUSE PREVENTION RAS-11 1177

APPLICATION FOR FUNDING

Appendix C

A) TYPE OF REQUEST:

Continuation of Previously funded Project ☐

New Project or Expanded Project ☐

Single Purpose Special Award ☐

TITLE XX or _____ (Specify Program) OTHER MATCH ☐

B) PROJECT APPLICANT:

_____
(Sponsoring Organization) (Employer I.D. Number) (Date of Incorporatio

_____
(Principal address) (Zip Code) (Telephone No.)

_____
(Short Project Title)

_____
(Location of Project)

C) ADMINISTRATIVE PERSONNEL:

1. Chief Administrator of Sponsoring Organization:

_____ _____
(Name) (Title)

2. Project Director (if different from Chief Administrator):

_____ _____
(Name) (Title)

3. Name of person to whom checks should be sent:

_____ _____
(Name) (Title)

_____
(Address) (Zip Code) (Telephone No.)

Is this person bonded? ___No ___ Yes Amount_____

_____
(Bonding Company)

Signature of Payee_____

D) BUDGET SUMMARY:

1. Total agency budget: _____
2. Total project budget: _____
3. Amount of this request: _____
4. Total OADAP Funds in Budget: _____
5. Total Funds to be matched: _____

E) ORIGINAL DATE OF THIS APPLICATION: _____

F) GRANT PERIOD DATES REQUESTED: _____

STATEMENT OF NEED (Why are you going to do it?)

In this part, identify in detail the problem which this project is intended to address. Accurate problem definition is essential. The problem as described here must be specifically related to the activities or effort proposed. Describe the problem in a manner which offers the potential to observe and measure its dimensions before, during and after the project activity.

As a minimum this item should:

1) Describe the nature and scope of the problem addressed in this application.

2) Provide supporting facts and figures which describe the existence of this problem and a summary of your analysis of the implications of this information.

3) Describe the underlying causes of the problem.

4) Provide a clear description of the impact or effect of the problem on other agencies or groups.

(Number Additional Pages if necessary, 2a, 2b, 2c, etc.)

GOALS AND OBJECTIVES (What's going to be the result of doing it?)

Goal Statement and Measurable Objectives: This section is vital to the application It should clearly and concisely present the goal statement and measurable objective for the project. In other words, this section should describe precisely what the project will achieve and/or demonstrate. The goal statement and measurable objectives presented in this section should be directly related to the statment of the problem (page 2) so that the project can be monitored and/or evaluated in terms of its ability to resolve the problem identified.

1) Specify a goal statement for the project. The goal statement should clearly communicate the intended result of the project as of the end of the grant period. The goal statement identifies, before the project starts, what must happen or be achieved in order for the project to be considered a success. The goal statement must be precise enough so that a person could, on the basis of project records and data, determine if the project goal has been achieved.

Below is one method for writing a precise goal statement:

a) Identify the terminal (end) behavior or condition which will be accepted as evidence that the project has achieved its goal.
b) Try to further define the desired behavior or condition by describing the important limits or circumstances under which the behavior and/or conditions will be expected to occur.
c) If possible, specify the criteria of acceptable performance and/or results by defining the minimum acceptable functioning level of the project.

NOTE: Complex projects may have more than one goal statement.

2) Identify implementation objectives for the project. Implementation objectives reflect major activities necessary to begin the project. They should be stated in the order in which they will happen. Describe how completion of each activity will be documented.

3) Identify performance objectives for the project. Performance objectives indica major behavior (activities) necessary to conduct the project as planned. Each performance objective should incorporate, where applicable, specific behavior, the method or procedures to be followed, time specifications and how achievement of the objective will be documented. Performance objectives should answer the questions (Who? (2) What? (3) Where? (4) When? (5) How? (6) Under what conditions? (7) To what level of acceptance? (8) As documented by what?

If this is a continuation of a previously funded project then the prior year's goal and objectives must be indicated along with a statement of the progress made toward achieving each specific goal or objective.

(Number additional pages 3a, 3b, 3c, etc.)

PROJECT DESCRIPTION (What are you going to do and how will you do it?)

Describe physical requirements for the project to be funded. List the types of clients to be served and describe the services to be delivered. Provide a list of project personnel requirements with job descriptions and special training and education requirements. Explain how this project will be made available to the specific client groups and identify sources of referral to and from your project. Indicate the relationship of each project activity to the goals and objectives stated in page 3. If this is a Single Purpose request, then describe only that purpose and indicate the impact on your program of not funding the request.

(Number additional pages if necessary, 4a, 4b, 4c, etc.)

PROJECT BUDGET SUMMARY (How much will it cost?)

Line	Specific Item	Total	Funding Source		
			OADAP	Title XX	Other
1.	PERSONNEL SERVICES: a. Salaries b. Fringe Benefits				
2.	CONSULTANT SERVICES: a. Sub-contracts b. Consultants c. Special Services				
3.	TRAVEL a. Mileage & Tolls b. Meals & Lodging				
4.	RENT OF QUARTERS:				
5.	CONSUMABLE SUPPLIES: a. Office supplies b. Postage c. Utilities d. Telephone e. Food f. Medical supplies g. Janitorial supplies h. Misc.				
6.	EQUIPMENT: a. Purchase b. Rental				
7.	INSURANCE a. Liability b. Fire & Theft c. _____ _____ _____				
8.	OTHER: a. Audit b. Admin. fee of sponsoring agency c. _____ _____ _____				
9.	TOTALS:				
10.	Percentage of Total Project Budget				

LINE ITEM COSTS JUSTIFICATION (Where did you get the cost?)

(USE THIS FORM TO JUSTIFY ALL COSTS EXCEPT PERSONNEL)

* Line Item # - Description of Item - Basis of Cost	Item Cost Within Line	Line Totals

* LINE ITEM NUMBER MUST AGREE WITH PAGE 5

APPLICATION FOR FUNDING

SUMMARY OF PROJECT PERSONNEL (Who's going to do it?)

mber of ersonnel	Position or Title	Total Weekly Hours Worked	Number of Hours spent on Project*	Total Salary for Project

*Weekly

Fringe Benefits

Type of Benefit	Factor	Cost
Total Cost of Fringes		

Summary

Total Number of Personnel =	
Total Salary	
Total Salary & Fringe =	

(Number additional pages 7a, 7b, 7c, etc.)

Remarks:

SOURCES OF INCOME (Who's going to pay for all of this?)

	Current Year 19__ - 19__	Grant Reque 19__ - 19
A. Total amount from OADAP and dates of Grant/Contract (s)		
_____		
_____		
_____		
_____		
Subtotal:	_____	_____
B. Total amount from other sources and dates of Grant/Contract (s)		
Source Dates		
_____		
_____		
_____		
_____		
_____		
Subtotal:	_____	_____
C. TOTAL:	═══════	═══════

D. Percentage of increase/decrease from current budget

% Increase	% Decrease
_____	_____

(Number additional pages 8a, 8b, 8c, etc.)

Please indicate seed money with an asterisk (*)
Please indicate straight money with an (s)
Please indicate inkind money with an (i)
Please indicate matched money with an (m)

FUTURE PROJECT FUNDING (Who will pay for it next time?)

Describe the steps that your agency plans to take concerning funding for this project for at least one year following the requested termination date of this grant. Identify sources of funding and indicate the proportion of the project that each source is expected to support. If this is a continuation of current activity request, then describe the progress which has been made during the previous funding period toward achieving funding goals.

(Number additional pages 9a, 9b, 9c, etc.)

EVIDENCE OF COMMUNITY SUPPORT (Who else knows about your project?)

1. List any inter-agency agreements which concern this project, and indicate in what ways they have been utilized, and how they will be used during the requested grant period.

2. Describe the involvement that the local community has had in developing this project. What attempts will be made to solicit local community support during the project period?

3. Provide evidence of community support if possible in the form of unsolicited endorsement letters from community leaders, municipal officials, legislative representatives, former clients (with the client's written permission only!), and other concerned citizens.

(Number additional pages 10a, 10b, 10c, etc.)

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

_____ (hereinafter called the "Sponsoring Agency"
(Sponsoring Agency)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Sponsoring Agency by the Department, this assurance shall obligate the Sponsoring Agency, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Sponsoring Agency for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Sponsoring Agency for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Sponsoring Agency by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Sponsoring Agency recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Sponsoring Agency, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Sponsoring Agency.

Dated _____ _____
(Chief Administrator of Sponsoring Agency)

By _____
(Project Director, if different)

APPLICANT CERTIFICATION

This grant application is complete and accurate to the best of my knowledge. The grantee acknowledges that he/she has read the OADAP grant guidelines and will abide by the conditions stated in those guidelines.

Chief Administrator of Sponsoring Agency

Date

Project Director (if different)

Date

GOVERNING AUTHORITY REVIEW

This application has been reviewed by the board of directors of the sponsoring agency on this date and is approved for submission to the Office of Alcoholism and Drug Abuse Prevention.

Date

Principal Board Officer

Typed Name and Title

APPENDIX D

REGULATIONS FOR THE RESIDENTIAL LICENSING OF SUBSTANCE ABUSE TREATMENT FACILITIES IN THE STATE OF MAINE

Department of Human Services

Office of Alcoholism and Drug Abuse Prevention
32 Winthrop Street
Augusta, Maine 04330
289-2781

October 26, 1976

M.R.S.A.
Title 22 §5-A. Inspection and licensing of residential facilities for the care, treatment or rehabilitation of drug users.

No person, firm, corporation or association shall operate, conduct or maintain in the State any residential facility for the care, treatment or rehabilitation of drug users, or any residential facility for the care, treatment or rehabilitation of alcohol users, not otherwise licensed as a medical care facility, without having in full force, subject to the rules and regulations of the department, a written license therefor from the department may promulgate rules and regulations which include but are not limited to the administration and staffing of the facility, the number of residents, the quality of treatment programs, the health and safety of staff and residents, community relations and licensing procedures. The department shall hold a public hearing after the promulgation of new regulations or any change in existing regulations. These regulations shall become effective only after a public review period of 60 days following the public hearing. The term of such license shall be for one year and the license may be suspended or revoked for just cause. The annual fee for such license shall be $50. When any such facility upon inspection by the department, shall be found not to meet all requirements of this section and departmental regulations then the department is authorized to issue either a temporary license for a specified period not to exceed 90 days, during which time corrections specified by the department shall be made by said facility for compliance with this section and departmental regulations thereunder, if in the judgment of the commissioner the best interest of the public will be so served, or a conditional license setting forth conditions which must be met by the facility to the satisfaction of the department or the department may refuse to issue any license. Failure of said facility to meet any of such conditions shall immediately void such conditional license by written notice thereof by the department to the conditional licensee or if the said licensee cannot be reached for personal service by notice thereof left at the licensed premises, provided that a conditional licensee shall have a right to file a statement or complaint with the Administrative Court Judge as provided in Title 5, chapters 301 to 307. The voidance of a conditional license shall be stayed pending an appeal to the Administrative Court Judge, unless, in the opinion of the Administrative Court Judge, a stay would immediately endanger the health or safety of persons living in the facility to such an extent as to create an emergency. Any appeal of the loss of a conditional license must be filed within 10 days of receipt of notice of voidance of the conditional license. The fee for such temporary or conditional license for facilities shall be $50. A new application for a regular license may be considered by the department if, when and after the conditions set forth by the department at the time of issuance of such temporary or conditional license have been met and satisfactory evidence of this fact has been furnished to said department. When the department believes a license should be suspended or revoked, it shall file a statement or complaint with the Administrative Hearing Commissioner designated in Title 5, chapters 301 to 307. Whenever, on inspection by the department, conditions are found to exist which violate this section or departmental regulations issued thereunder which, in the opinion of the commissioner, immediately endanger the health or safety of persons, or both such health or safety, living in such facilities to such an extent as to create an emergency, the department by its duly authorized agents may suspend said license until such time as the department determines that the emergency no longer exists or until a decision is rendered by the Administrative Hearing Commissioner. The department shall give written notice of such emergency suspension by delivering notice in hand to the licensee. If the licensee cannot be reached for a personal service, the notice may be left at the licensed premises.

Whenever a license is suspended by the department under this emergency provision, the department shall file a complaint with the Administrative Hearing Commissioner requesting suspension or revocation of such license. A person aggrieved by the refusal of the department to issue a license may file a statement or complaint with said Administrative Hearing Commissioner. No such license shall be issued until the applicant has furnished the department with a written statement signed by the Commissioner of Public Safety or his duly authorized representative or the proper municipal official designated in Title 25, chapter 311 to 321 to make fire safety inspections that the facility and premises comply with said Title 25, chapters 311 to 321 relating to fire safety. The department shall establish and pay any reasonable fees to the municipal official or the Commissioner of Public Safety or his duly authorized representative for such inspection. Said written statement shall be furnished annually thereafter.

Whoever violates this section shall be punished by a fine of not more than $500 or imprisonment for not more than 60 days.

INTRODUCTION

These regulations are authorized under Title 22 of the Maine Revised Statutes Annotated Sections 1369 and 7115, which empowers the Office of Alcoholism and Drug Abuse Prevention (OADAP) to establish regulations for residential alcoholism and drug abuse treatment programs and facilities.

Regulations for the licensing of drug abuse treatment facilities became effective in late 1974, and the regulations for the licensing of alcoholism treatment facilities became effective in late 1975. Through continued study of program requirements and through experience gained in the licensing process itself, it was determined that both sets of regulations should be updated, and could be combined into a single document with a single procedure. The alcoholism regulations, based upon the Joint Commission of Accreditation of Hospitals' manual and procedure were considered to be more comprehensive, and so the drug abuse requirements were absorbed into these regulations along with some specific requirements not contained therein. Thus the final document deals in terms of substance abuse.

There is a recognized need in Maine, as well as nationwide, not only to develop, but also to maintain and improve quality standards in the prevention and treatment of alcoholism and drug abuse. It is important that all people receiving treatment for any substance abuse should receive services of the highest quality, and it is for this reason that OADAP addresses itself to a single, meaningful procedure. A goal stated by the Joint Commission on Accreditation of Hospitals could well be our own: "Our purpose is to motivate and encourage health professionals to provide the best services possible and to assist each individual served to achieve the highest level of which he is capable." It is with this purpose in mind that the Office of Alcoholism and Drug Abuse Prevention establishes regulations for residential substance abuse treatment facilities in the State of Maine.

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CHAPTER 1
DEFINITIONS AND GENERAL REQUIREMENTS

§ 1. DEFINITIONS

As used in these standards, unless a different meaning is plainly required, the following words and variants thereof have the following meanings:

1. Accreditation: A voluntary formal approval of programs by the Accreditation Council for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals. Accreditation does not include approval of personnel or physical standards.

2. Administrative Staff: All personnel dealing directly with the day-to-day administration of the treatment program.

3. Administrator: The individual appointed by the governing authority to act in its (his/her) behalf in the overall management of the substance abuse program.

4. Affiliation: A relationship established by the governing authorities of two programs and signed by a written agreement under the terms of which specified services, space, and/or personnel are provided on a scheduled basis to one program by the other, but without exchange of monies.

5. Aftercare: A component which consists of the process of providing continued contact which will support and increase the gains made in the treatment process.

6. Alcoholism Treatment Facility: See Substance abuse facility.

7. Approval: Recognition by OADAP of satisfactory compliance with these regulations. Approval results in the issuance of a license for residential facilities, or a certificate of approval for non-residential programs.

8. Approved Facility: A public or private facility that meets the program requirements contained in these regulations and which holds a valid license from the OADAP.

9. Approved Public Treatment Facility (APTF): A specific type of alcoholism treatment facility which is licensed pursuant to these regulations or licensed as a medical care facility, approved under M.R.S.A. 22, §7114(6), and includes as part of its program the component of emergency care, and which has been specifically designated an APTF by the OADAP.

10. Audit: An independent opinion by a certified public accountant or an audit approved by the OADAP to ensure that an organization's financial reports accurately reflect its financial position and operating results.

11. Certificate of Approval: A certificate issued by the OADAP to a non-residential program which indicates satisfactory compliance with these regulations.

12. Client: Any individual who has applied for or has been given diagnosis or treatment in a substance abuse treatment program. This term does not include persons whose only contact with a program has been through the telephone.

13. Clinical Staff: That group of personnel of the substance abuse facility which is directly involved in client care and treatment.

14. Component: A part of a program into which a specific group of interrelated services can be classified. These components are: governing authority/management, aftercare, emergency care, inpatient care, intermediate care, outpatient care, outreach, and shelter.

15. Contract: A formal legal document adopted by the governing authority of the substance abuse program and any other organization, agency, or individual that specifies goods, services, personnel and/or space to be provided in the program, as well as the consideration to be expended in exchange.

16. Cost Accounting: The branch of accounting procedure concerned with the recording and analysis of expenditures, the preparation of statements and reports from the analysis, and the interpretation of such data for the use of management.

17. Department: The Department of Human Services.

18. Detoxification: The period during which and the procedures by which clients are withdrawn from their substance of abuse.

19. Director: The Director of the Office of Alcoholism and Drug Abuse Prevention, (OADAP).

20. Documentation: Provision of evidence that is written, dated and signed by the administrator, and, where applicable, the chief officer of the governing authority board, to substantiate compliance with regulations.

21. Drug Abuse Treatment Facility: See substance abuse facility.

22. Emergency Care: A component which consists of a network of services that provides all persons having acute problems related to alcohol or drug use/abuse with immediate diagnosis and care, as well as appropriate referral for continuing care after emergency treatment.

23. Governing Authority: That body which makes policy decisions regarding the operation of a substance abuse treatment program.

24. Governing Authority/Management: A component which defines the program authority and structure in relation to other components.

25. Incompetent: Any person who, though not insane, is by reason of old age, disease, weakness of mind or from other cause unable, unassisted to properly manage and take care of himself or his property.

26. Indicators: Measurable or definable items which can be used to demonstrate (client) change.

27. Inpatient Care: A component which consists of the process of providing care to persons who require twenty-four hour supervision in a hospital or other suitably equipped medical setting as a result of acute or chronic medical and/or psychiatric illnesses associated with alcohol or drug abuse and/or alcoholism.

28. Intermediate Care: A component which consists of the process of providing substance abuse treatment services in a full twenty-four hour residential therapy setting, or a partial (less than twenty-four hours) residential therapy setting.

29. License: Authorization by the OADAP to permit operation of a substance abuse facility in the State of Maine.

30. May: Verb used to reflect an acceptable method that is recognized but not necessarily preferred or mandatory.

31. Minor: Any client who has not attained his/her 18th birthday.

32. Outpatient Care: A component which consists of the process of providing non-residential diagnostic and substance abuse treatment service on both a scheduled and non-scheduled basis.

33. Outreach: A component which consists of the process of reaching into a community systematically for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the service delivery system.

34. Physician: Any person licensed to practice medicine by the Board of Registration in Medicine pursuant to M.R.S.A. 32, Section 3263, et. seq., or by the Board of Osteopathic Examination and Registration pursuant to M.R.S.A. 32, Section 2561, et. seq.

35. Professional Staff: Clinical and administrative staff who meet personnel standards set by the OADAP.

36. Program: A substance abuse program consists of Governing Authority/Management and Aftercare, as described herein, and one or more other components listed in §2(2). A program may be conducted in a residential or non-residential setting.

37. Program Budgeting: Preparation of a formal estimate of future income and expenditures by line items, with the expenditure estimates being categorized by the major service areas of the program; e.g.: treatment, medical services, room and board, research.

38. Referral: Assisting a person with substance abuse problems, or his family, to make use of other services which have been judged by the referring person and the client to be useful in beginning or enhancing medical, legal, psychological, social and vocational recovery from problems of alcohol misuse and abuse.

39. Shall: Verb used to indicate a mandatory statement, the only acceptable method under these regulations.

40. Shelter: A component which consists of providing food, lodging, sanitation, and clothing with the purpose of protecting and maintaining life, and motivating recipients to seek further treatment programs.

41. Should: Term used to reflect the most preferable procedure, yet allowing for the use of effective alternatives.

42. Substance Abuse: The use of alcohol or other drugs, licit or illicit, which results in an individual's physical, mental, emotional or social impairment.

43. Substance Abuse Facility: Any establishment, organization, or institution, public or private, which offers or purports to offer, maintain, or operate one or more facilities for the diagnosis, care, treatment or rehabilitation of two or more non-related individuals who are suffering physically, emotionally, or psychologically from the abuse of alcohol and or other drugs of abuse, and which includes as part of its treatment a requirement that the persons physically reside on the premises

A. Public Facility: A substance abuse facility operating under the direction and control of the OADAP or providing treatment through a contract with the OADAP or any facility funded in whole or in part by municipal, State or Federal funds.

B. Private Facility: A substance abuse facility which is sponsored by an individual, firm, or corporation, and which is not a public treatment facility.

44. Supportive Services: Subordinate and additional services which assist the client to derive the maximum benefit from the primary services of a program component.

45. Training: Special school, in-service programs, workshops, and other opportunities for facility staff intended to:

A. improve administration of programs,

B. develop skills in treating the alcohol abuser and his family, and,

C. increase knowledge of drug abuse, alcohol abuse, and alcoholism.

46. Update: A dated and signed review of a report, plan or program, with or without revision.

§ 2. GENERAL REQUIREMENTS

1. All substance abuse facilities shall comply with all requirements relating to Governing Authority/Management and Aftercare as contained in these regulations.

2. In addition to the requirements of Subsection 1 of this Section, all substance abuse facilities shall comply with the requirements of at least one of the following components:

A. emergency care,

B. in-patient care,

C. intermediate care,

D. out-patient care,

E. outreach,

F. shelter.

3. All substance abuse facilities shall have clearly delineated objectives and goals and philosophies reflected in their written policies, procedures, and organization plans.

4. Compliance with all regulations shall be verified through written policies and documentation supplied by the program administrator.

5. All substance abuse facilities shall be in compliance with the following required rules and regulations and any amendments thereto:

A. Life safety code,

B. State of Maine Rules and Regulations for Eating and Lodging Places,

C. State of Maine Plumbing Code, and,

D. State of Maine Plumbing Code - Part II.

6. All programs shall maintain an organized system to collect and provide to OADAP such information as OADAP may require.

7. All programs which receive OADAP funding must submit special reports as required by OADAP grant guidelines.

8. When initiating a program in a community, appropriate groundwork and consideration for established residents shall be observed. This may include a presentation to the local governing body or appropriate agency, newspaper announcements and home or business visits in the immediate area. The goals, the structure and the responsibilities of the program to the community should be presented to insure understanding and cooperativeness. Operational programs should make every effort to involve all levels of community resources. Programs shall cooperate with local health, law enforcement, social welfare, and human service planning agencies.

Upon the written request of the governing authority of the community, whether an individual or a group of individuals, OADAP may conduct a public hearing regarding the presence of the program in that community. If held, the public hearing shall be held in the community so requesting the public hearing.

9. An adequate insurance program shall be in force at all times. Coverage shall include comprehensive liability insurance for governing authority, clinical and administrative personnel, physical and financial resources.

10. An independent audit of all public substance abuse facilities by a certified public accountant shall be performed at least annually. It shall accurately reflect the organization's financial position. Programs which are completely funded by Department of Human Services monies may substitute an audit by departmental auditors.

11. All programs shall be in compliance with the following Federal rules and regulations and any amendments thereto:

A. Rules and Regulations regarding Confidentiality of Drug and Alcohol Abuse Patient Records.

12. All clients shall be read at the time of application, or as soon as possible thereafter, the statement Confidentiality of Substance Abuse Records and Information as provided by OADAP, and shall be otherwise informed and made aware of client rights regarding confidentiality. This statement shall be signed or initialed by the client and shall be included in the case record.

13. No program shall discriminate or permit discrimination against any person in any manner prohibited by the laws of the United States or the State of Maine.

CHAPTER 2
PROCEDURE FOR LICENSING

§ 7. APPLICATION

1. Any individual or corporation desiring to operate a substance abuse facility shall, prior to operation, obtain a license from the OADAP. Application for a license shall be made on forms provided by the OADAP on request.

2. All applicants must supply all information requested on the Application for License Form. Any incomplete application will be returned to the applicant and will not be considered until properly completed.

3. All applications shall be accompanied by a fee of $50.00 payable to the OADAP.

§ 8. INSPECTION

1. Upon receipt of a complete application, the OADAP will request and arrange State fire, health, and plumbing inspections.

2. Program inspections will be conducted by properly designated representatives of the OADAP.

COMMENT

The OADAP will make arrangements only for State inspections. Facility administrators, where required, are responsible for local fire, health, and sanitation inspections.

§ 9. LICENSE

1. A license shall be issued only when the facility is in substantial compliance with these and all applicable regulations.

2. Upon completion of inspection by the OADAP and other State officials, a determination shall be made within 30 days of the date of the last inspection and one of the following administrative actions shall be taken:

A. A temporary license may be granted for a period not to exceed 90 days during which time the facility must make corrections specified by the OADAP regulations which are not met;

B. a conditional license may be granted which sets forth conditions which must be met by the facility to the OADAP's satisfaction within specified periods of time;

C. a full license may be granted for a period of one year, or

D. a license may be denied.

3. Any facility granted a full license or a conditional license for a period of one year must apply for a new license 90 days prior to the expiration date of its present license. Any facility granted a conditional or temporary license for a period of less than one year must apply for a new license 30 days prior to the expiration date of its present license.

4. A license shall be displayed in a location highly visible to the public.

COMMENT

Decisions under Subsection 1 will be based on assessment of each program component. Compliance with regulations will be assessed in all of the following ways:

1. The statement of a responsible, authorized administrator and staff members,
2. documentary evidence of compliance provided by the program or its governing authority,
3. answers to detailed questions concerning the implementation of an item or example of its implementation that will enable a judgement of compliance to be made,
4. on site observations by persons designated by OADAP.

§ 10. LICENSE NON-TRANSFERABLE

1. A license is non-transferable. Any license granted by OADAP for the operation of a substance abuse facility applies both to the program and the premises upon which the program is to be operated. Any person or other legal entity acquiring an already licensed facility shall apply as provided herein for renewal of its approved status. Similarly, any person or legal entity having acquired a license and desiring to operate another facility in any other town or municipality or transfer to a separate location must apply for a separate license for each facility or location.

2. OADAP must be informed of any changes made in the facility's program. If, in the judgement of OADAP, the changes are substantial, OADAP may require an application for a new license.

§ 11. SUSPENSION, DENIAL AND REVOCATION

1. Suspension, denial or revocation of a license to operate a substance abuse facility shall be in accordance with procedures set forth in M.R.S.A. 5, Section 2301 et. seq. OADAP may deny, refuse to issue, or bring an action to revoke or suspend a license if in the opinion of OADAP the applicant has:

A. Engaged in activities deemed detrimental to the clients; i.e. resulting in physical, mental, moral, emotional damage to the client;

B. deviated from the program for which a license was issued;

C. engaged in activity which has violated any provision of Maine law;

D. been in violation of any local or State health, safety, sanitation, building or zoning code and has failed to correct same; or,

E. otherwise violated any of these standards or violated the rules and regulations pertaining to eating and lodging places, sanitation, and fire and safety.

2. Denial, suspension or revocation of a license does not prevent a facility from re-applying as soon as the deficiencies are corrected. Reasons for such a denial shall be fully explained in writing upon request of the applicant.

3. Appeal of a denial, suspension or revocation shall be made in accordance with the Administrative Code, § 2301 et. seq.

COMMENT

An explaination of the appeal process in Subsection 3 may be obtained from OADAP.

§ 12. PERIODIC REVIEW OF LICENSING REGULATIONS

1. Licensing standards shall be regularly reviewed and updated by OADAP.

§ 13. ADOPTION, AMENDMENT OR REPEAL

1. Any person may petition OADAP to request the adoption, amendment or repeal of any regulation. Any such petition shall be brought or mailed to OADAP and shall state specifically what modification is desired. OADAP shall acknowledge receipt of any petition within 10 days of the date of receipt. A disposition of the petition shall be made within 30 days after receipt of the petition, and OADAP shall notify the petitioner of its action in writing.

§ 14. CERTIFICATE OF APPROVAL

1. Any individual or corporation desiring to operate a non-residential substance abuse program may obtain a certificate of approval from OADAP. Application for a certificate shall be made on forms provided by OADAP on request.

2. All applicants must supply all information requested on the application form. Any incomplete application will be returned to the applicant and will not be considered until properly completed.

3. All applications shall be accompanied by a fee of $50.00 payable to OADAP.

4. Application for Certificate of Approval is optional. If an application is made, the program is subject to the rules and regulations herein, substituting "certificate" for "license", and "program" for "facility".

CHAPTER 3
GOVERNING AUTHORITY/MANAGEMENT

§ 20. OPERATION AND POLICIES

1. The governing authority of all substance abuse programs shall exercise general direction over, and establish policies concerning the operation of the program.

2. The governing authority shall:

A. remain responsible for the day to day operation of the program or hire an administrator in charge who remains responsible to the governing authority;

B. approve the hiring and firing of staff or delegate the administrator to hire and fire staff according to approved personnel policies;

C. provide or authorize the administrator in charge to provide a policy manual and other suitable documentation which describes regulations, principles and guidelines that determine the program's operations.

§ 21. INDIVIDUAL TREATMENT PLAN

1. An individual treatment plan consistent with treatment philosophy and program objectives shall be maintained for each client.

2. The treatment plan shall:

A. specify and describe the indicators used to assess the individual's progress, taking into consideration the physical, social, cultural, educational, vocational, spiritual and psychological needs of each individual;

B. include participation of the client, whenever possible;

C. be documented, reviewed and updated on a regular basis.

§ 22. CASE RECORDS

1. A case record for each client shall be maintained. This record shall include, but not be limited to:

A. identification data;

B. reports from referring sources;

C. pertinent case history;

D. problems and goals;

E. family evaluation, if appropriate, as part of the process leading to the development of the individual treatment plan;

F. individual treatment plan;

G. evaluation of progress reports;

H. correspondence pertinent to the case;

I. record of significant incidents, both positive and negative;

J. signed release of information form, where applicable;

K. referrals for service to other agencies;

L. a discharge summary which contains a final evaluation of the client's progress toward the treatment goals and objectives set forth in the initial treatment plan.

2. Case records and all other client records are confidential material and shall be kept in a locked file system.

3. All case records shall be protected in accordance with the Federal Rules and Regulations regarding Confidentiality of Drug and Alcohol Abuse Patient Records.

§ 23. REFERRAL OF CLIENTS

1. The substance abuse treatment program shall have definite written policies and procedures which facilitate client referral between the program's service components and/or between the program and other community service providers.

2. Procedures shall be established to insure placement and completion of the referral process under the following conditions:

A. when a prospective client is deemed inappropriate for admission to the program, but is still in need of care;

B. when the client is in need of examinations, assessments and consultations which are not within the professional domain or expertise of the staff;

C. when the client is in need of special treatment services;

D. when the assistance of other resources can contribute to the client's well-being; and

E. when the client is terminated from the program.

§ 24. ADMISSION AND DISCHARGE PROCEDURES

1. Every program shall have written admission policies which shall include:

A. who is or is not to be admitted;

B. special procedures to be followed; (e.g., medical examinations, approval of program staff, etc.);

C. orientation procedures;

D. fee schedules which shall be fully explained upon admission or as soon as possible after admission.

2. A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

3. Discharge policies and procedures shall include a statement about the general state of well-being to be achieved, and where applicable, the policies and procedures to be followed for discharge against medical advice. Such policies and procedures shall provide that:

A. The administrator, subject to rules adopted by him, shall refer the person to another program for treatment if possible and appropriate.

B. When a client is discharged from a substance abuse facility, he shall be encouraged to consent to out-patient treatment or other appropriate care. If it appears to the administrator that the client requires assistance in obtaining supportive services and/or additional residential care, the facility shall arrange for these services.

C. If a client leaves a substance abuse facility against the advice of the administrator, the facility should make reasonable provisions for his transportation to another facility or to his home. If he has no home, he should be assisted in obtaining shelter.

D. If the client is a minor or an incompetent person, the request for discharge from a 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.

§ 25. HUMAN AND LEGAL RIGHTS

1. Subject to reasonable rules regarding hours of visitation which the administrator shall adopt, clients in any 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. Neither mail nor other communication to or from a client in any treatment facility may be intercepted, read or censored.

3. The administrator shall adopt reasonable rules regarding the use of telephone by clients in treatment facilities.

4. Rules regarding hours of visitation, mail delivery, and use of the telephone shall be included in a list of house rules or resident guidelines which shall be given to the client at the time of admission or which shall be clearly posted on bulletin boards in the client living area.

5. Except to the extent the administrator determines that it is necessary for the medical welfare of the client to impose restrictions, and except where specifically restricted by other statute or regulations, but not solely because of the fact of admission to a mental hospital, every client shall retain his right 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 his property.

6. All exceptions and restrictions must be recorded by the administrator in the client's case records.

7. No mechanical restraint or seclusion will be used without written orders by the administrator:

A. if restraint or seclusion is utilized, this order shall be noted in the clinical record with the reason stipulated;

B. if a client is placed under physical restraint or in seclusion he will be observed by staff every 15 minutes, and such observation shall be documented.

§ 26. RESEARCH

1. Any substance abuse program that includes human subject research in its philosophy and objectives, or allows itself to be used as a resource for such research shall have written policies and procedures encompassing the purpose and conduct of all research utilizing the program's staff, clients, or services. These policies and procedures shall require informed consent for all research activities which place the subject in risk and shall specifically include the following methodology for obtaining consent:

A. a complete explanation of both the conventional and experimental procedures to be followed;

B. a description of potential discomforts and/or risks;

C. a description of potential benefits to be derived;

D. a disclosure of alternative procedures which might prove equally advantageous;

E. an offer to answer any inquiries regarding procedures and possible consequences;

F. an instruction that the subject is free to withdraw his consent and to discontinue participation in the project or activity at any time; and

G. if goals or procedures change as the research progresses, the above process for obtaining consent will be repeated.

2. If research findings are made public, the anonymity of the individual shall be protected in accordance with Federal Rules and Regulations regarding Confidentiality of Drug and Alcohol Patient Records.

3. If research involves violation of bodily integrity such as electro convulsive therapy, chemo-therapy, etc., medical supervision shall be required.

4. Prior to beginning the research, all proposals shall be reviewed and approved by the governing authority. A copy of the final research proposal shall be submitted to OADAP before the initiation of the project.

5. Any restriction of civil rights shall be noted in the client's record with the specific reason for such restriction.

§ 27. PERSONNEL REQUIREMENTS; ADMINISTRATOR AND TRAINING

1. Every substance abuse program shall:

A. describe the present organization administering the treatment program. An organizational chart is recommended;

B. Provide a job description for all employees, including part-time personnel, which includes qualifications, responsibilities, and lines of authority. When volunteers are used for a regular function, a job description for each position filled by a volunteer is required.

1. The staff shall be sufficient in number and qualification to insure the health and safety of the clients and the efficient operation of the program.

2. The program shall document the pattern of staff coverage throughout the treatment day.

2. Every substance abuse program shall provide written personnel policies and practices, which as a minimum shall:

A. state hours to be worked, provisions for vacations, sick leave, and fringe benefits, including educational benefits,

B. require that all personnel meet any local, State, or Federal requirements of their position if applicable; e.g., licensing, registration and/or certification;

C. provide that any wages paid to clients or staff working within the program shall be in accordance with local, State and Federal requirements;

D. provide that personal experience with problems related to drug or alcohol use and abuse is not a factor against employment nor an exclusive factor assuring employment;

E. provide methods and procedures for supervision of all personnel, including volunteers;

F. provide for a written evaluation of all personnel performance at least annually. Review of the evaluation by the employee shall be documented. The evaluation should insure that all staff shall:

1. be physically, mentally, and occupationally capable of performing assigned tasks;

2. contribute to a supportive environment for residents without abuse, exploitation or prejudice; and

3. be free of a substance abuse problem for at least one year.

G. provide a policy for hiring all employees including the administrator. The administrator should participate in the hiring of other staff;

H. provide grounds and mechanism for disciplinary action and dismissal of an employee consistent with fairness and due process, listing examples of unacceptable performance for which an employee can be dismissed and for which disciplinary action would be taken;

I. set forth an appeals and grievance procedure;

J. provide that written personnel policies and practices, along with revisions and updates, are given to each employee and are available to others upon request; and

K. as a condition of hiring, require a physical examination to determine that all personnel are free from all communicable and infectious diseases.

3. All substance abuse programs shall document that the governing authority has approved all personnel policies and practices, and that the governing authority has reviewed job descriptions and personnel matters at least annually.

4. An individual personnel file shall be established for each employee, and where practical, for each volunteer:

A. these records shall be secured in the same manner as clients' records;

B. where required, license numbers should be included in the employees' personnel file.

5. Volunteers may be used in any substance abuse treatment facility, if they add to the program in a positive manner:

A. a program using volunteers shall have a plan which describes how volunteers will be utilized in the program;

B. this plan must meet the approval of the Director of the OADAP.

6. The administrator shall be a person qualified by training and experience in the direction, organization and administration of treatment programs for alcohol or drug abusers, and should have knowledge of substance abuse and related problems.

7. Staff training shall be an integral part of the program. Each facility shall have a written plan describing how on-going training for all personnel will be provided.

8. The staff training plan will be based on:

A. what the individual identifies as his needs with respect to additional training;

B. specific personnel job descriptions; and

C. needs as identified by the evaluation process.

9. Training should include, but not necessarily be limited to, the following program areas:

A. program philosophy - the philosophy or theory which helps to define the kinds of care and the way in which care is given;

B. interviewing techniques and completion of forms;

C. the detection of abnormal physical and mental behaviors;

D. the development of a documented recovery plan;

E. knowledge of local community referral resources;

F. knowledge of local community transportation resources; and

G. knowledge of regulations on confidentiality.

10. Documentation of participation in any training or educational program shall be noted in the employee's personnel folder.

§ 28. PHYSICAL ENVIRONMENT

1. The physical environment of any treatment program must preserve the dignity and enhance the individuality of the client and provide for the development of a positive self-image of the client.

2. Each program shall have space adequate and appropriate to carry out that program.

3. Emergency procedures in case of fire and other life endangering contingencies shall be clearly defined and formulated in a written plan. This plan shall:

A. be posted and explained to all clients and staff;

B. be tested and evaluated periodically by appropriate drills which shall be recorded;

C. include the following:

1. specification of escape routes and procedures,

2. assignment of tasks and responsibilities,

3. instructions for the use of alarm systems and fire extinguishers.

4. Each program shall maintain records of inspection of the premises by local and state authorities for the purpose of ascertaining compliance with specific regulations, (fire, safety, health, OADAP) listing violations and corrections of non-conforming conditions.

§ 29. CONTROL OF MEDICATION

1. In the event that a substance abuse program has an organized pharmaceutical service, the director of pharmaceutical services shall be a competent pharmacist, registered in Maine, who shall be responsible to the administrator for all pharmaceutical services in the facility.

2. In the event that a service component obtains medication from a community pharmacy or from the pharmaceutical services of another component within the substance abuse program, it shall have policies to cover the prescription, administration, storage and dispensing of medications.

3. Policies governing medication control shall provide that:

   A. medication shall be administered by appropriate clinical staff according to State and Federal statute;

   B. self-administration of medication shall be permitted only when specifically ordered by the program's physician, and supervised by a member of the clinical staff;

   C. if clients bring their own drugs into the facility, these drugs shall not be administered unless they can be identified, and written orders to administer these specific drugs are to be given only by a program physician;

   D. if drugs brought by a client to the facility are not used, they shall be packaged, sealed, stored and returned to the client, parent, or significant others at the time of discharge, if such action is approved by a program physician;

   E. all of an individual client's drugs, except those released to the client upon discharge with approval of the program physician, shall be destroyed by a licensed nurse immediately after discharge or AMA departure of the client.

      1. Drugs shall be destroyed by a licensed nurse in the presence of a witness in such a manner that they cannot be retrieved, salvaged or used (i.e. flush down the toilet). They shall not be discarded with garbage or refuse.

      2. Destruction of the drug shall be recorded in the patient record; name of drug, strength, quantity, and signed by the licensed nurse and witness.

   F. there shall be a specific routine of drug administration, indicating dosage schedules and standardization of abbreviations;

   G. there shall be automatic stop orders for all medications, not to exceed 30 days;

   H. there shall be a specific method for control and accountability of drug products throughout the program;

   I. controlled substances prescriptions shall be stored in a locked, substantially constructed, non-portable and immobile metal cabinet or metal container within another separately locked enclosure;

   J. there shall be a mechanism for immediate reporting of drug reactions and medication errors to the physician responsible for the client;

   K. disinfectant and drugs for external use shall be stored separately from internal and injectable medications;

   L. drugs requiring special conditions for storage to insure stability shall be stored properly; e.g., biologicals and other medications affected by heat shall be stored in a separate compartment within a refrigerator that is capable of maintaining the necessary temperature. Such medications stored in a refrigerator containing items other than drugs shall be kept in a separate compartment with proper security.

M. antiodote charts and the telephone numbers of the regional poison control center, the hospitals and the administrator shall be kept in all drug storage and preparation areas;

N. records and inventories of the drugs listed in the current Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended shall be maintained as required by the act and accompanying regulations; and

O. first aid equipment, freshly stocked, is available and that adequate training has been given for its use.

§ 30. SUIDICE OR SERIOUS INJURY

Any suicide, serious injury, accident or death occurring among clients must be reported to the OADAP within 24 hours of its discovery. In each instance the administrator in charge shall report to the proper local authorities and also make his own investigation, retaining in his files a report of the findings and action taken and sending a copy to the OADAP. Under terms of this section, a serious injury means an injury which may result in permanent defect or handicap.

§ 31. DIETETIC SERVICES

1. Dietetic services shall be provided by every substance abuse facility which renders 24 hour care or an extended day care program. A written plan for the delivering of dietetic services is required.

2. The written plan shall provide for:

A. a varied and nutritious diet, which shall be documented through menus of meals provided.

1. Menus for the entire week shall be posted at the beginning of each week.

2. Menus shall be dated, and maintained in the records for at least 3 months.

B. A plan to identify and provide for clients with special dietary needs. Information pertinent to special dietetic treatment shall be maintained in the client's case record;

C. Food to be served in an appetizing manner at realistically planned mealtimes in a congenial and relaxed atmosphere.

3. The dining room should be large enough to accommodate all residents in one sitting.

§ 32. FISCAL MANAGEMENT

1. Systematic fiscal management policies and procedures shall govern:

A. the control of inventories;

B. purchasing authority and procedures;

C. product selection and evaluation;

D. storage and distribution of supplies;

E. accounts receivable;

F. handling of cash, including petty cash;

G. credit arrangements.

2. Suitable records shall document evidence of compliance with established policies and procedures.

3. There shall be a written plan for obtaining financial resources for the total program. The plan shall include:

A. a statement of expected financial resources for the program during the current fiscal year;

B. a statement of estimated financial resources for the program at least one year beyond the current fiscal year; and

C. a review and approval at least annually by the governing authority.

4. The program shall annually develop a formal, written, program-oriented budget of expected revenues and expenses which shall:

A. be developed with participation of appropriate clinical and administrative staff;

B. categorize revenues for the program by source;

C. categorize expenses by the types of services provided;

D. be reviewed and approved by the governing authority prior to the beginning of the fiscal year; and

E. provide that re-budgeting during the year due to program changes shall be approved by the governing authority and funding sources.

§ 33. EVALUATION

1. Every program shall have a written evaluation plan.

2. Every program must annually conduct at least one evaluation. This evaluation shall:

A. Detail goals in relation to client, program and fiscal plans, (fiscal plans should be projected two (2) years);

B. define the indicators used in measurement of goals and objectives;

C. examine the results of program measurements, (data collection);

D. include utilization review studies;

E. include as broad a base of participation as possible;

F. include evidence of staff and client participation;

G. show linkage to alcoholism and health planning organizations; and

H. take into consideration community awareness.

3. Results of the program evaluation, as well as the recommendations derived therefrom shall be presented in written form to the governing authority for their approval and action, if required.

4. Evaluation reports produced by the program shall be made available to proper administrative and clinical staff and to representatives of OADAP, and to funding sources where applicable.

CHAPTER 4
EMERGENCY CARE

§ 40. EMERGENCY CARE REQUIREMENTS

1. Emergency care is primarily a service providing for detoxification, whether in a medical or non-medical setting. The program shall describe its emergency care component in detail, including standing medication order and treatment procedures.

2. The emergency care system shall provide for 24 hour availability of the following services to all persons with problems related to alcohol and drug abuse:

A. immediate medical evaluation and care;

B. supervision of persons by properly trained staff until they are no longer incapacitated by the effects of alcohol or other drugs of abuse;

C. physical examination;

D. detoxification;

E. a systematic evaluation of the problem which shall include, but not be limited to, assessment of physical, psychological, and social needs leading to the development of a plan for continuing care;

F. chemo-therapy, if ordered by a physician;

G. individual and group counseling;

H. provision of special dietary requirements;

I. provision of a therapeutic environment which offers a drug and alcohol-free, controlled group living experience;

J. provision of family counseling or family involvement when appropriate; and,

K. referral to other services not provided by the emergency component.

§ 41. STAFF

1. Every emergency care component shall have 24-hour coverage, seven days a week.

2. Emergency care treatment shall include clinical services under the direction of a physician licensed to practice in Maine. His/her visits (which should be daily) shall be documented.

3. Every emergency care program should have 24-hour coverage of clinical services by an RN or LPN and at least one counselor on duty during each shift of every day.

§ 42. HOSPITAL CARE

Hospital care shall be arranged by a written agreement with a community or general hospital which shall provide in-patient care and other emergency medical care not provided for by the program.

§ 43. TRANSPORTATION

A transportation support system must be available 24 hours a day, and an agreement shall cover a transportation arrangement between the program and hospitals or other emergency medical facilities.

CHAPTER 5
IN-PATIENT CARE

§ 45. IN-PATIENT CARE REQUIREMENTS

1. The in-patient care component shall provide 24-hour supervised care under the direction of a physician in a hospital or other suitably equipped medical setting designed for the diagnosis and/or treatment of medical and/or psychiatric illnesses derived from or associated with alcohol abuse, drug abuse or alcoholism. The program shall describe its in-patient component in detail.

2. An evaluation of the medical needs of the client shall be conducted within 24 hours of the client's entry into the in-patient care component.

3. Medical supervision of all clinical staff shall be provided and documented.

4. The in-patient care component shall provide an area in which clients can meet with outside community service providers and other program component personnel who assist in fulfilling the goals and objectives of the treatment plan.

§ 46. TREATMENT PLAN

An individualized treatment plan shall be based on the diagnosis of the medical needs. Treatment plans and medical care shall be determined by hospital policy, and shall include provision for care beyond the in-patient care services.

§ 47. EVALUATION

An evaluation of the social/psychological needs of the client shall be completed prior to discharge from the in-patient care component.

§ 48. UPDATED PLAN

An updated plan based on the social/psychological evaluation shall be the basis for treatment following discharge from the in-patient care component. This plan shall:

A. Specify the services planned to meet the client's needs;

B. Include referrals for services not provided by the in-patient care component; and,

C. Be available to the component or other human service program which is to provide the needed services.

CHAPTER 6
INTERMEDIATE CARE

§ 50. INTERMEDIATE CARE REQUIREMENTS

1. The intermediate care component shall facilitate the recovery of the substance abuser by placing him in an organized therapeutic environment in which he may receive diagnostic services, counseling, vocational rehabilitation and/or work therapy while benefiting from the support which a full or partial residential setting can provide. The program shall describe the intermediate care component in detail.

2. The intermediate care component shall describe how the services provided by the component inter-relate with services to the alcohol and drug abuser provided elsewhere in the community. Where possible, arrangements for service provision by other community agencies should be covered by written agreement.

3. Services provided shall include, but not be limited to:

A. Physical examinations and laboratory examinations as appropriate;

1. For clients entering alcoholism treatment facilities, examinations may have been completed in another treatment component. However, examination shall be given, if in the judgment of the program's physician, such examinations have not been completed recently.

2. For clients entering drug abuse treatment facilities, the likelihood exists that such examinations have not been completed. Physical and laboratory examinations shall be administered by or under the supervision of a physician licensed to practice in Maine. The content of the examination may be determined by the physician, but shall include as a minimum:

(a) Investigation of the possibility of infectious disease, pulmonary, liver, cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems;

(b) Complete blood count and differential;

(c) Serological tests for syphilis;

(d) Routine and microscopic urinalysis.

3. All examinations shall be conducted as soon as practicable after the client's admission, but not later than 14 days after such admission.

B. Individual and group counseling;

1. In group counseling, the size of the group should range between 5 and 15 individuals.

2. There shall be a minimum of 10 hours per week of formalized counseling available for each client.

C. Chemo-therapy, if appropriate;

D. Recreational and vocational guidance;

E. Re-training, if appropriate;

F. Education;

1. Educational services may include, but are not limited to, remedial education, preparation for G.E.D., lectures, films, classes, workshops, physical education, tutoring.

2. Programs serving more than ten (10) clients under the age of sixteen (16) must provide an educational program that is approved by the State Department of Education and Cultural Services.

G. Social interaction, which may include parties, dinners, dances, picnics, development of interpersonal relationships and social skills, sports, etc.;

H. Orientation of clients to community programs, resources, and services which may include vocational rehabilitation, courts, social service departments, counseling agencies and Alcoholics Anonymous.

4. Each program should provide a minimum of 5 hours per week of professional mental health consultation per 100 patients.

5. Intermediate care facilities shall have staff coverage 24 hours a day, including week-end coverage.

§ 51. ORIENTATION

1. The client, referral agency or legal guardian shall be given sufficient information about the program to enable him to make a decision regarding admission.

2. Prospective clients shall be informed of their rights and responsibilities as program participants.

3. An orientation policy shall spell out the client's introduction to the program and facility.

§ 52. INDIVIDUAL TREATMENT PLAN

1. The individual treatment plan (Chapter 3, §21) shall take cognizance of predictable crisis periods in the recovery process, and ways in which the

facility helps residents cope with them.

2. Each treatment plan must include documented information relating to:

A. Short and long term goals for treatment generated by both staff and client;

B. The assignment of a primary counselor;

C. A delineation of the type and frequency of counseling services to be provided;

D. A delineation of those supportive services needed by the individual client; and,

E. Treatment plan is to be reviewed with the client and signed by the client and the primary counselor.

3. The individual treatment plan shall be reviewed by the counselor and client at least every 15 days in an alcoholism treatment facility, at least every 30 days in a drug abuse treatment facility. This shall be documented by signature or initials of client and counselor.

§ 53. PROGRAM COMPLETION CRITERIA

1. The program shall provide within its structure the means for on-going review of the degree to which each client is meeting his individual treatment goals. When it becomes evident to key staff that the client has received optimum benefit from treatment and that further progress requires a return to functioning in the community, or when the program length of stay has newly expired, joint planning for the client's discharge shall be undertaken in consultation with the client.

2. Criteria for successful completion of the program shall include:

A. The client shall no longer be dependent for social activity upon those who abuse alcohol or drugs or upon the treatment facility, and his avocational interests and behavior must have become established in socially acceptable recreational and social pursuits.

B. The client shall have assumed responsibility for himself and shall have completed his treatment goals.

C. The client shall have developed the capacity to be as economically self-sufficient as possible.

D. The client should have demonstrated either job stability or responsibility in seeking employment.

3. The client's meeting of criteria for discharge shall be documented in the final case review.

§ 54. PHYSICAL PREMISES

1. The physical environment of any treatment program must preserve the dignity and enhance the individuality of the client and provide for the development of a positive self-image of the client.

2. The physical environment shall be free from alcohol and drugs of abuse and shall encourage:

A. The development of life patterns conducive to good health and sobriety;

B. Personal responsibility and independence on the part of the residents;

C. The provision of a peer group of fellow residents with which to identify and with which to give and receive support.

3. The facility must be clean, and a schedule for the maintenance of the premises must be posted.

4. If possible, the premises should conform to the other homes in the area of the facility. The physical premises shall also ensure that:

A. The interior of the home shall be furnished adequately with a homelike setting;

B. Personal touches in room displays and decorations are allowed;

C. There shall be privacy in personal hygiene;

D. There shall be proper separation in sleeping quarters and bathroom facilities serving male and female residents;

E. There shall be one or more living rooms or day rooms;

F. Space for meeting, television and a quiet room shall be set aside;

G. There shall be access to an area of solitude when needed;

H. There shall be adequate:

1. Closet and storage space for personal property, including some lockable storage space on the premises;

2. Lighting;

3. Temperature and ventilation control including adequate screening;

4. Appliances and equipment in good operating order.

I. There shall be room for office space for the manager, house records, telephone and individual counseling. If records are kept in the office, they shall be kept under lock and key, and so placed that only the clinical and administrative staff have access to them;

J. Office space should be in an area separate from the residential area to ensure privacy of the residents;

K. A sign in/sign out system shall be maintained and required for residents upon entering and leaving the premises.

5. Clients shall be actively involved in helping to maintain a homelike atmosphere.

A. They shall have a responsibility in maintaining their own living quarters;

B. They shall have a responsibility in maintaining the general cleanliness and reasonable upkeep of the premises.

§ 55. VALUABLES

The facility shall be responsible only for valuables of clients entrusted to its care during the time of residency. A list of valuables entrusted to the facility shall be made upon entry to the program. This list and the return of the valuables shall be documented by the client's signature or initials. The facility shall not be responsible for valuables remaining on the premises in possession of the client.

§ 56. MEDICAL AFFILIATION

1. An intermediate care component shall have a documented medical affiliation with:

A. A general hospital, mental hospital, or comprehensive mental health center; or

B. One or more physicians; or

C. Other resources not included in this section, which shall meet the medical needs of the intermediate care component.

§ 57. TRANSPORTATION

Access to 24 hour transportation services shall be available between the intermediate component and the general or community hospital, and the in-patient component, where applicable.

CHAPTER 7
OUT-PATIENT CARE

§ 60. OUT-PATIENT CARE REQUIREMENTS

1. The out-patient treatment component shall provide or provide access to a variety of diagnostic services to substance abusers and their families whose physical and emotional status allows them to function in their usual environment. The program shall describe its out-patient component in detail.

2. The services shall be offered according to a prescribed plan on a scheduled basis.

3. There shall be a social/psychological evaluation that includes, but is not limited to:

A. Drinking or drug abuse history and previous treatment;

B. Determination of current emotional state;

C. Vocational history;

D. Family relationships;

E. Educational background; and

F. Socio-economic status.

§ 61. MEDICAL EVALUATION

1. The program shall determine the necessity of a medical evaluation which must be completed prior to the development and implementation of a treatment plan.

2. When necessary, the medical evaluation shall be conducted by a qualified physician and shall be contained in the individual treatment plan.

§ 62. TREATMENT PLAN

1. The individualized treatment plan as required by §21 of Chapter 3 shall:

A. Be based on the social/psychological evaluation, and a medical evaluation, if applicable;

B. Specify the services planned for meeting of the client's needs; and,

C. Include referrals for services not provided by the out-patient care component.

2. The client shall participate in the development of the treatment plan and its objectives.

§ 63. MEETING ROOM

The out-patient component should provide a room in which clients can meet with outside community service providers for other activities consistent with the program.

CHAPTER 8
OUTREACH

§ 67. OUTREACH REQUIREMENTS

1. The outreach component shall identify within a target population persons and their families who have problems related to the use of alcohol and other drugs and enable them to procure substance abuse services. The program shall describe its outreach component in detail.

2. Outreach shall alert all public and private human service agencies who serve the same target population of the importance of early identification and easy access to the service delivery system.

3. Outreach shall involve as many organizations, agencies and individuals as may be in contact with part of the target population.

4. Requirements for an outreach program shall include:

   A. Identification of persons in need of services;

   B. Location of services to fill needs;

   C. Assisting clients to enter the service delivery system;

   D. Ensuring contact at point of entry to the service delivery system;

   E. Alerting relevant agencies and individuals of the importance of early detection, and assisting them in the role of case findings;

   F. Reporting back to any agency, individual, or organization which has assisted in the identification of a client (the report shall include services to the individual); and

   G. Maintaining liaison and interaction with all appropriate community organizations and agencies.

5. The outreach component philosophy, goals and objectives shall relate to those of the treatment component, and must follow logically from them.

§ 68. HUMAN SERVICES DIRECTORY

The outreach component shall be aware of all the public and private human services agencies in the area, and shall have a directory of available services.

CHAPTER 9
AFTERCARE

§ 75. AFTERCARE REQUIREMENTS

1. The aftercare component shall provide services to clients who have progressed sufficiently through emergency, in-patient, intermediate and/or out-patient treatment to a point in their recovery where they will benefit from a level of continued contact which will support and increase the gains made to date in the treatment process. Every program shall describe its aftercare component in detail.

2. The aftercare philosophy, goals and objectives shall relate to those of the treatment component, and shall follow logically from them.

3. Every program shall provide aftercare for a minimum time period of one year.

§ 76. PROVISION OF SERVICES

1. The aftercare component shall provide aftercare services through:

   A. Referral to another program, or

   B. Contractual agreement with an agency providing aftercare services, or

   C. Direct follow-up.

2. If aftercare is provided by referral to another program, the treatment program shall:

   A. Contact the referral program;

   B. Discuss the appropriateness of the referral;

   C. Complete the placement of the client into the referral program; and

   D. Require progress reports at specified intervals.

3. If the aftercare is provided by contractual agreement with an agency providing aftercare services, the program shall:

   A. Document the contractual agreement between the program and the agency;

   B. State the nature of the services provided, and define the responsibility of the program and the agency;

   C. Ensure that progress reports are made to the program at specified intervals; and

   D. Ensure that aftercare services provided by unlicensed programs meet the approval regulations of OADAP.

4. In cases where no referral is made and no contract is provided, the program shall provide aftercare by direct follow-up of the client:

A. By personal contact;

B. By telephone;

C. By re-visit to the facility; or

D. By other meaningful methods documented by the program.

§ 77. INDIVIDUAL TREATMENT PLAN

1. The aftercare component shall include an individualized service plan designed to establish continuing contact for the support of each client according to his/her specific individual needs. Contact shall be made at least every 90 days.

2. The aftercare plan shall:

A. Be formulated by the treatment provider, aftercare personnel, the client, and his family where applicable;

B. Have provisions for periodic review and updating;

C. Include a mechanism for referral of clients who may require or desire services unavailable through the component. Alternative resources for unavailable services shall be listed or described and the mechanism for ensuring continuity of care during the referral services shall be described; and,

D. Provide for re-entry into the treatment system, if necessary.

CHAPTER 10
SHELTER

§ 80. SHELTER REQUIREMENTS

1. The shelter component shall be a pre-treatment program. Services provided are not considered treatment, instead they provide the necessities of life and the possibility for motivation to move into treatment programs. The program shall describe its shelter component in detail.

2. The premises of the shelter shall be clean, light, bright, fresh, providing an element of human dignity for those in the facility.

3. The shelter shall comply with all the necessary standards concerning health, fire, and sanitation.

4. Services provided shall include:

A. Well balanced meals, with soup, coffee and other food available on a 24 hour basis;

B. Clean clothing, with laundry facilities available on the premises;

C. Clean bedding;

D. Shower facilities; and

E. Toilet articles, with proper precaution for razors, or other possibly harmful items.

§ 81. STAFF

1. Staff coverage shall be provided on a 24 hour basis. The staff shall:

A. Be able to recognize danger signs in the residents;

B. Know where to call in case of emergency;

C. Know the telephone numbers of hospitals and emergency care facilities in the area;

D. Have the ability to gain trust;

E. Be able to talk about detoxification and available treatment;

F. Know the lines of referral;

G. Be able to keep records of shelter use; and,

H. Perform other shelter service tasks.

2. The shelter staff personnel should preferably be recovering substance abusers who are able to maintain a continuing sobriety and drug-free status.

§ 82. AGREEMENTS WITH FACILITIES

1. Written agreements shall be arranged between the shelter and in-patient facilities, emergency care facilities, and hospitals.

2. Such agreements should define procedures for emergency treatment and responsibility for transportation.

§ 83. TRANSPORTATION

Transportation shall be available on a 24 hour basis.

CHAPTER 11
ADDITIONAL REGULATIONS FOR ALL APPROVED PUBLIC TREATMENT FACILITIES (APTF)

§ 90. GENERAL

Any public treatment facility that possesses an emergency care component and is otherwise in compliance with these regulations may be designated an APTF. All APTF's shall comply with the regulations set forth in this chapter.

§ 91. EXAMINATION

Any person brought to an APTF by the police or any other person shall be examined forthwith by a physician. He may then be admitted as a client or referred to another health facility. The referring APTF shall arrange for his transportation.

§ 92. ADMISSION; REFUSAL TO ADMIT

1. A person, who is not admitted to an APTF, is not referred to another health facility and has no funds, may be taken to his home, if any. If he has no home, the APTF shall assist him in obtaining shelter.

2. If a patient is admitted to an APTF, his 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, his request shall be respected.

§ 93. DETENTION OF CLIENTS

A person, who by medical examination is found to be incapable of realizing he needs emergency care and incapable of making a rational decision regarding his need for emergency care, may be involuntarily detained at the APTF until he is no longer incapacitated by alcohol, provided however, that such an incapacitated person may not be held against his will for more than 48 hours after admission as a client unless he is committed under either M.R.S.A. 22 §7119 or §7120 (Judicial Commitment).

§ 94. USE OF FORCE

If an incapacitated client is detained in an APTF pursuant to §95 of this chapter or involuntarily committed pursuant to M.R.S.A. 22 §7119 or §7120, the administrator or any designated member of the APTF staff may use whatever force is reasonably necessary to protect the health and safety of the client, staff member or other person, or to prevent the destruction of property. Any incident involving the use of force shall be noted in the client's treatment record.

§ 95. EMERGENCY COMMITMENTS

1. A person who has threatened, attempted or inflicted physical harm on another or a person who is incapable of realizing he needs treatment and is incapable of making a rational decision regarding his need for treatment may be involuntarily committed to an APTF by the administrator

pursuant to M.R.S.A. 22 §7119 (Emergency Commitment).

2. The administrator of every APTF shall have read and shall understand and possess a good working knowledge of the procedures for emergency commitments as contained in the OADAP publication - Procedural Manual for the Involuntary Commitment of Intoxicated, Incapacitated and Alcoholic Persons in Maine.

3. A record of all involuntary commitments shall be carefully maintained.

4. OADAP shall be immediately notified of any emergency commitment involving difficult or unusual circumstances.

CHAPTER 12
JUDICIAL COMMITMENT OF ALCOHOLICS

§ 100. COMMITMENT

1. An alcoholic who has threatened, attempted, or inflicted physical harm on another, or a person who is incapable of realizing he needs treatment and incapable of making a rational decision regarding his need for treatment may be involuntarily committed under M.R.S.A. 22 §7120 (Judicial Commitment) to an APTF, a private facility, a treatment program, a hospital, or any place that can provide adequate and appropriate residential or outpatient treatment.

2. The administrator of every facility, before accepting an involuntarily committed person for treatment, shall have read, and shall understand and possess a good working knowledge of the procedures for commitment as contained in the Procedural Manual for the Involuntary Commitment of Intoxicated, Incapacitated, and Alcoholic Persons in Maine.

3. OADAP shall be notified at least three days prior to the commencement of any Judicial Commitment.

4. A record of all Judicial Commitments shall be carefully maintained.

COMMENT

The Procedural Manual for the Involuntary Commitment of Intoxicated, Incapacitated and Alcoholic Persons in Maine is available from the OADAP office in Augusta. Advice concerning procedural or legal problems involving commitments may also be obtained by contacting OADAP.

STATE OF MAINE

MAR 8 '78
BY GOVERNOR

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-EIGHT

S. P. 696 — L. D. 2138

AN ACT to Revise the Statute on Operating a Motor Vehicle While under the Influence of Intoxicating Liquor or Drugs.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, an inconsistency between 2 bills enacted by the Legislature has made it impossible to carry out the legislative intent with regard to mandatory driver education courses for persons convicted of operating a motor vehicle while under the influence of liquor or drugs; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

Sec. 1. 29 MRSA § 1312, sub-§ 10, as last amended by PL 1977, c. 438 and c. 481, § 21, and as repealed and replaced by PL 1977, c. 498, § 1, is repealed and the following enacted in its place:

10. Penalties.

A. Notwithstanding the provisions of Title 17-A, section 4-A, any person who, while under the influence of intoxicating liquor or drugs, operates or attempts to operate a motor vehicle within this State shall be punished, on his first conviction, by a fine of not more than $1,000 or by imprisonment for not more than 90 days, or by both.

B. Notwithstanding the provisions of Title 17-A, section 4-A, any person who is convicted of a 2nd violation under this section shall be punished by imprisonment for not less than 24 hours or for not more than 6 months. Any term of imprisonment up to and including 48 hours or the first 48 hours of any term of imprisonment of more than 48 hours shall be served consecutively. In addition, such a person shall be punished by a fine of not less than $250 and not more than $2,000.

Any term of imprisonment up to and including 48 hours and the first 48 hours of any term of imprisonment of more than 48 hours shall not be suspended unless the court sets forth in detail in writing the reasons why, having regard to the nature and circumstances of the violation and the history and character of the defendant, it is of the opinion that exceptional features of the case justify the imposition of a sentence other than imprisonment.

The court shall order such a term of imprisonment up to and including 48 hours to be served at a time that will cause the least disruption to the convicted person's employment and other personal affairs, but that is within 30 days of the date of conviction. Such a term of imprisonment up to and including 48 hours may be served in either a county jail or local lockup, as the court shall direct. The provisions of this paragraph regarding the term of imprisonment up to and including 48 hours for a 2nd conviction shall apply only if the State alleges the prior conviction in accordance with Title 15, section 757; provided that the certified copy of the prior conviction from the office of the Secretary of State shall be admitted in evidence as proof of the prior conviction.

C. Notwithstanding the provisions of Title 17-A, section 4-A, any person convicted of a 3rd or subsequent violation of this section shall be punished by imprisonment for not less than 48 hours or for not more than 10 months. Any term of imprisonment up to and including 72 hours and the first 72 hours of any term of imprisonment of more than 72 hours shall be served consecutively. In addition, that person shall be punished by a fine of not less than $250 and not more than $2,500.

Any term of imprisonment up to and including 72 hours and the first 72 hours of any term of imprisonment of more than 72 hours shall not be suspended unless the court sets forth in detail in writing the reasons why, having regard to the nature and circumstances of the violation and the history and character of the defendant, it is of the opinion that exceptional features of the case justify the imposition of a sentence other than imprisonment.

The court shall order such a term of imprisonment up to and including 72 hours to be served at a time that will cause the least disruption to the convicted person's employment and other personal affairs, but that is within 30 days of the date of conviction. Such a term of imprisonment up to and including 72 hours may be served in either a county jail or local lockup, as the court shall direct. The provisions of this paragraph regarding the minimum term of imprisonment for a 3rd or subsequent conviction shall apply only if the State alleges 2 or more prior convictions in accordance with Title 15, section 757; provided that the certified copy of the prior convictions from the office of the Secretary of State shall be admitted in evidence as proof of the prior convictions.

D. For the purposes of this section, a prior conviction of operating or attempting to operate while under the influence of intoxicating liquor or drugs shall be considered a prior conviction if it occurred within a 6-year period of the date of the most recent conviction.

E. Except for the purpose specified in paragraph B, it shall not be necessary to comply with the procedures set out in Title 15, section 757, to establish prior convictions under this section. After a conviction, the court shall conduct an inquiry to determine whether or not the defendant has been convicted of any offenses which are considered to be prior offenses for the purposes of this section. Certified copies of the record of prior conviction or convictions from the Secretary of State or any court of record shall be admissable. On receipt of a copy and being satisfied that the defendant is the person named in that certified copy, the court shall treat the present conviction as a subsequent conviction and sentence the defendant accordingly.

Sec. 2. 29 MRSA § 1312, sub-§ 10-A is enacted to read:

10-A. Suspension of license.

A. On receipt of an attested copy of the court record of a conviction, the Secretary of State shall immediately suspend the person's license or permit and privilege to operate a motor vehicle. The suspension shall be for the following minimum periods from the date of suspension:

(1) In case of a first conviction, 30 days;

(2) In case of a 2nd conviction, 6 months; and

(3) In case of a 3rd or subsequent conviction, 2 years.

B. After the minimum suspension period, the Secretary of State may issue a license or permit to the person if:

(1) In case of a first conviction, the secretary receives written notice that the person has satisfactorily completed the alcohol education program of the Department of Human Services;

(2) In case of a 2nd conviction, the secretary receives written notice that the person has satisfactorily completed the education program, and, if required by the Department of Human Services, has also satisfactorily completed an alcohol treatment or rehabilitation program approved or licensed by the department; and

(3) In case of a 3rd or subsequent conviction, if the person petitions the secretary for a license or permit after the period of minimum suspension and if the person presents clear and convicing evidence that he has satisfactorily completed an alcohol or drug treatment program approved or licensed by the Department of Human Services and that he has abstained from the use of intoxicating liquor or drugs for a period of 2 years immediately prior to the date of the petition.

C. The Secretary of State may issue the license or permit with whatever conditions, restrictions or terms he deems advisable, having in mind the safety of the public and the welfare of the petitioner. In the case of a 3rd or subsequent conviction, the license or permit may contain the condition that the person continue to abstain from the use of intoxicating liquor or drugs.

D. The Secretary of State may also issue a restricted license or permit to any person whose license or permit has been suspended for a first refusal under subsection 2, if the conditions of issuing after a first conviction are met by the person.

E. The Department of Human Services may charge a registration fee not to exceed $40 to participants in the education program, which shall be applied to defraying the expenses of the program.

F. If any person convicted for a violation of this section appeals the judgment or sentence of a court, the license or permit and privilege to operate a motor vehicle shall be suspended during the time an appeal is pending, unless the court shall otherwise order, or unless the Secretary of State shall restore the license, permit or privilege to operate pending decision on the appeal.

G. Any suspension under this section shall run consecutively to any suspension

imposed for refusal to submit to a chemical test to determine blood-alcohol level by analysis of blood or breath.

Sec. 3. 29 MRSA § 1312, sub-§ 11, as enacted by PL 1977, c. 498, § 2, is repealed and the following enacted in its place:

11. Accidents and officer's duties.

A. After making an arrest for a violation of this section, the arresting officer shall investigate to determine whether the arrested person has any prior convictions under this section. As part of his investigation, the arresting officer shall make the necessary inquiries of the Secretary of State. If the arresting officer determines that the arrested person has a prior conviction, he shall cause to be issued a complaint for a 2nd violation in accordance with subsection 10, paragraph B.

B. Any officer authorized to arrest for violations of this section may arrest, without a warrant, any person involved in a motor vehicle accident, if the officer has probable cause to believe that that person has violated this section.

C. Every person operating a motor vehicle which has been involved in an accident or which is operated in violation of any of the provisions of this Title shall, at the request of a police officer, submit to a breath test to be administered by the police officer. If the test indicates that the operator has consumed alcohol, the police officer may require the operator to submit to a chemical test in the manner set forth in this section.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

IN HOUSE OF REPRESENTATIVES, ... 1978

Read twice and passed to be enacted.

.....Speaker

IN SENATE, ...1978

Read twice and passed to be enacted.

..... President

Approved..... 1978

.....Governor

THE DRIVER EDUCATION AND EVALUATION PROGRAM (DEEP)

On October 24, 1977, the Driver Rehabilitation Course (DRC) was transferred from the Motor Vehicle Division to the Office of Alcoholism and Drug Abuse Prevention in accordance with legislation (Title 29 of the Maine Revised Statutes Annotated, Section 1312) enacted during the 108th session of the State Legislature. Other legislation also was enacted (Title 29 of the Maine Revised Statutes Annotated, Section 1) which has expanded the responsibilities of the course by requiring that more attention be given to the multiple OUI offender and to the detection and referral of problem drinkers. The new legislative mandate has resulted in a redesign of the program and the adoption of a new name - the Driver Education and Evaluation Program (DEEP) - which more accurately reflects current program activities.

THE DEEP PROGRAM

DEEP conducts a week-long educational program designed to: a) acquaint the OUI offender with the effects of alcohol on the human body and driving performance; and, b) to explore personal drinking habits and to consider changing those habits if necessary. During the course, each participant is evaluated to determine if he or she has a drinking problem. The Mortimer-Filkins test is the primary tool used to detect the presence of a drinking problem. Individuals found to have such a problem are referred to treatment programs.

Courses normally begin with a three-hour session on Monday evenings. Tuesdays and Wednesdays are set aside for the course instructor to conduct individual sessions with each participant. During these sessions the Mortimer-Filkins interview is administered and, upon completion, the entire Mortimer-Filkins test is scored. Individuals who score in the presumptive problem drinker or the problem drinker range are informed that they must obtain treatment services. The course instructor discusses available treatment programs with the participant and a mutually agreed-

upon decision is reached regarding the treatment program to be used.

Before the end of the week, the course instructor will initiate the referral by completing the DEEP Client Referral Form and sending it along with an Authorization for Release of Confidential Information Form and a blank Treatment Status Form to the appropriate treatment program. The referrals are informed that they must make contact with the treatment program within two weeks. The referrals are made aware that the treatment program is being contacted regarding their case.

The course concludes with two, three-hour sessions on Thursday and Friday evenings.

There is a $40.00 charge for enrolling in the course.

DEEP PARTICIPATION, TREATMENT REFERRAL AND LICENSE RESTORATION

Prior to October 24, 1977, the DRC was primarily concerned with providing a drinking and driving prevention education course to first-time OUI offenders. If the first-time offender satisfactorily completed the course, he could regain his operator's license after thirty days of the mandatory 120-day suspension period. There was no similar incentive for the multiple OUI offender (a person with more than one OUI conviction within a ten-year period) to attend the course.

The new law does not alter the penalties or incentives for course participation for the first-time OUI offender; however, it requires all multiple offenders to participate in the DEEP program (either the course or the treatment referral component, or both) before they are eligible for license restoration. It also provides rewards for such participation.

Although DEEP is no longer a part of the Motor Vehicle Division, it continues to closely coordinate its activities with the Bureau of Licensing Control, Motor Vehicle Division. Current policies for license restorations for OUI offenders are as follow:

1. First-time offenders receive an indefinite suspension of their operators' licenses. If they elect to participate in DEEP and satisfactorily complete the course, they can be issued restricted licenses after thirty days of suspension. A restricted license allows a person to operate a motor vehicle at certain designated hours of the day, usually to drive to and from his place of employment, or for some equally essential driving. The restricted license is issued for a 90-day period. When the restricted license expires, a full license is issued. When the first-time offender has been referred to treatment by DEEP, a restricted license will be issued after 30 days of suspension only if the offender has satisfactorily completed the course and no adverse treatment report is received by the Motor Vehicle Division. If a restricted or full license is issued before treatment is satisfactorily completed, the offender will be informed by Motor Vehicle officials that he must satisfactorily complete the DEEP treatment requirement in order to retain his license. Failure to complete the DEEP treatment requirement will result in a case review or hearing, at which time a decision will likely be made to re-suspend the individual's license until such time that treatment is satisfactorily resumed or completed.

First-time OUI offenders who do not participate in DEEP can petition Motor Vehicle for a restoration hearing after 60 days of their suspension. At such hearings, Motor Vehicle officials will require DEEP participation as a condition of license restoration in virtually all instances.

2. Individuals experiencing a second OUI conviction during a ten-year period will receive a one-year suspension of their operator's license. In addition, they are required by law to satisfactorily complete the DEEP course, and when required by DEEP, to satisfactorily complete treatment. A restricted license can be issued after six months of suspension if the second-time offender has completed the DEEP course satisfactorily, and if required, is satisfactorily engaged in--or has satisfactorily completed treatment. The restricted license is issued for a

six-month period or until the end of the original one-year suspension period. When the restricted license expires, a full license is issued. If a restricted or full license is issued prior to the satisfactory completion of treatment, the offenders will be informed by Motor Vehicle that they must satisfactorily complete the DEEP treatment requirement. They will also be informed that failure to do so will result in a case review or hearing. At that time, a decision will likely be made to re-suspend the individual's license until such time as treatment is satisfactorily resumed and/or completed.

Second-time OUI offenders who do not participate in DEEP can petition Motor Vehicle for restoration of their licenses after a one-year period of suspension. In virtually all such cases, the offender will be required to participate in DEEP as a condition of his license restoration. This policy may be altered if the Attorney General rules that Motor Vehicle must restore a license after a one-year suspension.

3. Individuals with three or more OUI convictions within a ten-year period will have their licenses permanently suspended. However, after two years of suspension, the offender may petition Motor Vehicle for a license restoration hearing. In order to be eligible for restoration, the offenders must present at the hearing, clear and convincing evidence that they have satisfactorily completed an alcohol or drug treatment program. They also must have abstained from the use of intoxicating liquor or drugs for a two-year period. This is the only way the OUI offenders with three or more convictions can obtain their suspended operators' licenses.

REGULATIONS FOR THE APPROVAL OF ALCOHOL OR DRUG TREATMENT SERVICES FOR OUI OFFENDERS

The new law requires that all OUI offenders required to obtain alcohol or drug treatment as a condition of license restoration, must receive treatment services from organizations or individuals who are approved or licensed by the Department of Human Services. This regulatory responsibility has been placed with the OADAP. Regulations have been drafted and implemented

by the OADAP to establish approved OUI treatment programs.

The OUI treatment programs' approval regulations limit eligibility for approval to: a) organizations, facilities, or programs which are licensed or approved under OADAP's REGULATIONS FOR THE LICENSING AND APPROVAL OF SUBSTANCE ABUSE TREATMENT PROGRAMS IN THE STATE OF MAINE; b) persons or individuals who are licensed or registered in the State of Maine as Substance Abuse Counselors, Physicians, Osteopaths, Psychologists, or Social Workers; and c) persons or individuals who are examined by OADAP and determined to be competent alcohol or drug treatment service providers.

The regulations also establish guidelines for the provision of clinical services. Organizations or individuals desiring to be approved as service providers should contact the OADAP for a copy of the regulations and for information regarding approval procedures.

REPORTING PROCEDURES FOR APPROVED TREATMENT PROVIDERS

All approved treatment services must comply with the reporting system set forth in the regulations. When a referral is initiated, the DEEP instructor shall notify the treatment provider by completing a DEEP Client Referral Form (RAS-6 1077 DEEP-3) and sending it to the provider. Accompanying this form, will be an Authorization for Release of Confidential Information form (RAS-5 1077 DEEP-2) which has been signed by the referral and a blank DEEP Treatment Status Form (RAS-7 1077 DEEP-4). This form is to be filled out by the treatment provider and submitted to the DEEP office at the OADAP within five days after the date of admission to treatment. The service provider shall keep the green copy of the Treatment Status Form and send the blue and yellow copies to DEEP.

If the referral fails to contact the treatment provider and make arrangements for an initial interview within fourteen (14) days from the date of client referral (this date is on the Client Referral Form), the service provider should complete the Treatment Status form indicating the referral has not made contact.

The blue and yellow copies of the form shall be submitted to DEEP within five days after the fourteen-day period.

At any time during treatment, the approved service provider shall, upon the request of the DEEP, submit to the DEEP within ten (10) days, a completed copy of the Treatment Status Form. Such requests will routinely be made twenty (20) days prior to a motor vehicle hearing.

If at any time during the treatment process a referral is determined to not be continuing satisfactorily, a Treatment Status Form should be submitted to DEEP indicating the adverse determination. The form shall be submitted to DEEP within five days after such a determination is made. An adverse treatment status decision shall be made when the referral fails to satisfactorily progress towards treatment goals and objectives.

At the completion of treatment services, a Treatment Status Form shall be completed and submitted to the DEEP within five (5) days of the completion of treatment services. The form shall indicate if treatment was completed satisfactorily.

Satisfactory completion of treatment services means the referral has attended and actively participated in scheduled treatment sessions and has substantially attained the goals and objectives of the treatment plan.

For each referral admitted to treatment, there will be at least two Treatment Status Forms submitted to DEEP. The first form submitted, within five days of the date of treatment entry, shall include the following information:

1.	Name of Client:	Full legal name
2.	Program:	Name of treatment organization or individual provider
3.	Date of Birth:	Month, day and year of client's birth
4.	Sex:	Client's sex; female or male
5.	Date of Referral:	Date found on DEEP Client Referral Form
6.	Date of Treatment Entry:	Date client formally entered treatment
7.	Treatment Continuing Satisfactorily:	If the client has entered treatment and everything is progressing properly, this item does not need to be answered at this time. Subsequent status forms should include a response to this item.

8. Anticipated Date of Completion:	If the approximate date of treatment completion is known, it should be entered.
9. Client Withdrew from Treatment:	This item needs no response unless the client leaves treatment against the advice of the treatment program.
10. Date of Last Visit:	This item should not be completed. It would be completed on all subsequent status forms submitted to DEEP.
11. Treatment Satisfactorily Completed:	This item should not be completed until treatment is terminated.
12. Date of Completion:	Complete this item at time treatment is terminated.
13. Client Has Abstained From Use of Alcohol:	This item is for clients with three or more OUI convictions only. Do not complete this item until treatment is completed.
14. Client Referred for Medical Evaluation:	If a determination has been made to require a medical evaluation, please indicate in response to this item. If no medical evaluation is being required, leave blank.
15. Signature of Therapist/ Date:	Enter signature of individual providing direct service to the client and the date signed.
16. Recommendations:	This item is for any additional information which may be of significance to the case.

Subsequent Treatment Status Forms submitted to DEEP should include the client's name, the treatment program name, and the client's date of birth. The only additional information required is an indication of current treatment status, i.e.; is the client continuing satisfactorily; did the client withdraw from treatment; is the treatment satisfactorily completed, etc. The other items shall be completed only if they provide additional information concerning the client's current status, or if there is a change from information provided on a previous Treatment Status Form.

REGULATIONS FOR THE APPROVAL AND OPERATION OF THE OUI (OPERATING UNDER THE INFLUENCE) TREATMENT PROGRAMS

Maine Department of Human Services
Office of Alcoholism and Drug Abuse Prevention

DRIVER EDUCATION AND EVALUATION PROGRAM

§§ 1. Eligibility for Approval

1. These regulations are authorized under Title 22 of the Maine Revised Statutes Annotated, Section 5-A and Section 7115 and Title 29, Section 1312, which enpower the Department of Human Services to approve or license treatment or rehabilitation programs which provide services to individuals who are convicted of Operating Under the Influence of intoxicating liquor or drugs (OUI) and who are required by the Department of Human Services to satisfactorily complete alcohol or drug treatment or rehabilitation as a condition of the restoration of driving privileges.

2. No organization, facility, or program shall offer services for OUI offenders who are required to obtain treatment as a condition of license restoration unless they:

   A. are licensed or approved under M.R.S.A. 22, Section 5-A and the Regulations for the Licensing and Approval of Substance Abuse Treatment Programs in the State of Maine, and

   B. are in full compliance with these regulations.

3. No person or individual shall offer services for OUI offenders who are required to obtain treatment as a condition of license restoration unless they:

   A. are licensed or registered under M.R.S.A. 32, Chapter 79 (substance abuse counselors) or M.R.S.A. 32, Chapter 48 (physicians), Chapter 36 (osteopaths), Chapter 56 (psychologists), or Chapter 62-A (social workers), or

B. are examined by the Office of Alcoholism and Drug Abuse Prevention and determined to be competent providers of alcohol and/or drug treatment services, and

C. are in full compliance with these regulations.

4. Nothing in these regulations shall prevent facilities, programs, or persons from offering alcohol treatment services to OUI offenders provided that such services are not offered to OUI offenders who are required to obtain treatment as a condition of license restoration.

§§ 2. Case Records

1. A case record for each client shall be maintained. This record shall include, but not necessarily be limited to:

A. Identification data;
B. Reports from referring sources;
C. Pertinent case records;
D. Problems and goals;
E. Family evaluation, if appropriate, as part of the process leading to the development of the individual treatment plan;
F. Individual treatment plan;
G. Evaluation of progress reports;
H. Correspondence pertinent to the case;
I. Record of significant incidents, both positive and negative;
J. Signed Release of Information Form, where applicable;
K. Referrals for service to other agencies; and
L. A discharge summary which contains a final evaluation of the client's progress toward the treatment goals and objectives set forth in the initial treatment plan.

§§ 3. Confidentiality

All personnel providing treatment services to OUI offenders shall have a full understanding and working knowledge of the Federal Rules and Regulations on the Confidentiality of Alcohol Abuse Patient Records. A summary of these rules and

regulations may be obtained from the OADAP.

§ 4. Fraud and Deceit

No person, program, or organization shall utilize fraud, deceit, or misrepresentation in presenting information to the client, the OADAP, or the Secretary of State. Any use of fraud, deceit, or misrepresentation may result in an immediate suspension of approval.

§ 5. Non-discrimination

No program shall discriminate or permit discrimination against any person in any manner prohibited by the laws of the United States or the State of Maine.

§ 6. Non-compliance

Non-compliance or other violations of these regulations may result in an immediate suspension of approval under these regulations.

§ 7. Treatment Procedures

Any person, program, or organization that offers services to OUI offenders required to obtain treatment as a condition of license restoration shall comply with the following procedures and regulations;

1. No OUI offender shall be admitted into treatment until the treating person, program, or organization has received a DEEP Client Referral Form (RAS-6 1077).

2. A Treatment Status Form (RAS-7 1077) shall be completed at the date of scheduled entry into treatment. This form shall be submitted to the DEEP at 32 Winthrop Street, Augusta, Maine within five (5) days of the date of scheduled entry. The date of scheduled entry will be determined by the treatment person, program, or agency but it shall be set within fourteen (14) days of the referral date appearing on the Client Referral Form.

3. Prior to entry into treatment, the Federal Rules and Regulations on the Confidentiality of Alcohol Abuse Patient Records shall be clearly summarized and explained to each OUI offender.

4. Prior to entry into treatment, complete fees and costs of treatment shall be clearly explained to each OUI offender.

5. Upon entry into treatment, there shall be conducted a social/psychological evaluation that includes, but is not necessarily limited to, the following:

   A. Drinking and drug abuse history and previous treatment,
   B. Determination of current emotional state,
   C. Vocational history,
   D. Family relationships,
   E. Educational background, and
   F. Socio-economic status.

6. Upon entry into treatment, the person, program, or organization shall determine the necessity of a medical evaluation. When necessary, the medical evaluation shall be conducted by a physician or osteopath and shall be completed prior to the development and implementation of a treatment plan.

7. Upon completion of the social/psychological, and where necessary, medical evaluations, an individual treatment plan consistent with treatment philosophy and program objectives shall be developed and maintained for each individual. The treatment plan shall;

   A. Be based on the social/psychological and medical evaluations,
   B. Establish goals and short and long term objectives for treatment,
   C. Specify the type and frequency of services planned for meeting the treatment objectives,
   D. Delineate those supportive services needed by the individual client,

E. Be developed with client participation, whenever possible,

F. Establish a date when treatment is likely to be completed, and

G. Be reviewed by the counselor and client at least every thirty (30) days.

8. At the conclusion of treatment services the person, program, or organization shall determine the degree to which the client has achieved his or her treatment goals and objectives.

9. At any time during treatment, a person, program, or organization shall, upon the request of the DEEP, submit to the DEEP within ten (10) days a completed copy of the Treatment Status Form (RAS-7 1077). Such requests will routinely be made twenty (20) days prior to a motor vehicle hearing.

10. At any time during treatment, if an adverse treatment status decision is made, it shall be reported to the DEEP within five (5) days on the Treatment Status Form (RAS-7 1077).
An adverse treatment status decision means a failure to satisfactorily progress towards treatment goals and objectives.

11. At the satisfactory completion of treatment services, a Treatment Status Form shall be completed and submitted to the DEEP within five (5) days of the completion of treatment services.
Satisfactory completion of treatment services means a person has attended and actively participated in scheduled treatment sessions and has substantially attained the goals and objectives of the treatment plan.

§§ 8. Application Procedures

1. Any organization, facility, program, person or individual desiring to be approved under these regulations shall, prior to offering alcohol treatment services to OUI offenders referred as a condition of license restoration,

obtain approval from the OADAP. Applicants shall request approval from the OADAP in writing. This request shall include documentation of the applicant's eligibility for approval in accordance with the requirements set forth in the regulations, and a description of the applicant's treatment philosophy and objectives.

Individuals who must be examined by OADAP to determine their eligibility, shall request the scheduling of an examination.

2. Upon receipt of an applicant's request for approval, the OADAP shall determine the eligibility of the applicant and inform the applicant of their status within seven (7) days from the date the request for approval is received.

3. Applicants who are eligible for approval shall be sent a letter of agreement for their signature at the time they are notified of their eligibility. The agreement shall state that the applicant has read and fully understands the approval regulations and guarantees full compliance with the regulations in the provision of alcohol or drug treatment services to OUI offenders referred to treatment as a condition of license restoration. The agreement shall be signed by the applicant and returned to the OADAP within thirty (30) days from the date the agreement is issued.

4. Individuals who must be examined by the OADAP to determine their eligibility for approval will be informed in writing: a) of the date, location and time of their examination, and b) that they are required to bring to their examination a portfolio of relevant employment, training and life experiences which supports their claim to be a competent provider of alcohol and/or drug treatment services. This notification shall be sent to the applicant within seven (7) days from the date the request for approval is received by the OADAP.

The examination date shall be within ninety (90) days from the date the request for approval is received by the OADAP. A determination of eligibility shall be made within seven (7) days after the date of examination.

5. Individuals examined by the OADAP and subsequently determined to be eligible for approval shall be sent a letter of agreement for their signature within seven (7) days from the date of their eligibility examination. The agreement shall state that the applicant has read and fully understands the approval regulations and guarantees full compliance with the regulations in the provision of alcohol or drug treatment services to OUI offenders referred to treatment as a condition of license restoration. The agreement shall be signed by the applicant and returned to the OADAP within thirty (30) days from the date the agreement is issued.

6. Upon receipt of the signed letter of agreement, the OADAP shall issue a three-year Certificate of Approval within fourteen (14) days.

7. During the three-year period of approval, the OADAP shall conduct a minimum of three site visits to review OUI client case records maintained by the approved service provider. Such inspections shall be conducted by properly designated representatives of the OADAP. The purpose of these inspections shall be to monitor program compliance with the approval regulations.

8. Each approved service provider shall notify OADAP at least thirty (30) days prior to the date that his/her certificate of approval expires. Certificates of Approval shall be renewed for an additional three-year period for treatment providers who, in the opinion of OADAP, continue to be in full compliance with the regulations at the time of renewal.

9. Suspension, denial or revocation of approval to provide alcohol or drug treatment services to OUI offenders referred to treatment as a condition of license restoration shall be in accordance with procedures set forth in M.R.S.A. 5, Section 2301 et. seq.

10. Appeal of a denial, suspension or revocation shall be made in accordance with the Administrative Code, §§ 2301 et. seq.

11. On the date these regulations become effective, any organization, facility, or program actively providing alcohol or drug treatment services to OUI offenders required to obtain treatment as a condition of license restoration, may continue to provide such services for a period of one hundred and twenty (120) days.

Letter of Agreement to Provide Alcohol Treatment Services for Persons Participating in the Driver Education and Evaluation Program (DEEP).

I certify that I have read and that I understand the duties and responsibilities required of me by sections 1 through 7 of the Regulations for the Approval and Operation of the OUI Treatment Programs.

I agree to faithfully comply with these regulations, especially the reporting procedures and deadlines described in section 7. If I do not remain in strict compliance with these regulations, I recognize that my approval for participation in the Driver Education and Evaluation Program may be immediately revoked by the Office of Alcoholism and Drug Abuse Prevention.

Date _____ Signed _____

(Please print or type)

Address _____
Street

_____
City Zip Code

Telephone _____

APPROVED

Signed _____ Date _____
(OADAP)

Certificate of Approval # _____ Expiration Date _____

GUIDELINES FOR APPLICATION COMPLETION — APPENDIX H

Check "License" if the application is for a residential facility.

Check "Certificate" if the application is for a non-residential program.

1. Name of sponsoring agency or program providing the services.

2. Fill in completely.

3. If the program providing the services is different from sponsoring agency listed in (1), give name, address, phone number and zip code of the program providing the services. If the information is the same as (1) and (2) and the address is easily located in a city or town, list "same". If the facility location is out of town and difficult to locate, please list directions indicating how to get there.

4. Means the administrator of the program providing the services, not the sponsoring agency.

5. If the Articles of Incorporation have been sent previously, there is no need to repeat. If there is an update on the names and addresses of the Board of Directors, please enclose. If there are no changes in either, indicate with "same".

6. If the constitution and by-laws have been sent, it is necessary to send only the up-dates and revisions. If there is no change, indicate with "same".

7. List names of insurance and the coverage provided.

8. If yes, attach a copy of the fee schedule.

9. Governing authority, management and aftercare are mandatory; at least one other component is necessary, which will determine whether or not the program is residential in nature.

10. NA for non-residential programs. The number of beds listed shall be verified by the health inspector and the accepted number of beds shall be listed on the license. Use of more beds than listed on the license shall be considered a violation of the licensing regulations.

11. Sheet enclosed. All staff are to be included, including administrative, clerical, janitorial, cooks, volunteers, etc.

12. State, region, county, population, etc.

13. Specifically: program capacity at any given time, program capacity for a year. Generally: approximate number of people in the area who may at one time wish to avail themselves of the services.

14. List also if clients are in commitment.

15. If there are major deficiencies, these should be worked on before the inspection date. Use the regulations as your guideline in determining deficiencies.

ATTACH ALL ITEMS REQUIRED TO BE ATTACHED.

APPLICATION MUST BE DATED AND SIGNED. NO UNSIGNED APPLICATION WILL BE ACCEPTED.

STATE of MAINE

OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

32 Winthrop Street

Augusta, Maine 04330

289-2781

APPLICATION FOR

☐ LICENSE, SUBSTANCE ABUSE TREATMENT FACILITY

☐ CERTIFICATE OF APPROVAL, SUBSTANCE ABUSE TREATMENT PROGRAM

For OADAP Use Only

☐ 1. NAME OF SPONSORING AGENCY _____

☐ 2. ADDRESS: _____ PHONE: _____

_____ ZIP CODE _____

☐ 3. LOCATION OF FACILITY (directions): _____

_____

_____

☐ 4. PROGRAM ADMINISTRATOR: _____

☐ 5. IS THE PROGRAM INCORPORATED? Yes_____ No_____
(If yes, attach a copy of the Articles of Incorporation, including names and addresses of Board of Directors)

(If no, attach a list of names and addresses of all owners)

☐ 6. DOES THE PROGRAM HAVE A CONSTITUTION AND BY LAWS? Yes___ No___
(If yes, please attach a copy of the constitution and bylaws)

☐ 7. IS THE PROGRAM INSURED? Yes___ No____
(If yes, please list the names of insurers and the full extent of coverage)

☐ 8. IS THERE A FEE FOR SERVICES? Yes____ No____
(If yes, please attach a copy of the fee schedule)

9. CHECK PROGRAM COMPONENTS TO BE APPROVED:

____Governing authority/management

____Aftercare

____Emergency care

____Inpatient care

____Intermediate care

____Outpatient care

____Outreach

____Shelter

10. NUMBER OF FACILITY BEDS: Total:_____

____Detox

____Rehab.

____Shelter

11. NUMBER OF STAFF: Total:_____
(Staff Information sheet must be filled completely and accurately)

12. GEOGRAPHIC AREA TO BE SERVED_____

_____

13. NUMBER OF PEOPLE TO BE SERVED (explain how the figure was determined): At any one time:_____

_____

Over a year's time:_____

14. ARE ANY CLIENTS ACCEPTING TREATMENT AS A CONDITION OF PROBATION OR AS A RESULT OF DIVERSION FROM THE JUSTICE SYSTEM? Yes_____ No_____. (If yes, please indicate number of clients in each category)

_____

15. IS APPLICANT ABLE TO PROVIDE ALL INFORMATION REQUESTED IN THE REGULATIONS PERTAINING TO GOVERNING AUTHORITY/MANAGEMENT, AFTER CARE, AND OTHER APPROPRIATE COMPONENTS? Yes_____ No_____
(If no please explain nature of deficiencies)

_____

-3- Staff Information

Please list name, job title, salary, job responsibilities, qualifications of all program staff. Please indicate those staff members whose room and board is provided by the program on facility premises. If a staff member must be licensed to practice his/her profession, please indicate the license number and date of issue. Please use code letters ** (below) for employment status.

Name	Title	Salary	Responsibilities	Qualifications	Code	Resident Yes/No	License No.

** F = Full time Pt - Part time V = Volunteer

SUMMARY OF THE REHABILITATION PROGRAM IN TERMS OF PHILOSOPHY, GOALS AND OBJECTIVES, HOW THEY ARE TO BE ATTAINED, HOW THEY ARE TO BE EVALUATED.

THE FOLLOWING MUST BE ATTACHED:

- ☐ $50.00 non-returnable fee, payable to: Office of Alcoholism & Drug Abuse Prevention.
- ☐ Evidence of inspection, or compliance with local and State codes in respect to zoning, health and sanitation, fire and safety.
- ☐ A copy of the audit of the immediately preceding fiscal year, along with the source of support and budget for the year for which application is made.

THE SIGNERS OF THE APPLICATION WITNESS THAT:

a. They have read the OADAP standards appropriate to their program.

b. They agree to permit properly designated representatives of the OADAP to enter upon and inspect any and all premises for which a license or certificate of approval has been either applied for or granted. This inspection may be conducted at any reasonable hour and in a reasonable manner.

c. Their program shall maintain an organized system to collect and provide to OADAP such information as OADAP may require.

d. Special reports shall be required by programs who receive funding from OADAP.

e. The application is a true representation of the program.

Date:_____ Signed:_____ _____
Administrator

_____
President, Board of Directors

FOR OADAP USE ONLY

_____NEW

_____RENEWAL

Date of form and inspection request_____

Date application received_____

Date of fire inspection_____

Date of sanitation inspection_____

Date of OADAP inspection_____

Date of license or certificate of approval issue; number and type _____

INSPECTION SCHEDULE

Appendix I

OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION

9:00 Introduction of team members
Interview with director of facility

9:15 Physical plant inspection

9:45 Inspection of policy & procedures
Examination of program documentation

12:00 Lunch

1:00 Licensing team progress assessment (Licensing team members only)

*1:30 Group interview with available facility staff

*2:15 Group interview with available clients/patients
(Participation shall be voluntary on the part of client/patients)

*3:00 Interview with Board members
(It is requested that as a minimum requirement, one Board of Director's Officer will be in attendance for this interview.)

3:30 Debriefing session with director and Board members.
(We encourage as many Board members as possible to attend this session)

4:00 Licensing team final assessment (Licensing team members only)

*If any client, staff or Board member would like to meet individually with a member or members of the licensing team, time will be allowed.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Appendix J

Minutes of Full Council Meeting

August 17, 1977 OADAP Conference Room Augusta

PRESENT

A. Russel Didsbury
Paul H. Adams
Charles C. Aleck, Jr.
Nancy A. Bellhouse
John Blatchford
Deborah A. Buccina
Edward H. Jones
Grace E. Ridlon
Frederick Wendelken, Jr.
James H. Word
Eaton W. Tarbell

OADAP STAFF

Michael D. Fulton, Acting Director
Richard M. Clark, Attorney
Dwight F. Lanning, Grants Manager
Linwood K. Oakes, Alcoholism Program Specialist
Barbara Prime, Secretary

CALL TO ORDER

The meeting was called to order at 9:45 a.m. by Chairman Didsbury. Minutes of the previous meeting were dispensed with on the motion of Paul Adams. A general introduction of new Council members and OADAP staff followed.

LEGISLATION

Richard Clark of OADAP was introduced and gave a general presentation on our Legislation in the 108th Legislature.

The following bills were defeated:

Drugs: L.D. 135, 374, 1432 - bills increasing the penalties for selling various drugs.

*L.D. 1500 - bill to recriminalize the personal possession of marijuana.

Alcohol: L.D. 857 - tax on alcoholic beverages.
L.D. 1340 - diversion of alcoholic criminals from criminal justice system into treatment.
L.D. 976 - alcohol prevention and education.
L.D. 1104 - require alcoholism coverage in group health insurance plans.
*L.D. 1430 - bill to recriminalize public intoxication.

*Sponsored at the request of the Maine Chief's of Police Association.

The following bills were passed:

Drugs: L.D. 1124, 1126 - deals with special education facilities and services at drug treatment facilities who have exceptional children as clients.

Alcohol: L.D. 6, 310, 1667 - provides for transfer of driver rehab program from motor vehicle to OADAP and also provides new incentives to encourage drivers with alcohol problems to seek treatment.

L.D. 530 - establishes a Board of Registration for Substance Abuse Counselors.

L.D. 4, 53, 240 - Age of purchasers of alcoholic beverage (raised to 20).

L.D. 587 - changes the makeup of the Governor's Advisory Council.

A general discussion of the L.D.'s and legislation process followed. Copies of requested L.D.'s will be sent to all members.

A.A. AND ALCOHOLISM PROGRAMS

The issue of the relationships between A.A. and Alcoholism programs was raised between Eaton Tarbell and Paul Adams. It was agreed that that discussion should continue within the Council over a period of time in a constructive and balanced manner.

EXPECTATIONS OF THE GOVERNOR

Fred Wendelken moved that the Chairman write a letter to the Governor requesting his expectations and goals for the Council, this was seconded by Paul Adams. The Chairman reviewed the correspondence between himself and the Governor. After much discussion, it was agreed that the Governor's response should be considered to be the Governor's general charge to the Council. Mr. Wendelken withdrew his motion in concurrence with that sentiment.

COUNSELOR REGISTRATION

During the discussion initiated by the Chairman on the Counselor Registration Legislation, a small Committee was appointed to deal with the Council's responsibility under that Legislation. The members of that Committee are: Fred Wendelken, Ed Jones, Grace Ridlon, and Rev. Word. The Committee will meet on Thursday, August 25, 1977, at 9:30 a.m., in the OADAP Conference room. They are charged with developing a consistant format for receiving suggested norminations to the Board of Registration. That format in someway will specify at least the legislative criteria to be used in making normination, some background information and unique qualifying criteria for the individual norminee, if any. They will also draft a cover letter inviting norminations from interested parties. OADAP staff are to provide the committee with a draft format and cover letter.

HOMEWORK ASSIGNMENTS

The idea of Homework Assignments was discussed. It was agreed that each Council member would come to the next meeting prepared to discuss goals and major areas of concern.

Hopefully the discussion at the next meeting will result in charting out the coming year's activity for the Council. Written goals and objectives for OADAP begin on page 33 of the Alcohol State Plan. Those goals may be used in preparation for the next meeting. It is also hoped that once the Council agrees on major areas of concern, the committee assignments can be made which relate to those areas. In addition, the tasks that the Council assumes will dictate the frequency of Council and committee meetings.

The Chairman will appoint the Review and Comment Committee members as soon as possible, so that that committee can begin its work.

DEBRIEFING

During the course of the meeting, various members requested the following items: 1) minutes of the previous meeting, 2) copies of the Governor's correspondence with the Chairman, 3) copies of enacted Alcohol and Drug Abuse Legislation, 4) the grant allocations for fiscal year '78 and, 5) a copy of the Governor's veto message, L.D. 976, An Act to Provide for the Prevention of Alcohol Abuse. These items will be mailed with the minutes of this meeting.

Rev. Word moved that a letter be addressed to Father Feeney, former Chairman of the Governor's Council, commending him for his involvement and dedication in the field of Alcohol and Drug Abuse. Motion was seconded by Paul Adams and passed unanimously.

ADJOURNMENT

The meeting was adjourned at 12:00 noon. The next meeting of the Council will be held on September 14, 1977, at 1:00, in the OADAP Conference Room.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting

September 14, 1977 OADAP Conference Room Augusta

PRESENT

A. Russel Didsbury
Fred Wendelkin
Charles Aleck, Jr.
Edward H. Jones
Grace E. Ridlon
Eaton W. Tarbel
John Blatchford
James H. Word
Paul H. Adams

OADAP STAFF

Michael D. Fulton, Acting Director
Barbara Prime, Secretary

CALL TO ORDER

The meeting was opened by Chairman Didsbury at 1:18 p.m. Motion by John Blatchford was made to dispense with the reading of the minutes to the meeting and approved unanimously as written. The minutes to the last meeting were approved by the Council members.

OLD BUSINESS

As a point of information for the Council, Paul Adams introduced the growing need for a Security Treatment Unit to hold people involuntarily who are currently in Correction Systems. Although the need for such a facility for Alcohol and Drug Abuse is limited, the Council should be aware that the Mental Health System is exploring programming around a Security Treatment Unit.

Eaton Tarbell explained for the Council the heavy drug abuse being experienced by Industry in the Bangor area. It was agreed at the end of the discussion that the Director of OADAP would explore that situation and report back to the Council.

Jim Word reported on work of the Planning Subcommittee for the Counselor Registration, explaining that letters and guidelines for nominating people for the Counselor Registration Board had been sent to those groups enumerated in the Law and other interested people. As a result of the previous Sub-committee meeting, Rev. Word introduced the following motion which was seconded by Mr. Wendelkin.

Motion that the planning subcommittee be continued, to screen applicants to be submitted to the governor for the Board of Substance Abuse Counselor Registration; that all applications be received by October 1; that the committee review all applications and submit a list of 27 names to the

October meeting of the Advisory Board for approval. A complete list of applicants with addresses will also be furnished all members of the Advisory Board. Members may suggest substitutions for any of the 27 recommended names, using the following criteria:

1) Justify the applicant being suggested.

2) Give any known reasons why a particular recommendation should be removed from the list.

A maximum of 27 names shall be submitted to the governor.

This motion was unanimously passed.

Although the subcommittee had established a time line for the Councils consideration of Registration nominees which carried into November, the Governor requested that the Council submit the nomination to him by October 14th. A new time frame was established, agreed to by the Council whereby nomination would be received by October 1, screened by the subcommittee to establish a list of 27 names and to be submitted to the Council for final approval on October 12th.

GOALS AND MAJOR AREAS OF CONCERN

General discussion followed revolving primarily around two major areas of concern. Prevention and the general assessment of the current state of the Alcohol Treatment System and its future direction. Some indirect topics of discussion were APTF's, Hospital based treatment, profit making alcohol treatment and public relations.

Ref. to Nov. 10th. meeting.

Out of that discussion, the Council appointed Charles Alick to Chair a Committee to investigate the current Alcohol Treatment System and to begin to define the ~~Industrial~~ Treatment System which we would like to see in the future. Mr. Alick's appointment to this Committee was an obvious choice due to his active interest in developing Alcohol Programming suitable to meet the needs of the broadest target population. It was suggested that all Council members submit their ideas and suggestions to Mr. Alick and that Mr. Alick would call upon individual Council members for assistance as he required it.

NEW BUSINESS

The Council acted on the membership of two Committee's. The Review & Comment Committee and the Certification Committee. The other standing Committees of the Council will not be considered until the need arises. John Blatchford, Robert Ohler, Fred Wendelken and James Word were appointed and agreed to serve the Review and Comment Committee. Paul Adams, although his term expires January, 1978, will be allowed to participate in the Review and Comment process as needed and as his time permits. An additional charge was given to the Review and Comment Committee of monitoring the financing costs issues in the field.

The Rev. James Word is the current Vice Chairman of the Council. The Council by unanimous acclamation asked him to continue in this capacity. Rev. Word agreed to continue.

HOMEWORK ASSIGNMENT

1) Amend By-Laws with respect to a quorum.
2) Discuss Involuntary Commitment.
3) Look into Eaton Tarbell's stated drug problem with Private Industry.
4) Revise time line for Counselor Registration recommendation.
5) Assist Mr. Alick as he request.

ADJOURNMENT

The meeting was adjourned at 4:37 p.m. The next meeting of the Council will be held on October 12, 1977, in the OADAP Conference Room at 9:00 a.m.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting

October 12, 1977 Central Office Conference Room Augusta

PRESENT

A. Russell Didsbury
Grace E. Ridlon
James H. Word, Rev.
Charles C. Aleck, Jr.
Fred Wendelken, Jr.
Eaton W. Tarbell
Edward H. Jones
John Blatchford

OADAP STAFF

Michael D. Fulton, Acting Director
Richard M. Clark, Attorney
Barbara Prime, Secretary

CALL TO ORDER

The meeting was called to order by Chairman Didsbury at 9:18 a.m. Motion by Rev. Word was made to dispense with the reading of the minutes to the meeting and approved unanimously as written.

OLD BUSINESS

Charles Aleck was asked to give a report on the Alcoholism Treatment System. He informed the Council Members that this report would be given at the next meeting.

BY-LAWS

A report was given by the secretary on the outcome of the By-Laws with respect to a quorum. Ballots were sent to each Council Member. The Council received 15 affirmative ballots - none were negative. Motion was unanimously passed to accept the By-Law change.

Chairman Didsbury announced a change of address for the Council members to update their list. Senator Minnette Cummings, Rowell Road, Hampden ME 04444, telephone 862-3035.

COUNSELOR REGISTRATION

A list of the Counselor Registration Nominees was passed around to each member. After a lengthy discussion, it was decided that the Council has not received enough names and resumes. (21 names received) It was recommended that the subcommittee meet two days prior to the next Advisory Council meeting. Recommendation was made that Chairman Didsbury send a letter to Governor Longley,

explaining the need for extended time in order to receive more resumes and to have more to select from. Also, to stress the importance of having quality people for this Board.

At this point, Richard Clark, Attorney for OADAP, was asked to clarify the Counselor Registration. He described the difference between a consumer, nonprovider, provisionally registered substance abuse counselor, registered substance abuse counselor, substance abuse counseling services and substance abuse counselor. Richard stressed "...Adhering to spirit of the law because if one is inappropriate for the Board, they can be taken off by an applicant's challenge to the make-up of the Board." He also stressed the fact that when recommending a person for the Board, to be consistant, "...draw the line equally to all applicants." Mr. Clark went into reasons for being eligible and ineligible. The Council members asked Mr. Clark if he would present them with Guidelines for them to go by. Mr. Clark agreed to do this. They will be sent along with the minutes. The Council members emphasized the need for the subcommittee to recommend someone of value to be a member of this board - that each member of the Council contact 3 or 4 people. Be certain that a statement is enclosed acknowledging the fact that they would like to serve on the Board and attach a complete resume.

LETTER FROM THE GOVERNOR

Chairman Didsbury read a letter to the Council from Governor Longley expressing a desire to meet with the Council and Commissioner David Smith. Members agreed that they would like to meet with both these people and it was decided that a letter be sent to Governor Longley advising him that the Council could meet with him at his convenience.

HOMEWORK ASSIGNMENTS

- Report from subcommittee
  Fred Wendelken urgently request from the full Council 3 or 4 names with resumes - deadline for names/resumes is October 31st.

  The subcommittee will have two meetings between October 31st and November 10th. Meeting to be announced.

- Report on Alcoholism Treatment Systems - Charles Aleck

- Answer letter from Governor Longley - meeting with Council

DEBRIEFING

Motion was made at this time by Charles Aleck for the Council to go into an Executive session in order to discuss organization and finances. Motion accepted. OADAP Staff was asked to leave at this point.

NEXT MEETING

The next meeting will be held in the Central Office Conference Room at 9:00 a.m., on November 10, 1977.

DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting

November 10, 1977 Central Office Conference Room Augusta

PRESENT

A. Russel Didsbury
D. Dwight Dogherty
Steve Hughes
James H. Word
Grace E. Ridlon
Charles C. Aleck
Frederick Wendelken

OADAP STAFF

Michael D. Fulton, Acting Director
Barbara M. Prime, Sec'y

Guest:

Tim Morrison

CALL TO ORDER

The meeting was called to order by Chairman Didsbury at 9:27 a.m. Motion was made by Jim Word to dispense with the reading of the minutes to the last meeting and approved unanimously as written.

OLD BUSINESS

Charles Aleck moved that a change be made in the Minutes of September 14th under "Goals and Major Areas of Concern", second paragraph, third sentence, "Industrial" to read "Treatment". The motion was seconded and approved unanimously.

COUNSELOR REGISTRATION

Chairman Didsbury informed the Council that he received a letter from Governor Longley in response to the Council's request for extended time in order to receive more names for the Board of Registration for Substance Abuse Counselors. The Governor will be looking forward to hearing from the Council as soon as they can obtain the final list.

The Subcommittee met previously; unsuccessfully as they did not have enough candidates to choose from. Upon receipt of more candidates, the Subcommittee met on Monday, November 7th with much help from Susan Wolford, Drug Program Specialist with OADAP, and Hank Chaiklin, part time Consultant with OADAP, a list of 28 candidates were reviewed. They were divided into three categories: Substance Abuse Counselor, Nonprovider, and Consumer Nonprovider. Under each of these headings were Recommended Members and Other Qualified Applicants. A list was given to each Council member. Jim Word explained the procedure by which the Subcommittee chose the candidates and how they were qualified and/or disqualified.

It was moved by Jim Word to give those members who were not familiar with the list of candidates ten minutes to look it over and ask questions. This was seconded by Fred Wendelken and approved unanimously. After a brief discussion, the Chairman read a draft letter to the Council members which was to go to the Governor along with the prepared list of candidates. Charles Aleck moved that this letter along with the names of candidates be submitted to the Governor. This was opened for discussion. Steve Hughes inquired about qualified drug abuse consumers. It was explained that there were none available. Dwight Dogherty raised his concern about Charles Meserve being recommended for the Registration Board. From personal experience he agreed against the appointment.

It was mentioned again by members of the Subcommittee and Chairman the outstanding work done by Susan Wolford and Hank Chaiklin--a big "Thank You".

The Council met with Governor Longley on November 1st, at which time the Governor requested copies of the minutes be sent to him. Also, poor attendance of Council members was reported. The Governor requested that a list of attendance be sent to his office. Deborah Buccina sent a letter to the Chairman explaining her problem with not being able to attend the meetings as she is in Boston. Jim Word moved that the letter be submitted to Governor Longley with a request that she be replaced. Motion seconded by Fred Wendelken and approved unanimously.

Charles Aleck passed out a type written report on an Alcoholism Treatment Facility in Rumford. He asked that each member read this and report back to him at the next meeting.

NEW BUSINESS

When the Council met with Governor Longley and Comm. Smith, Comm. Smith requested that he be invited to the next Council meeting to discuss the process and procedure for appointment for Director of OADAP. The Comm.'s Office was contacted and he will attend the next meeting scheduled for November 30th, at 9:00 a.m.

Mr. Fulton discussed his expectations of the Council and what their expectations might be of OADAP. After a lengthy discussion, it was determined that more open communication was needed. Michael explained that even if he or the Council was not pleased with certain issues, it's important to discuss them at the meetings rather than letting them build up. Charles Aleck suggested that the Council have a "round table" discussion with Mr. Fulton. Mr. Fulton advised the Council that he would be more than glad to answer any questions they might have and also stated that any of his staff would do likewise.

Chairman Didsbury and members of the Council requested a list of OADAP's staff and salaries. Mr. Fulton stated that he is presently involved in a Functional Job Analysis being done by the Bureau of Rehabilitation and that he would give the Council a report on this when it is finished. The question of OADAP having a full time Attorney was brought up. Mr. Fulton stated that Mr. Clark is a Research Analyst who happens to be an attorney. Although Mr. Clark's legal training and background is sometimes useful, he is not employed as an attorney. The Council accepted this clarification and noted again that communication resolves such misunderstandings.

Charles Aleck asked for a "travel account" of the Regional Coordinator and raised questions around difficulties in the Lewiston Region. Mr. Fulton agreed to speak to the regional coordinator informally in an effort to resolve questions raised by Mr. Aleck. The Council also understands that (with one exception) regional coordinators are not state employees. After a brief discussion, the Council decided that it would invite other members of OADAP and the regional coordinators to the Council meetings when questions the Council raised related to them.

It was brought to the attention of the Chairman a need for some means of identification for the Council Members when they visit the facilities. It was moved by Charles Aleck that a letter be submitted to the Governor's Office requesting an identification card from his Office. Motion seconded by Fred Wendelken and unanimously approved.

HOMEWORK ASSIGNMENTS

- Members report back to Charles Aleck on Rumford Alcoholism Treatment Facility
- List of Regional Council Board Members
- Regional Coordinators - update
- Identification Cards
- Minutes to the Governor with copy to the Commissioner
- Report on Functional Job Analysis

ADJOURNMENT

The meeting was adjourned at 11:20 a.m. The next meeting will be on November 30th at 9:00 a.m. It will be held at the State House, Room 327 (third floor) in Augusta.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting

November 30, 1977 Capitol Building, Room 134 Augusta

PRESENT

A. Russell Didsbury
Nancy A. Bellhouse
Robert L. Ohler, M.D.
Paul H. Adams
Charles Aleck
John Blatchford
D. Dwight Dogherty
Fred Wendelken
Grace Ridlon
Steve Hughes

OADAP STAFF

Michael D. Fulton, Acting Director
Dwight F. Lanning, Grants Manager
Melvin H. Tremper, Planning Associate
Barbara M. Prime, Secretary

GUEST

David E. Smith, Commissioner

CALL TO ORDER

The meeting was called to order at 9:35 by Chairman Didsbury. Mr. Wendelken moved and Mr. Aleck seconded a motion to dispense with the reading of the minutes to the last meeting. The minutes were approved unanimously as written.

DAVID E. SMITH - Commissioner

Chairman Didsbury introduced David E. Smith, Commissioner, to the Council members and OADAP Staff. Major concerns brought to the Council's attention were: a Director for OADAP, Council appointments, and a treatment system plan for the Council to present to the Department.

The Commissioner informed the Council of the procedure to be taken in appointing a Director for OADAP. An updated job description will be sent to the Commissioner. This will go to personnel; personnel will open the Register to the Public; applications and resumes will be sent to personnel. Personnel will send these to the Council. These will be screened by the Selection Committee, along with a representative from State Personnel. They will select six most qualified people. One day will be set aside for interviews which will be conducted by the Selection Committee along with Commissioner Smith. A single recommendation will be presented to the Commissioner. The Commissioner will then make the final decision.

The Commissioner recommended that a list of pertinent questions be compiled before interviewing, with emphasis on judgements and values.

MOTION

Chairman Didsbury moved that the same people on the Counselor Registration Committee screen the applications and resumes as the Selection Committee. These people are: Fred Wendelken, Ed Jones, Grace Ridlon, Rev. James Word, and Russell Didsbury. Motion seconded by Fred Wendelken and unanimously accepted.

NEW APPOINTMENTS

The Council expressed concern about the length of time it might take appointing new members for the Council. The Commissioner assured them that appointments would be filled immediately.

After a lengthy discussion regarding current alcohol and drug programs statewide, Title XX monies being cut, Health Care Systems, the Commissioner recommended that the Council establish goals and systematic standards for OADAP. It was recommended that the Council evaluate the current alcoholism treatment system. The evaluation should yield a defense for continued financial support of alcoholism services while also being the basis for designing a more adequate system. The Council was asked to present a plan to the Department which was based upon the evaluation of the current system, was not based solely on the self interest of the status quo , took into consideration the best interests of the client, and could be implemented within the current financial and political constraints.

The Commissioner informed the Council of problems with Budgets within Human Services and the importance of presenting to the Commissioner sound goals and objectives, as well as where money can be utilized most effectively. The deadline for this plan is July 1st, 1978. The Fiscal Year for federal funding is October 1st through September 30th.

OLD BUSINESS

Chairman Didsbury read three letters from the Governor. The first, thanking the Council for their work in presenting him with a list of candidates for the Counselor Registration.

The second letter was to the Chairman advising him that OADAP's request for a federal grant to implement an Information System has been denied. After a lengthy discussion, Chairman Didsbury informed the Council that he would respond to the Governor's letter informing him of the importance of implementing this program and asking him to reconsider.

A third letter was read by the Chairman from Jean E. Litchfield, Alcoholism Counselor at Tri-County Mental Health Services, expressing her opinion and concern "about the ways in which alcoholism funds are being spent" and the "lack of cooperation between the various agencies funded through OADAP as being wasteful and need of change." After much discussion between Council members and OADAP Staff, it was left up to the Chairman whether or not to respond to this letter.

PROBLEMS IN RUMFORD

Again, Charles Aleck expressed his concern regarding Western Region Council. The Chairman asked Mr. Fulton to invite John Coffey, Regional Coordinator for Western Regional Council, Ed Dennison, Program Director for Fellowship House, and Raymond Blanchette, Chairman of Western Regional Council, to our next Council meeting. Members of the Council expressed their desire to have John Coffey explain the Minneapolis Model to them, as this may be a model that all regions can use. The Council made it clear that they were not going to respond to clearly local and individual concerns around the Western Regional Council.

UPDATE ON GRANT REVIEW PROCESS

Dwight Lanning, Grants Manager for OADAP, explained to the Council members the guidelines set for the coming grant funding review committee. Copies of letters sent to all programs were passed out to members of the Council. (Copies attached for those members not present.) Mr. Lanning expressed his concern with budget cutting. He also stressed the importance of getting applications in before the deadline of February 1, 1978.

ASSIGNMENTS

Letter to the Governor in response to the Information System Grant - Chairman

Letter to John Coffey, Ed Dennison and Raymond Blanchette - Chairman

Report on Goals for Director of OADAP -

ADJOURNMENT

Meeting adjourned at 12:30. The next meeting will be at 9:30 a.m. in the Central Office Conference Room on Tuesday, December 20th. The Council will also meet on January 20th from 9:30 - 12:00 noon; the Review and Comment Committee will meet in the afternoon.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting Time: 9:44

December 20, 1977 Central Office Building Augusta

PRESENT

A. Russell Didsbury
James Word
Fred Wendelken
Paul Adams
Eaton Tarbell
John Blatchford
Charles Aleck
Grace Ridlon
Ed Jones
Robert Ohler
D. Dwight Dogherty
Sen. Minnette Cummings
Rep. Steve Hughes

OADAP STAFF

Michael D. Fulton, Acting Director
Barbara M. Prime, Sec'y

GUEST

John Coffey, Regional Coordinator, Western Regional Council
Ed Dennison, Director, Fellowship House
Tim Morrison, Pastor, High Street Congregational Church
Dick Cunningham, Assis. Administrator, St. Mary's Hospital
Ray Guest, Director of Alcoholism Services, Tri-County Mental Health

INTRODUCTION

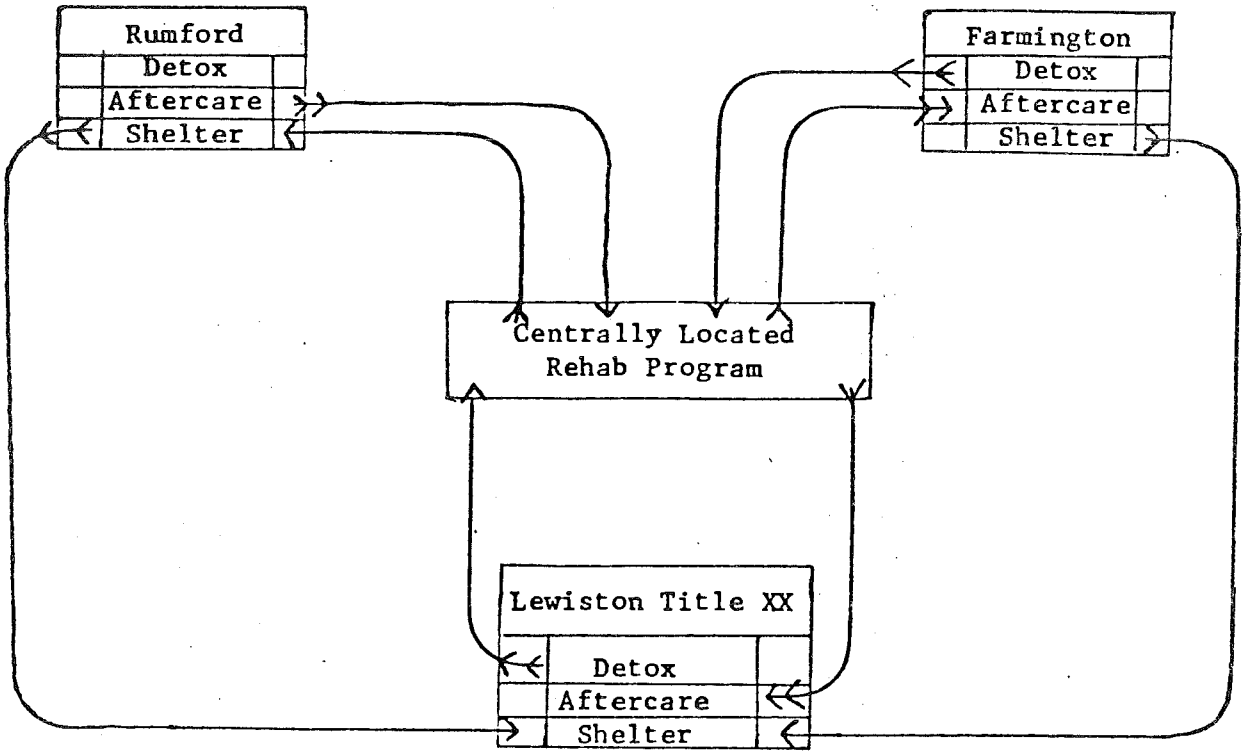
Chairman Didsbury introduced the guest speakers from Western Regional Council. Mr. Coffey and each of his members told the Council members of their visit to Minneapolis and their plan to implement the Minneapolis model at St. Mary's Hospital in Lewiston.

REPORT FROM WESTERN REGIONAL COUNCIL

The following is a brief description of the proposed St. Mary's project. The model integrates Lewiston's existing services, as well as Rumford and Farmington hospitals, giving a comprehensive approach which services any alcoholic at any stage of the disease. It will not be necessary for everyone to go through the inpatient part of the program. When a person contacts the program, a diagnosis is made as to what the client needs. Only the appropriate program components are then used for treatment. The literature on this model indicates an 80-85% success rate.

Much of this rate is attributed to extensive Alcoholics Anonymous involvement and the extensive volunteer aftercare component.

M O D E L



The inpatient core of the program will run 4-5 weeks on the following schedule:

Week 1:

Group therapy
Feelings/defenses
1:1
1st step AA preparation
Family and other concerns
Treatment plan

Week 2:

Group work
1st step AA presentation
AA

Week 3:

Group
1st step AA completion
2nd step AA
3rd step AA
Family week (Monday a.m. thru Friday p.m.)

Week 4:

4th step AA
Group
Steps 2 & 3 AA
Continued family work

Week 4 1/2 (or 5):

AA - client
Al-Anon & Ala-Teen - family members
Growth group
Halfway House
Social worker
Court system
Family plans
Discharge plan

CALL TO ORDER

The meeting was called to order at 11:25 by Chairman Didsbury. John Blatchford moved and Jim Word seconded a motion to dispense with the reading of the minutes to the last meeting. The minutes were approved unanimously as written.

OLD BUSINESS

Russ Didsbury asked Mr. Fulton to explain the Planning Process for the Council. Mr. Fulton suggested that the Council/OADAP evaluate the Treatment System as it exist, evaluate how it should exist, eliminating what's not needed. The kinds of things we should look for are: what does the Treatment System need; do we support Western Regional Council's model; if so, what and how do we do it. We have to think about long term policy issues, and short term funding problems. Are we moving in the direction of a hospital core concept? Mr Fulton stated that he would like to put all this together on paper for the Council to work with at the next meeting. The Council agreed this would be acceptable.

Eaton Tarbell gave a brief report on drug problems in his Region. He stated that at this time there is not much to report on, The drug problems still exist and he is very concerned about this. He informed the Council three nurses would be visiting the drug facilities statewide to see what ideas they may have. Mr. Tarbell stated that there is a big drug problem at Diamond International and Great Northern Paper Company. He stated union leadership was not helpful in the beginning, but recently shows more cooperation. Mr. Tarbell stressed again the fact that the Police Department is not helpful with drug problems. Chairman Didsbury asked Mr. Tarbell if he would keep the Council informed regarding this problem. Mr. Tarbell agreed he would.

NEW BUSINESS:

Mr. Fulton asked the Council if they would object to a Bulletin release paper with the Council's name on it for purpose of Legislative release and/or any kind of informational release. The Council agreed they did not object to this.

The Council asked Mr Fulton the status of the Functional Job Analysis. He explained that it is in process now and should be finished in the Spring. He will give a report at that time.

The Council asked Mr. Fulton when applications would be available for the Director's position for OADAP. He informed them those should be available by the end of January, 1978.

DEBRIEFING

The Council members wanted to know the status on Substance Abuse Counselor Registration. As of Thursday, December 15, 1977, no action had been taken.

Mr. Fulton asked the Council members if they would return the stamped envelopes that are being sent each month with the minutes and agendas. Members agreed they would do this.

ASSIGNMENTS

- Report on Treatment System . . . Michael D. Fulton

ADJOURNMENT

Meeting adjourned at 1:45. The next meeting will be held at the Central Office Conference Room on Friday, January 20, at 9:30. Review and Comment Committee will meet at 1:30, same place.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting

January 20, 1978

PRESENT

Fred Wendelken
Rev. James Word
Eaton Tarbell
D. Dwight Dogherty
Sen. Minnette Cummings

OADAP STAFF

Michael D. Fulton, Acting Director
Linwood K. Oakes, Sr., Alcoholism Program Specialist
Barbara M. Prime, Sec'y

CALL TO ORDER

In the absence of the chairman, Rev. Word opened the meeting at 9:58. He noted that a quorum was lacking which made it impossible for the members to conduct official business. It was decided that they proceed with the agenda. The minutes of the last meeting were accepted; however, Eaton Tarbell informed the council that his discussion regarding the proposed plans for Hope House were not reflected.

Michael Fulton informed the council that Charles Aleck is now home from Togus, and will not be able to return to work for at least eight weeks.

APPOINTMENTS

Council members are requested to bring in names for the Governor's consideration for replacement of council members. These names will be submitted to the Governor's office.

SUBSTANCE ABUSE COUNSELOR REGISTRATION

Michael Fulton reported to the council members on the Substance Abuse Counselor Registration. He stated that the Governor selected nine candidates (see enclosed list). The next step will be the first meeting of the Registration Board. Susan Wolford has been assigned to be liaison person with the Board and will therefore schedule the first meeting. At this meeting, the Board will have to decide what relationship it wishes to exist among the Board, OADAP and the Bureau of Business Regulation, under which it exists. OADAP has proposed for the Board, a contract with Hank Chaiklin to structure the examination instructions and registration processes.

BULLETIN

There was a brief discussion regarding the use of the BULLETIN. It was suggested that it might be used as a news media, sending copies to agencies such as Health Systems Agency, State Planning Office, mental health Agencies, Human Services, the Governor's office, et cetera. The council felt that Michael Fulton should have the choice of sending it to whom he felt appropriate. Another suggestion was to use it for information being released to newspapers.

I.D. CARDS

There was a brief discussion regarding I.D. cards for members of the council. Some members showed a great interest in having a means of identification. The secretary said she would find out what the procedure is and let the council know at the next meeting.

TREATMENT SYSTEM

Linwood Oakes, Alcoholism Program Specialist, spoke to the council regarding the Treatment System--the needs of the alcoholic. A copy of his report is enclosed.

ADJOURNMENT

The meeting adjourned at 11:25. The next meeting will be on February 15, 1978 at 9:30. The place of the meeting will be at Central Office in the large conference room.

MAINE COUNCIL ON ALCOHOL AND
DRUG ABUSE PREVENTION AND TREATMENT

Minutes of Full Council Meeting

February 15, 1978

PRESENT

A. Russell Didsbury
Nancy Bellhouse
Rev. James Word
Ed Jones
Fred Wendelken
Dr. Robert Ohler

OADAP STAFF

Linwood K. Oakes, Sr., Alcoholism Program Specialist
Barbara M. Prime, Sec'y

CALL TO ORDER

The meeting was called to order by Chairman Didsbury at 9:43. Apologies were expressed by the secretary as the minutes of the last meeting were not prepared. Members accepted the apologies. The secretary reported that she talked with Katy Perry of Human Services regarding the I.D. cards. She will be contacting and hopefully have all the pertinent information regarding these before the next meeting.

Linwood Oakes, Alcoholism Program Specialist, did not feel it necessary to go through his discussion on the Treatment System again, as the same people were at the last meeting and he felt it would be repetitious. The secretary apologized to Mr. Oakes for not getting his report sent to the members. A report is enclosed with the minutes.

INTERVIEWS - OADAP DIRECTOR

Chairman Didsbury read a letter from David Smith regarding the interviews for OADAP Director. They will be held in the Commissioner's office on February 22, 1978. All people involved should be at the Commissioner's office at 8:45. Those people are: C. Owen Pollard, Comm. David Smith, Chairman A. Russell Didsbury, along with the subcommittee--Fred Wendelken, Ed Jones, Grace Ridlon and Rev. James Word. The following are the five candidates for OADAP Director: John Greene, Carl Mowatt, Jack White, Frank Heller and Michael D. Fulton.

NEW APPOINTMENTS

The chairman brought to the attention of the council members again, names should be submitted to the Governor for recommendation for appointment to the council. He informed the council members that the following people's terms expired December 31, 1977: Paul Adams, Grace Ridlon, Dr. Robert Ohler, and Alberta Nicola. Also, Deborah Buccina's vacancy will have to be filled. Members were reminded that the above people are still active

until the Governor appoints new members. Jim Word recommended that a letter be sent to Clem Pooler, who has been unable to attend the meetings due to poor health, requesting his resignation.

NOTICES

Jim Word informed the council of a luncheon on February 25, 1978, in honor of Sen. William D. Hathaway, and Luther A. Cloud, M.D., sponsored by the National Council on Alcoholism.

The Chairman informed members having questions on the procedures of the Review and Comment Committee regarding grants, to contact Dwight Lanning.

ADJOURNMENT

Fred Wendelken motioned that the meeting be adjourned--Ed Jones seconded it. Meeting adjourned at 11:05. The next meeting will be on March 15, 1978, at 9:30. It will be held at the Central Office in the large conference room.

ONE HUNDRED AND EIGHTH LEGISLATURE

Legislative Document **No. 857**

H. P. 731 House of Representatives, March 9, 1977

On motion of Mrs. Post of Owls Head, referred to Committee on Taxation. Sent up for concurrence and 2,000 ordered printed.

EDWIN H. PERT, Clerk

Presented by Mrs. Post of Owls Head.

Cosponsors: Messrs. Norris of Brewer, Curran of South Portland, Brenerman of Portland.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-SEVEN

AN ACT to Raise the Tax on Beer, Wine and other Alcoholic Beverages to Provide Funds for the Operation of Alcoholic Treatment Facilities, the Establishment of Education and Treatment Programs for Alcohol Abusers Convicted of Operating under the Influence and other Minor Crimes and the Establishment of a Program of Substance Abuse.

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

Sec. 1. 28 MRSA § 451, 1st ¶, 1st sentence, as repealed and replaced by PL 1967, c. 544, § 65, is repealed and the following enacted in its place:

All spirits and wines, except table wines, shall be sold by the commission at a price to be determined by the commission which will produce a state liquor tax of not less than 75% based on the less carload cost F.O.B., State Liquor Commission warehouse. There shall also be levied and imposed on all spirits and wines, except table wines, sold by the commission, a surtax of 3% of the price determined by the commission.

Sec. 2. 28 MRSA § 452, 1st ¶, last sentence is amended to read:

A wholesale licensee who imports malt liquor shall pay an excise tax of ~~25¢~~ 29¢ per gallon and at a like rate for any multiple or fraction thereof.

Sec. 3. 28 MRSA § 452, 2nd ¶, 1st sentence, as enacted by PL 1969, c. 360, § 15, is amended to read:

There shall be levied and imposed an excise tax of ~~30¢~~ 33¢ per gallon, or

fraction or multiple thereof, on all table wine containing 14% or less alcohol by volume imported into this State; except the excise tax shall be ~~20¢~~ 23¢ per gallon or fraction or multiple thereof on all still wine containing 14% or less alcohol by volume which is manufactured or bottled in this State; and an excise tax of ~~$1~~ $1.05 per gallon or multiple or fraction thereof on all sparkling wines manufactured in or imported into this State.

Sec. 4. Appropriation. There is appropriated from the General Fund to the Department of Human Services the sum of $4,456,989 for the biennium to carry out the purposes of this Act. The breakdown shall be as follows:

	1977-78	1978-79
HUMAN SERVICES, DEPARTMENT OF		
Office of Alcoholism and Drug Abuse Prevention		
Personal Services	(6) $ 40,488	(6) $ 96,400
Capital	18,000	—
All Other	1,712,101	2,590,000
Total	$1,770,589	$2,686,400

STATEMENT OF FACT

The purpose of this bill is to generate new revenue from the sale of alcoholic beverages to fund a major attack on alcohol abuse and alcoholism. Alcoholism is now America's 3rd largest health problem, surpassed only by heart disease and cancer. Nationally, alcohol accounts for over 28,000 auto fatalities and over 1,000,000 major auto injuries each year. In Maine, there are an estimated 60,000 alcoholics and problem drinkers, and in 1974 alone, there were approximately 15,000 alcohol-related criminal offenses committed. Also, the cost of alcoholism resulting from loss of production and absenteeism in industry, health and medical care and police, prosecutorial and judicial time amounted to $126,000,000 in Maine in 1974. The cost of the most tragic consequence of alcoholism, broken families and ruined lives, is incalculable.

The moneys raised by this bill would be used to fund a 3-pronged attack on alcoholism and alcohol abuse. First, part of the revenue would be used to continue funding and upgrade the quality of treatment for Maine's in-patient and out-patient alcoholism programs and to provide for occupational and industrial alcoholism counseling. Secondly, these moneys would be used to implement a program of prevention of alcohol abuse and thirdly, this revenue would provide for the education and treatment of alcohol abusers who are convicted of operating under the influence and other Class C, D and E criminal offenses.

Based on sales for the fiscal year ending June 30, 1976, this bill would add approximately $2,492,087 per year to the General Fund. The 3% surtax on

bottled liquor would contribute $1,441,641, the surtax on beer would contribute $1,010,722 and the surtax on sparkling and table wines would contribute approximately $39,724. The additional cost to the consumer would be approximately 2¢ per 6-pack of beer, 1¢ per fifth of table wine and sparkling wine and 15¢ on a $5.00 purchase of liquor.

This tax increase would fall primarily on persons who drink heavily, for studies have shown that 9% of adults buy about 50% of all alcoholic beverages and that 15% of adults purchase more than 75% of all alcoholic beverages.

Appendix L

APPROVED
JUL 7 '77
BY GOVERNOR

CHAPTER
466
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-SEVEN

H. P. 418 — L. D. 530

AN ACT to Create a Board of Registration of Substance Abuse Counselors.

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

Sec. 1. 10 MRSA § 8001, 2nd sentence, as last repealed and replaced by PL 1977, c. 78, § 36, is amended to read:

The department shall be composed of the following bureaus, boards and commissions:

Board of Examiners on Speech Pathology and Audiology;

Bureau of Banking;

Bureau of Consumer Protection;

Bureau of Insurance;

Electricians' Examining Board;

Oil Burner Men's Licensing Board;

Maine State Boxing Commission;

Real Estate Commission;

State Board of Examiners of Psychologists;

State Claims Board; ~~and~~

State Running Horse Racing Commission; and

Board of Registration of Substance Abuse Counselors.

Sec. 2. 32 MRSA c. 79 is enacted to read:

CHAPTER 79

SUBSTANCE ABUSE COUNSELORS

SUBCHAPTER I

GENERAL PROVISIONS

§ 6201. Board of Registration of Substance Abuse Counselors

There is created and established the Board of Registration of Substance Abuse Counselors within the Department of Business Regulation to carry out the purposes of this chapter.

§ 6202. Objective

The objective of this legislation is to establish a Board of Registration of Substance Abuse Counselors, which will establish and ensure high professional standards among substance abuse counselors and which will encourage and promote quality treatment and rehabilitation services for substance abusers.

§ 6203. Definitions

As used in this chapter, unless a different meaning clearly appears from the context, the following terms shall have the following meanings.

1. Board. "Board" means the Board of Registration of Substance Abuse Counselors.

2. Consumer. A "consumer" is a nonprovider who has received substance abuse counseling services within the State of Maine.

3. Nonprovider. A "nonprovider" means an individual who neither is presently nor has been any of the following:

A. A substance abuse counselor;

B. An administrator or board member of a facility or program which provides substance abuse services; or

C. The spouse of any of those persons listed in paragraphs A and B.

4. Provisionally registered substance abuse counselor. "Provisionally substance abuse counselor" means a substance abuse counselor as provisionally registered under this chapter.

5. Registered substance abuse counselor. "Registered substance abuse counselor" means a substance abuse counselor as registered under this chapter.

6. Substance abuse counseling services. "Substance abuse counseling services" are those counseling services offered as part of the treatment and rehabilitation of persons abusing chemical substances. The purpose of substance abuse counseling services is to help individuals, families and groups confront and resolve problems caused by the abuse of chemical substances.

7. Substance abuse counselor. A "substance abuse counselor" is a person who presents himself to the public or gives or offers substance abuse counseling services to any public or private individual, corporation or agency.

§ 6204. Reporting

No later than August 1st of each year, the board shall submit to the Commissioner of Business Regulation, for the preceding fiscal year ending June 30th, an annual report of its operations and financial position, together with such comments and recommendations as the board deems essential.

§ 6205. Unlawful use of title "provisionally registered" or "registered" substance abuse counselor

No person shall represent himself to the public, or assume or use the title or designation "provisionally registered" or "registered" substance abuse

counselor or the abbreviation "P.R.S.A.C." or "R.S.A.C." or any other title, designation, words, letters or device tending to indicate that such a person is a "provisionally registered" or "registered" substance abuse counselor unless such person is provisionally registered or registered with and holds a current and valid certificate of provisional registration or certificate of registration from the board. Any person who offers or gives substance abuse counseling services in violation of this section shall, upon conviction, be punished by a fine of not less than $50 and not more than $500 for each such offense.

§ 6206. Exemptions

Nothing in this chapter shall prevent any person from engaging in or offering substance abuse counseling services provided that such person does not represent himself as, or use the title of, "provisionally registered" substance abuse counselor or "registered" substance abuse counselor.

§ 6207. Registration required

In order to safeguard the health and safety of Maine's citizens, any person who performs or offers to perform substance abuse counseling services as a "provisionally registered" or "registered" substance abuse counselor shall be required to submit evidence that he is qualified to so practice and shall be provisionally registered or registered in accordance with this chapter.

SUBCHAPTER 2

MAINE BOARD OF REGISTRATION OF SUBSTANCE ABUSE COUNSELORS

§ 6208. Appointment; terms; vacancies

1. Membership. There is created a Board of Registration of Substance Abuse Counselors, to consist of 9 members who shall be appointed by the Governor. The Maine Council on Alcohol and Drug Abuse Prevention and Treatment shall submit to the Governor a list of at least 3 recommendations for each initial board member to be appointed. The list may include recommendations from the Office of Alcoholism and Drug Abuse Prevention (OADAP), the Maine Association of Alcoholism Program Directors, the Regional Alcoholism Councils and the Maine Addiction Professionals Association. The Governor shall act promptly by making the initial appointments from this list. Five of the initial board members shall be eligible for registration under this chapter. Four of the initial board members shall be nonproviders. Two of the nonproviders shall be consumers. Subsequent appointees to the board shall be registered substance abuse counselors, with the exception that 2 members of the board shall be nonproviders, one of whom shall be a consumer.

2. Terms of office. The terms of office shall be for 3 years, provided that in the appointment of the initial board 3 members shall be appointed for one year, 3 members for 2 years and 3 members for 3 years. Two of the initial board members appointed for a 3-year term shall be nonproviders.

3. Vacancy. Any vacancy occurring during a term shall be filled by appointment within 30 days by the Governor.

4. Successor member. Upon expiration of a term of office, the Governor shall fill the vacancy by making an appointment within 30 days. Upon such expiration, a member shall continue to serve until his successor is appointed.

5. Limitation. No board member shall serve for more than 6 consecutive years.

§ 6209. Removal of board members

Any board member may be removed from office by the Governor for any of the following reasons:

1. Attendance. Failure to attend 2 consecutive meetings of the board;

2. Criminal conviction. After appointment to the board, any criminal conviction which if committed within this State would constitute a Class A, B or C crime under the laws of this State;

3. Fraud or deceit. The practice of fraud or deceit in granting a certificate of provisional registration or certificate of registration under this chapter or in connection with services rendered as a member of the board;

4. Active abuse. Active abuse of alcohol, or any other drug which is detrimental to the performance or competency of a board member or in any way jeopardizes the integrity of the board;

5. Mental incompetency. A legal finding of mental incompetency;

6. Unprofessional conduct or negligence. Any gross negligence, incompetency or misconduct in the performance of duties as a board member; or

7. Valid cause. Any other valid cause.

§ 6210. Meetings; elections; quorum

Within 30 days after their appointment, the board shall meet and organize by electing a chairperson, secretary and treasurer. The board shall hold regular meetings, at least semiannually, and such additional meetings at such times and places as it may deem necessary. The board shall keep a written record of all its proceedings. Five members of the board shall constitute a quorum for the transaction of business under this chapter.

§ 6211. Compensation

Members of the board shall receive no compensation for their services as members of the board, but they shall be reimbursed for reasonable travel and incidental expenses incurred in carrying out this chapter, provided that such expenses do not exceed the fees collected by the board. If the fees to be collected under this chapter are insufficient to pay the expenses provided by this section, the board members shall be entitled to a pro rata payment in any years in which such fees are insufficient.

§ 6212. Powers and duties of the board

The board shall have the following powers and duties in addition to all other powers and duties imposed by this chapter.

1. Set standards. In addition to those standards set forth in section 6213, the board in consultation with the Office of Alcoholism and Drug Abuse Prevention may set additional standards of eligibility for persons desiring to become registered substance abuse counselors.

2. Adopt criteria. The board, in cooperation with the Office of Alcoholism and Drug Abuse Prevention, may design and adopt an examination or other suitable criteria for establishing a candidate's knowledge, skill and experience in substance abuse counseling.

3. Registration and standards. The board may register and set standards of practice for provisionally registered or registered substance abuse counselors working in Maine.

4. Rules and regulations. The board shall have the power to adopt such rules and regulations and establish such advisory committees as the board may deem necessary and proper to carry out this chapter.

5. Contracts. The board may enter into contracts to carry out its duties or responsibilities under this chapter.

6. Complaints. The board shall have the power to investigate complaints on its own motion and those lodged with the board or its representatives regarding the violation of any section of this chapter and the violation of any rules and regulations adopted by the board pursuant to its authority.

SUBCHAPTER 3

REGISTRATION

§ 6213. Eligibility requirements

To be eligible to apply for registration as a substance abuse counselor, an applicant shall:

1. Age limit. Be at least 18 years of age;

2. Qualifications. Have been employed in the profession of substance abuse counseling for a minimum of 2 years in the 4-year period immediately preceding the date on which application is made or have the equivalent of 2 years of paid employment as a substance abuse counselor. In determining such equivalent, an applicant shall have been employed at least one year in the profession of substance abuse counseling and the board may substitute work-based educational experience for the remaining period of required paid employment at a rate of no less than 2 months of work-based educational experience for each one-month period of required paid employment. Both the paid employment and the work-based educational experience shall have taken place within the 4-year period immediately preceding the date on which application is made; or have the equivalent of 2 years of paid employment as a substance abuse counselor. In determining such equivalent, an applicant shall have been employed at least 1½ years in the profession of substance abuse counseling and the board may substitute volunteer work for the remaining period of required paid employment at a rate of no less than 2 months of volunteer work for each one-month period of required paid employment. Both the paid employment and the volunteer work have taken place within the 4-year period immediately preceding the date on which application is made; and

3. Abstinence from drugs and alcohol. Have abstained from the active abuse of alcohol or any other drug which in the judgment of the board has been or could have been detrimental to the applicant's performance or competency as a substance abuse counselor. It is strongly recommended that applicants have abstained for at least the 2-year period immediately preceding the date on which application is made. In considering an applicant for registration, the board shall not consider a history of previous alcoholism or drug addiction as an essential qualification nor disqualification for registration.

§ 6214. Certificate of registration

1. Registration. The board shall issue a certificate of registration upon the affirmative vote of at least 5 members of the board to any applicant who has satisfactorily met the following minimal requirements:

A. Met the eligibility requirements set forth in section 6213;

B. Obtained a passing grade, as established by the board, on any examinations the board may prescribe by its rules and regulations;

C. Completed 30 semester hours of college level course work in appropriate social science fields or its equivalent in appropriate substance abuse training; and

D. Met any other criteria the board may prescribe by its rules and regulations.

2. Provisional registration. The board may issue a certificate of provisional registration upon the affirmative vote of 5 members of the board to any applicant who has met the following minimal requirements:

A. Met the eligibility requirements set forth in section 6213;

B. Obtained a provisionally passing grade, as established by the board, on any examinations the board may prescribe by its rules and regulations; and

C. Met any other criteria the board may prescribe by its rules and regulations.

The certificate of provisional registration shall be issued for a single nonrenewable period not to exceed 3 years. A certificate of provisional registration may be issued only once to any individual. During the period the provisional certificate is valid, the provisional registrant will be expected to take appropriate action necessary to qualify for registration. During the period of provisional registration, a provisional registrant may apply for full registration at any time, provided that he may not apply on more than 2 separate occasions.

3. Reapplication for certificate. Any applicant who is not issued a certificate of provisional registration or a certificate of registration may again apply for registration after a period of not less than 6 months from the date of the last denial.

§ 6215. Application; membership fees

Application for registration as a registered substance abuse counselor shall be on a form prescribed and furnished by the board. A nonrefundable application fee shall be established by the board in an amount not to exceed $100 which fee shall accompany the application. A fee shall be established by the board in an amount not to exceed $25 for provisionally registered substance abuse counselors who reapply for registration. A biennial fee for registered substance abuse counselors shall be established by the board in an amount not to exceed $50 biennially. A triennial fee for provisionally registered substance abuse counselors shall be established by the board in an amount not to exceed $50 triennially.

§ 6216. Examinations

Written or oral examinations or written and oral examinations shall be held at least twice a year at such times and places as the board shall determine. The examinations shall be based on substance abuse counseling competencies.

SUBCHAPTER 4

SUSPENSION AND REVOCATION

§ 6217. Suspension and revocation

The board shall have the power to suspend or revoke the certificate of provisional registration or certificate of registration of a substance abuse counselor for any of the following reasons:

1. Criminal conviction. After issuance of a certificate of provisional registration or a certificate of registration, any criminal conviction which if committed within this State would constitute a Class A, B or C crime under the laws of Maine;

2. Fraud or deceit. The practice of fraud or deceit in obtaining a certificate of provisional registration or a certificate of registration under this chapter or in connection with services rendered as a substance abuse counselor;

3. Active abuse. Active abuse of alcohol, or any other drug, which in the judgment of the board is detrimental to the performance or competency of a substance abuse counselor;

4. Mental incompetency. A legal finding of mental incompetency;

5. Aiding and abetting misrepresentation. Aiding or abetting a person, not duly certified as a provisionally registered or registered substance abuse counselor, in representing oneself as a provisionally registered or registered substance abuse counselor in this State;

6. Unprofessional conduct or negligence. Any gross negligence, incompetency or misconduct in the performance of substance abuse services; or

7. Valid cause. Any other valid cause.

§ 6218. Hearing on refusal; revocation; suspension

The board may suspend, revoke or refuse to issue or to renew any certificate of provisional registration or certificate of registration as specified in section 6217 after written notice has been sent by registered mail to the person's last known address stating the reasons for suspension, revocation or denial, at least 10 working days prior to any action taken by the board. The written notice shall inform the person of his right to appeal the decision of the board at a special meeting of the board.

At such meeting, the applicant or registrant shall have the right to appear personally and by counsel, to cross-examine witnesses appearing against him and to produce evidence and witnesses in his own defense.

If, after such a meeting, at least 5 members of the board vote in favor of suspension, revocation or denial, such suspension, revocation or denial shall remain in effect pursuant to this section.

The board, for reasons it may deem sufficient, may issue or reissue a certificate of provisional registration or certificate of registration to any person whose certificate of provisional registration or certificate of registration has been denied, suspended or revoked, provided at least 5 members of the board vote in favor of such issuance.

§ 6219. Expiration and renewal

The certificate of provisional registration is nonrenewable and shall expire 3 years from the date of initial issuance. The certificate of registration shall expire biennially on August 31st or at such other time as the Commissioner of Business Regulation may designate. Registration may be renewed for the succeeding 2-year period upon written application of the registrant, the approval of the board and the payment of the fee provided. A fee for renewal of registration shall be set by the board in an amount not to exceed $25 and shall be due and payable on or before the expiration date. Before a certificate of registration may be renewed, the applicant shall present evidence of continued professional learning and training of a type which is acceptable to the board.

Any person, who fails to renew his registration prior to its date of expiration, shall be stricken from the rolls and his registration may be renewed only after again meeting the requirements of this chapter. The board shall be responsible for mailing notification of the date of expiration of a certificate of provisional registration or a certificate of registration to any provisionally registered or registered substance abuse counselor not later than 30 days prior to the date of expiration.

§ 6220. Reciprocity

The board may waive any examinations for applicants who are recognized by other credentialing bodies as having met qualifications and standards determined by the board as comparable to those set forth in this chapter.

IN HOUSE OF REPRESENTATIVES,.....1977

Read twice and passed to be enacted.

.....*Speaker*

IN SENATE,.....1977

Read twice and passed to be enacted.

.....*President*

Approved.....1977

.....*Governor*

ONE HUNDRED AND EIGHTH LEGISLATURE

Legislative Document No. 1104

H. P. 904 House of Representatives, March 17, 1977

On Motion of Ms. Clark of Freeport referred to the Committee on Business Legislation. Sent up for concurrence and ordered printed.

EDWIN H. PERT, Clerk

Presented by Mr. Norris of Brewer.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-SEVEN

AN ACT to Require Alcoholism Treatment Benefits in Health Insurance Policies.

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

Sec. 1. 24 MRSA § 2320 is enacted to read:

§ 2320. Benefits for expense of treatment of alcoholism

All individual and group contracts issued by any nonprofit hospital or medical service organization operating under this chapter, shall provide for benefits for expense arising from treatment of alcoholism which are at least equal to the following minimum requirements.

1. Inpatient. In the case of benefits based upon confinement as an inpatient in an accredited or licensed hospital or in any other public or private facility licensed by the Department of Human Services, which provides services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics, the benefits shall be extended at least 30 days in any calendar year.

2. Outpatient benefits. In the case of outpatient benefits, these shall cover, to the extent of $500 over a 12-month period, services furnished by an accredited or licensed hospital, or by any public or private facility or portion of that facility which provides services especially for the rehabilitation of intoxicated persons or alcoholics, and which is licensed by the Department of Human Services for those purposes. Consultant or treatment sessions furnished by a facility under this subsection, shall be rendered by either an employee or a private or public treatment facility approved under Title 22, section 7115, or a licensed physician or a licensed psychologist.

The requirements of this section, shall apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act.

Sec. 2. 24-A MRSA § 2745 is enacted to read:

§ 2745. Minimum requirements; benefits for expense arising from treatment of alcoholism

All individual health insurance policies providing coverage on an expense incurred basis shall provide as benefits, if so elected by the subscriber, expenses arising from treatment of alcoholism which are at least equal to the following minimum requirements.

1. Inpatient. In the case of benefits based upon confinement as an inpatient in an accredited or licensed hospital or in any other public or private facility licensed by the Department of Human Services, which provides services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics, the benefits shall be extended at least 30 days in any calendar year.

2. Outpatient benefits. In the case of outpatient benefits, these shall cover to the extent of $500 over a 12-month period, services furnished by an accredited or licensed hospital, or by any public or private facility or portion of that facility which provides services especially for the rehabilitation of intoxicated persons or alcoholics, and which is licensed by the Department of Human Services for those purposes. Consultant or treatment sessions furnished by a facility under this subsection, shall be rendered by an employee of a private or public treatment facility approved under Title 22, section 7115 or a licensed physician or a licensed psychologist who devotes a substantial portion of his time treating intoxicated persons or alcoholics.

The requirements of this section shall apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act.

Sec. 3. 24-A MRSA § 2837 is enacted to read:

§ 2837. Blanket health insurance policies to provide for benefits for expense arising from treatment of alcoholics

All group or blanket health insurance policies shall, if so elected by the policyholder, provide for benefits for expense arising from treatment of alcoholism which are at least equal to the following minimum requirements.

1. Inpatient. In the case of benefits based upon confinement as an inpatient in an accredited or licensed hospital or in any other public or private facility licensed by the Department of Human Services, which provides services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics, the benefits shall be extended at least 30 days in any calendar year.

2. Outpatient benefits. In the case of outpatient benefits, these shall cover to the extent of $500 over a 12-month period, services furnished by an accredited or licensed hospital, or by any public or private facility or portion of

that facility which provides services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Department of Human Services for those purposes. Consultant or treatment sessions furnished by a facility under this subsection shall be rendered by an employee or a private or public treatment facility approved under Title 22, section 7115, or a licensed physician or a licensed psychologist.

The requirements of this section shall apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act.

STATEMENT OF FACT

This bill requires health insurance policies to provide alcoholism treatment benefits.

SALARY STANDARDS AS PASSED UNANIMOUSLY BY MAAPD, 12/29/77

CLASSIFICATION	TIME IN CLASSIFICATION						
	START	6 Months	1½ Years	2½ Years	3½ Years	4½ Years	5½ Years
APPRENTICE Counselor/ Specialist	$7300 $3.51/hr	$7665 $3.69/hr	$8048	$8451	$8873	$9317	$9383
QUALIFIED Counselor/ Specialist	$8500	$8925 $4.29/hr	$9371	$9840	$10332	$10848	$11391
SENIOR Counselor/ Specialist	$9900 $4.76/hr	$10450	$11000	$11550 $5.55/hr	$12128	$12734	$13371
SUPERVISING Counselor/ Specialist	$10450	$11000	$11550 $5.55/hr	$12128	$12734	$13371	$14039
ASSISTANT Director for	$11250 $5.41/hr	$11875	$12500	$13125 $6.31/hr	$13781	$14470	$15194
DIRECTOR/ Executive Director	$13500 $6.49/hr	$14250	$15000	$15750 $7.57/hr	$16538	$17364	$18233

Appendix N

Memo of Agreement

The Office of Alcoholism and Drug Abuse Prevention, the Single State Agency for drug abuse prevention, and the Maine Criminal Justice Planning and Assistance Agency, the State Planning Agency, under the Safe Streets Act as amended, recognize that many clients of the criminal justice system have problems associated with the abuse of drugs and alcohol. We further recognize that improved cooperation between the criminal justice and alcohol/drug abuse treatment systems is one means of significatnly reducing these problems. Improved linkages between the two systems will occur as the result of establishing an on-going exchange of information, and, of jointly planning for additional treatment services, especially in county jails and state correctional institutions.

The Office of Alcoholism and Drug Abuse Prevention will make available to MCJPAA any information from the drug and alcohol management information system that would be pertinent to MCJPAA's needs. For its part the MCJPAA will provide the OADAP with data from the Uniform Crime Reports (UCR) that is relevant to drug and alcohol abuse planning.

The OADAP, in cooperation with MCJPAA, will prepare a proposal for augmenting existing treatment services in the county jails. Because funds are limited, county jails, which presently have fewest services, are assigned highest priority. The services will focus on improving diagnosis and referral within the jail setting and will make maximum use of existing community-based treatment programs.

Training and education are other areas of mutual concern to the OADAP and MCJPAA. In the coming year we propose to discuss the possibility of jointly sponsored programming in these areas.

Michael D. Fulton
Acting Director
Office of Alcoholism and
Drug Abuse Prevention

Maine Criminal Justice
Planning and Assistance Agency

STAGE	PHYSICAL SYMPTOMS	PSYCHOLOGICAL SYMPTOMS	SOCIAL SYMPTOMS	NEEDS
PROBLEM DRINKER	- Frequent alcohol intoxication. - No addiction to alcohol or drugs.	- No dependence on alcohol. - Consistent pattern of drunken episodes.	- Social encouragement by peers. - Possible arrest and conviction of OUI. - Possible financial difficulties through excessive spending. - Possible problems from alcohol-affected behavior.	- Alcoholics Anonymous (AA). --- - Intervention/Confrontation. - Information/Education. - * Community Education. * To address encouragement by peers of harmful drinking habits and behavior.
EARLY	- Few observable physical harms or alcohol-related injuries. - Addiction and tolerance increase.	- Drinking to relieve stress. - Dependence.	- Avoidance of non-alcohol oriented activities. - Minor family, job, and social problems. - Encouragement by peers.	- Intervention. - Outpatient. - * Education. * To address encouragement by peers of drinking in excess.
MIDDLE	- Minimal physical impairment. - Addiction. - Tolerance decrease.	- Dependence. - Inability to cope. - Denial	- Instability of meaningful relationships. - Declining peer group status. - Conformance to dominant social values. - Declining job performance. - Some legal problems.	- Intervention. - Detoxification (medical, social setting, ambulatory). - Outpatient/Aftercare - * Short-term rehabilitation (30 days). * If assessed as necessary.
LATE	- Frequent withdrawal symptoms. - Malnutrition - Alcohol-related health problems.	- Guilt. - Anxiety. - Resentment. - Distrust. - Alibis.	- Few personal relationships maintained. - Employment or unemployment problems. - Minimal life goals. - Acceptance of dominant social values. - Recurrent legal problems.	- AA Sponsor --- - Intervention - Detoxification & physical evaluation. - Long-term rehabilitation (90 days) - Outpatient/Aftercare
FINAL	- Severe alcohol-related health problems. - Organic deterioration.	- Emotional disorganization. - Ethical deterioration.	- Lack of personal relationships. - No realistic life goals. - Financial irresponsibility. - * Lack of adequate living quarters. * Many remain in one geographical area in sub-standard rooms.	- AA --- - Detoxification. - Physical evaluation/ restoration. - Temporary and long-term housing.

APPENDIX Q

TRAINING NEEDS ASSESSMENTS

APPENDIX Q

Training Needs Identified in the State Plan Development Process

1. Training for program staff in utilizing volunteers.

2. Training for regional council members in consumer advocacy.

3. Training for employees of industry who are responsible for making referrals to treatment.

4. Training especially designed for recovering alcoholics who become counselors in alcohol programs.

5. Training for regional coordinators and OADAP staff people in specific skill areas, including administration, models of health care delivery and treatment modalities.

SUMMARY OF TRAINING NEEDS ASSESSMENT FOR SUBSTANCE ABUSE ADMINISTRATORS

A copy of the training needs assessment approved by the Training Advisory Committee was mailed to twenty-eight substance abuse agencies, including the five regional alcohol and drug abuse councils, in January, 1978. Fifteen responses were received and the information they contained on training content and structure was compiled.

For each identified training content need, the number of respondents at a particular level of need was weighted in the following way to obtain a single indication of the level of need:

> Using "Public Relations" as an example, one respondent indicated minimal need, five indicated moderate need, five recorded substantial need, and four indicated a high priority need. The single indication was then calculated: $(5.1) + (5.2) + 4.3) = 27$

Using this method, nine priority needs were identified, each having an indication of need equal to or greater than 24.

1. Assessing and Securing Local Financial Resources
2. Grantsmanship
3. Approaching Private Foundations
4. Public Relations
5. Management by Objectives
6. Establishment of Assessment Criteria for Program Evaluation
7. Use of Information Systems
8. Staff Development
9. Evaluation of Staff Performance

Agency training needs in the areas of clinical supervision and ethics/ confidentiality were assessed with two specific questions. The answers to those questions are outlined here.

> DO YOU, OR DOES YOUR AGENCY, HAVE TRAINING NEEDS RELATED TO EITHER OF THE FOLLOWING AREAS? PLEASE DESCRIBE AND COMMENT.

Clinical Supervision

No 9
Yes 6

- "Formalizing the process."
- "Inexperience and lack of formal training."
- "Training needs more around on-going development of clinical skills per se rather than supervision."
- "Training in the area of effective models for offering clinical supervision would be of interest. Specifically if emphasis is placed on the development of trust between supervisor and supervisee which promotes a growth experience for the supervisee."

- "Questions pertaining especially to the use of consultants and need or lack of need for contracts between agency and consultants. Feasibility of using more than one consultant (with varying treatment modalities) and how to be consistent."
- "Working under Consultant Psychologist and in cooperation with Mental Health Clinics as paraprofessionals, staff and administration need assistance working with dual sets of success criteria, i.e. success treating alcoholism and success treating problem which caused it per Mental Health."

Ethics & Confidentiality

No 10
Yes 5

- "Would like to do a training package around the proposed NIAAA standards."
- "As clearinghouse of client numbers (NAPIS)."
- "Staff needs more training on working with confidentiality regs. on a day-to-day basis - mostly greater familiarity with all the provisions of the regs."
- "There is a need for training around the confidentiality law - how it concerns and affects administrators, staff, alcoholism counselors and the clients themselves."
- "I think a policy and training is needed for my program re: ethics and professional relationships. Confidentiality guidelines should be clearer, more concise and readily accessable to all staff. A Workshop just on confidentiality guidelines would be useful."

Finally, the assessment included questions on training structure. Answers to those five questions are summarized below.

STATE ANY PREFERENCES THAT YOU HAVE RELATED TO THE LENGTH/FORMAT/TIME OF YEAR OF TRAINING FOR SUBSTANCE ABUSE ADMINISTRATORS:

- "Length should be kept to a reasonable amount of time with enough breaks to prevent fidgeting. Small group sessions in an informal type atmosphere rather than a lecture type session."
- "One day sessions are preferable - These sessions may be over a period of several weeks or months."
- "Would prefer shorter, more specific time segments and agenda - prefer didactic presentation followed by Q & A or experiential (role playing, etc.) process."
- "Only that consideration be given for distance that must be traveled by Directors. This might dictate that a format of a six week program with one session per week would not be workable."
- "Half day every two weeks with study assignments between time - reliance on home study."

- "Half-day sessions preferable over whole day or several day workshops - due to nature of services, it's difficult to leave on a training program when crises are taking place, etc."
- "After contract negotiations, not on weekends, day time, extended."
- "Less traveling the better - would rather have concentrated program."
- "Length - $\frac{1}{2}$ to 1 day; format - structured with effective speaker and questions and answers (no touchy-feelie); time of year - not winter."

CAN YOU IDENTIFY ANY TRAINING NEEDS THAT COULD BEST BE MET IN A TRAINING SESSION INVOLVING SUBSTANCE ABUSE ADMINISTRATORS AT THE EXCLUSION OF OTHER TYPES OF ADMINISTRATORS?

No 5
Yes 5

- "Ethical considerations may be specific in substance abuse field."
- "Working with outside agencies, negotiating, utilizing services."
- "Problems encountered with recovering staff members - recruiting, standards, personnel problems."
- "Program evaluation."
- "Nothing except treatment. However, it would be helpful as an administrator to know a lot more about treatment and to participate in some treatment training (particularly new techniques or the differences between drug treatment and alcohol treatment)."
- "Not really - The key type would be administrators of human service programs of roughly equivalent size."
- "No - Administration is administration."

DO YOU HAVE A DESIRE FOR CREDIT BEARING TRAINING? IF YOU DO, AT WHAT DEGREE LEVEL WOULD THAT CREDIT BE USEFUL TO YOU?

No 4
Yes 9

Bachelor's level - 2
Master's level - 7
Doctoral level - 1

BRIEFLY DESCRIBE YOUR AGENCY'S RESOURCES FOR PROVIDING/PURCHASING STAFF TRAINING.

- "At the present time, the Northeast Indian Alcoholism Training Program provides for staff training but the program will be defunct as of June 1978."
- "Title XX." (2)
- "Limited."

- "0."
- "We currently support staff development through inservice trainings, sponsoring agency workshops, study groups, sending staff to outside workshops. Financial support is consistent with funding guidelines and available AMHC funds."
- "At the present time, we can allot less than $200/year for six staff members to attend workshops/training sessions of their choice."
- "Minimal - We have $55.00/person for training and this is supposed to be combined for a group of staff - to come up with an inservice training plan that would benefit the group."
- "$1500/year budgeted for training of entire staff."
- "We have put in for training monies with NIAAA grant. EMMC has fund for all employees for college courses. $2,000 available for contract training or workshops."
- "Minimal funds available for purchase of training."
- "None in the budget of the Council; staff time can be used if OADAP sponsors and both OADAP and the Council approves."
- "Current plans are to set aside $200 per person for all training. This mostly is tied in with clinical and case management training."

CURRENTLY THERE ARE AGENCIES AND ORGANIZATIONS IN MAINE WHICH OFFER TRAINING PROGRAMS IN THE ADMINISTRATIVE CONTENT AREAS LISTED ABOVE. IF YOU OR ONE OF YOUR STAFF MEMBERS HAS RECENTLY ATTENDED SUCH A PROGRAM, PLEASE PROVIDE THE FOLLOWING INFORMATION.

Title of the Program	Sponsoring Agency	Comments on Program
Fund raising techniques	UMPG Business School	too elementary
Adm. of non-profit agencies	YCCS	very good & pertinent
Training in Organization for Supervisors	University of Maine - Augusta	Held in 1976 - not that relevant to my particular needs
The Counseling Center	Bangor	Frequent workshops on varied subjects. However, much too expensive for smaller programs to take advantage of them.
Management	YCCS	excellent

Appendix Q

May, 1976

PRIORITY TRAINING NEEDS FOR SUBSTANCE ABUSE COUNSELORS

1. Knowledge of major drug types and their psychological/physiological effects.
2. Knowledge of patterns of addiction associated with various drug types.
3. Knowledge of basic counseling theories and techniques.
4. Knowledge of basic principles of network therapy.
5. Ability to assess underlying emotional disturbances in substance dependent people.
6. Ability to select and apply appropriate treatment strategy/model.
7. Knowledge of substance abuse counseling techniques.
8. Knowledge of learning theories.
9. General knowledge of laws affecting common situations found by substance abuse counselors.
10. Knowledge of principles of group therapy.
11. Ability to state areas of agreement/disagreement in non-judgemental, non-coercive manner while assisting a client to reach a decision regarding treatment.
12. Ability to apply crisis counseling techniques.