STATE PLAN
FOR PREVENTION, TREATMENT AND REHABILITATION OF ALCOHOL ABUSE AND ALCOHOLISM IN MAINE

APRIL 1973

Maine State Department of
Health and Welfare
Bureau of Rehabilitation
Division of Alcoholism Services
32 Winthrop Street
Augusta, Maine 04330

STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
AUGUSTA

ADDRESS REPLY TO:

32 Winthrop Street

DEAN FISHER, M. D.
COMMISSIONER

April 2, 1973

Morris E. Chafetz, M.D.
Director
National Institute on Alcohol Abuse
and Alcoholism
5600 Fishers Lane
Rockville, Maryland 20852

Dear Doctor Chafetz:

The attached document is the completed second year revision of the Maine State Plan on Alcohol Abuse and Alcoholism as required under P.L. 91-616.

This document reflects the changes in state planning activity during fiscal year '72. Modifications in this plan are represented on the blue pages.

In making the assumption that demographic data has not changed too much over the past year, we have not revised that part of the Plan. We should, however, have a data collection system which will provide us with demographic information for the third year Plan.

We hope you find these revisions acceptable, and that we will be notified to that effect in writing when final review has been completed.

Sincerely yours,

Max P. Good, Director
Division of Alcoholism Services

MPG/c

cc: Mrs. Anne Twomey
Gertrude Hunter, M.D.
Dr. Dean Fisher
C. Owen Pollard

HEALTH COUNCIL OF MAINE

133 State Street
Augusta, Maine 04330
207 - 622-3661

President: I. Carl Mayhew, D.M.D.

Executive Director: Peter C. Doran, Ph.D.

Commissioner Dean Fisher, M.D.
Department of Health and Welfare
State House
Augusta, Maine 04330

Dear Dr. Fisher:

Re: Study of the Problems of Alcohol Abuse and Alcoholism.

I am pleased to transmit to you on behalf of the Health Council, Inc., of Maine, the State Plan for Alcoholism Services which it has been our privilege to help prepare in cooperation with, and under a contractual arrangement with your Bureau of Rehabilitation and your Director of Alcoholism Services.

The Council wishes to take this opportunity to commend its observations and recommendations to the thoughtful consideration of your Department; to the State Alcoholism Advisory Council; the seven-member Advisory Committee to the Division of Alcoholism Services; to Governor Curtis and the Executive Department; to the Maine State Legislature, and its Subcommittee on Intoxication and Treatment, and to the many individual workers in both governmental and non-governmental programs, and by no means least, to the citizens of the State of Maine.

The Health Council also wishes to express appreciation to the hundreds of public spokesmen who participated so enthusiastically in

our regional planning. Special recognition goes to the Department of Mental Health and Corrections, Community Mental Health Centers, Regional Comprehensive Health Planning Services, Law Enforcement Planning and Assistance Agency, State Planning Agency, Maine State Library, Alcohol Safety Action Program, individual members of Alcoholics Anonymous throughout the State, and the many private programs which all gave generously of their time, contributing significant facts, figures, plans and recommendations on very short notice.

The overwhelming response to the prospects of continuing regional planning with a groundswell of public and private support for improved alcoholism programs is encouraging. The need is clear and the desire is strong throughout the State.

This plan is intended to provide a basis and framework for public reaction, modifications and improvements. We believe you will find it a meaningful point of departure in carrying out the provisions of the Hughes Bill.

Sincerely,

Peter C. Doran, Ph.D.
Executive Director

State of Maine
Executive Department
State Planning Office
189 State Street, Augusta, Maine 04330

KENNETH M. CURTIS
GOVERNOR

PHILIP M. SAVAGE
STATE PLANNING DIRECTOR

TEL. (207) 289-3261

April 3, 1972

Dr. Dean Fisher, Commissioner
Department of Health & Welfare
State House
Augusta, Maine 04330

Dear Dr. Fisher:

The Maine State Planning Office, designated by the Governor to review all Federally required State Plans and Plan revisions, hereby acknowledges receipt of the Maine State Plan for Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation.

A report of this review will be returned within 45 days, transmitting all comments, if any, upon the relationship of this Plan to other State Plans and Programs.

Sincerely,

Philip M. Savage

Philip M. Savage
State Planning Director

PMS:cs

DISCRIMINATION PROHIBITED*

1. All services provided under this State Plan will be made available without discrimination as to race, creed, color, sex, marital status, or duration of residence.

2. The designated State agency responsible for administering the Plan, and/or any other agency, organization, or institution administering and/or carrying out any activity under the Plan shall not discriminate in any way against any employee with respect to compensation, terms, conditions, or privileges of employment solely on the grounds of race, color, creed, sex, or national origin.

3. The State agency or any other agency, organization, or institution administering and/or carrying out any activity under the State Plan shall not refuse employment to any qualified applicant for a position solely on the basis of the fact that he or she has had or has not had a problem with alcohol.

4. It is understood that no formula grant funds will be awarded any public or private general hospital that has received Federal funds for alcohol treatment programs and that refuses admission and treatment to alcoholic patients solely on the basis of their alcoholism.

*Guidelines for Preparation of State Plans for Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Programs, Interim Draft, National Institute for Alcohol Abuse and Alcoholism, February 2, 1972, p. 31.

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PART I

I. PURPOSE OF THE STUDY

The State plan described here has been developed for the express purpose of presenting a coordinated, comprehensive program for the orderly development and provision of needed alcoholism prevention, treatment, and rehabilitation programs and facilities for the State of Maine.

It is intended also to provide a more rational and effective basis for the procurement and utilization of Federal, State and other financial resources to aid in planning, establishing, maintaining, coordinating, and evaluating these programs under terms of the Hughes Act primarily, but also as a means of assuring that all available financial resources are employed with optimum effectiveness and efficiency.

Hopefully this plan will serve to generate other forms of support, both public and voluntary, expressed not only in financial terms but through personal influence, involvement, and full participation in decision-making, with all its consequent responsibilities for the furtherance of direct and purposive action.

In the drafting of it, it has been our hope that it may serve to point some directions for the setting of appropriate and realistic goals and priorities; that it may have some usefulness for practitioners in the field as a tool for evaluation; that it will help bring about more enlightened attitudes and break down some of our old stereotypes and prejudices; and that ultimately it may contribute to the overall growth and betterment of our State.

Among its principal concerns have been:

1. Decentralization of authority and responsibility for program planning, development and implementation through the formation of five alcoholism planning regions.
2. A priority system based on the availability of comprehensive alcohol abuse and alcoholism prevention, treatment and rehabilitation programs in each region, with highest priority given those areas having the greatest unmet needs.
3. The requirement that comprehensive services for problem drinkers and alcoholics be provided without discrimination; that no person shall be excluded solely by reason ofhis inability to pay, and that service processes be so implemented as to assure continuity of care.

PART II

I. BACKGROUND OF THE STUDY

A. HISTORICAL SUMMARY

The emergence of national, state and regional programs for dealing with problems caused by excessive drinking and alcoholism is of comparatively recent date. The repeal of Prohibition in 1933 returned to the states the power to control the sale and distribution of alcoholic beverages, and the practice of "local option" left it up to voters in local elections to decide whether or not alcoholic beverages could be sold within the boundaries of their own jurisdictions. State laws regulating such sales and imposing penalties for their infraction have proliferated, along with criminal statutes intended to curb offensive drinking behavior and reduce the number of alcohol related crimes through arrest, conviction, fines and/or commitment.

1. Alcoholics Anonymous (AA)

The first steps away from a misconduct concept of alcoholism and the recognition of it as a treatable disorder were taken by the two founders of AA, Bill W. and his friend, Dr. Bob S., who in 1935 brought together a small group of alcoholics in Akron, Ohio, and from that point on encouraged the formation of similar small local groups in other parts of the country. The movement, patterned originally after the Oxford Groups, gained momentum and has since become international in scope, with many thousands of local groups now organized, of which more than 75 hold regular meetings here in the State of Maine.

An important aspect of the AA approach has been the identification of alcoholism as a disease. As such, it is seen as a disorder that involves considerably more than offensive behavior. Consequently the traditional approach of punishing the offender rarely seems to help him nor deters others. The person unable to control his drinking must acknowledge to himself that he is unable to use alcohol in a normal manner and must therefore leave it alone. The first step is therefore to come to the inescapable conclusion that one has become powerless over alcohol and that his life has become unmanageable as the result. Help is to be found by turning one's life and will over to a Higher Power, in the embracing fellowship of fellow sufferers.

The phenomenal growth of this movement and its high rate of "successes" among those who sincerely followed its precepts gradually brought it to the attention not only of the general public but to medical practitioners, who began recommending the program to their alcoholic patients.

2. The "Yale Plan"

Yale University's Laboratory of Applied Psychology, established in 1923, is recognized as the first organized attempt in the United States to use scientific techniques in investigating the physiological and psychological effects of alcohol and the causes of socially deviant drinking behavior. The Center of Alcohol Studies, as it has become known, was inaugurated in 1943 and devoted its attention primarily to applied research. In 1962, with major grants from the National Institute of Mental Health primarily, but also with

funds from private sources, the Center and its professional staff moved from Yale to Rutgers, the State University of New Jersey and established the Rutgers Center of Alcohol Studies as a major training resource.

3. Nationally Funded Programs

(a) It has only been in the past decade that programs for the treatment and rehabilitation of problem drinkers and alcoholics have come within the purview of the Federal Government. The first of these was the formation of the Cooperative Commission on the Study of Alcoholism (1961) which resulted in the publication of Alcohol Problems: A Report to the Nation, and the creation of the National Center for Prevention and Control of Alcoholism within the National Institute of Mental Health.

(b) A contributing factor has been the emphasis given to rehabilitation programs by the Federal Government during this decade. Although State-Federal vocational rehabilitation programs had been established as early as 1920, when Congress passed the Smith-Fess Act, these made slow progress at first and only persons with very evident physical disabilities were accepted as eligible. However, in 1965, major modifications of the national Vocational Rehabilitation Act not only extended its provisions to a much broader segment of the population but also increased its level of funding. These 1965 amendments gave formal recognition to the needs of the psychosocially handicapped, defined as those whose employability is seriously jeopardized by medically definable emotional and/or behavioral disorders resulting from educational, cultural, environmental, or related causes.

Additional amendments enacted by Congress in 1968 extended treatment and rehabilitation services to any "handicapped" individual, defined as one who is "seriously limited in his ability to secure or retain appropriate employment by reason of physical or mental disability, youth, advanced age, low educational attainment, ethnic or culturalfactors, prison or delinquency records, or any condition which constitutes a barrier to his employment".

It was under these amendments that State-Federal vocational rehabilitation programs were able to include in their caseloads persons whose deviant drinking behavior constituted a recognizable vocational handicap.

(c) Somewhat earlier than this Congress had responded to the late President Kennedy's call for a "bold, new approach" to the prevention and treatment of mental illness by enacting the Community Mental Health Centers Act of October 1963 (P.L. 88-164). This law implemented the concept of the comprehensive community mental health center which had been formulated after a Cabinet level review of the Joint Commission's final report, Action for Mental Health, 1961.*

Prior to this time, Maine's community mental health programs had consisted of clinics that were part of public health and appendages of the state institutions. Following directly upon the passage of the 1963 Federal legislation, the State embarked on an extensive two-year community planning effort that culminated in the Maine Comprehensive Mental Health Plan which was published in 1965. Its

*From "Continuity of Care", unpublished manuscript by Rosalyn Bass, November 1970.

recommendations by the regional citizens' committee led to the formation of 15 mental health regions. Later, in compliance with regulations adopted by NIMH on population size of catchment areas, the original 15 were reorganized into 5, then more recently into 8 mental health areas.

The first federally funded Comprehensive Mental Health Center was established in 1966. Since that time, four of the eight areas have fully operational comprehensive community mental health centers (Aroostook, Bangor, Tri-County, and Cumberland) which serve 67% of the population of Maine. Two others are rapidly approaching this status. Kennebec Valley is constructing a new facility which is nearing completion and has a $750,000 staffing grant which has been approved by NIMH but not yet funded. The Mid-Coast area has an approved construction grant for a new facility, and York County has been approved for a mental health staffing grant of nearly one million dollars. All mental health centers and clinics are private, non-profit corporations, each with its own board of directors. Federal funds are supplemented from local funding sources including United Funds, county and municipal taxes, school districts, and Title I funds (Elementary and Secondary Education Act).*

*"Maine State Mental Health System," report by the Bureau of Mental Health, Department of Mental Health and Corrections, November 1971.

(d) The most recent breakthrough came in December 1970 when Congress enacted "The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act," P.L. 91-616, commonly referred to as the Hughes Act.

This act, which allocates approximately $84 million dollars to the states for 1972 and some $130 million for fiscal 1973 differs in many respects from other laws enacted by Congress in the health field. Basically there is a strong requirement for planning, for maximum utilization of already existing services and facilities and a desire for inter and intra-agency cooperation and coordination, in both the public and private sectors. It is unique, also, in that it is probably one of the first times that a bill of such wide-reaching implications has been piloted by someone who had an intimate knowledge of the matter to which he was addressing himself.

Title I of the Hughes Act reconstituted what had been the National Center for Prevention and Control of Alcoholism within the National Institute of Mental Health, renamed it the National Institute on Alcohol Abuse and Alcoholism, and gave it authority to administer the programs and authorities assigned to the Secretary of the Department of Health, Education, and Welfare, under the Hughes Act and also Part C of the Community Mental Health Centers Act. Thus, the Institute specifically addresses itself to alcohol abuse and alcoholism programs at both the National and Regional levels.

Title II of the bill establishes an alcohol abuse and alcoholism prevention, treatment and rehabilitation program for Federal civilian employees (which will be commented upon in a later section of this

report). Considering, however, that there are over 3 million federal civilian employees in the country, this represents not only an enlightened Federal initiative in dealing with this issue, but creates a model which the bill strongly urges state and local governments, as well as private industry, to follow.

Title III of the bill is in three parts, the first of which allocates the sum of $30,000,000 to states for the upcoming fiscal period "to assist them in planning, establishing, maintaining, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism". (Title III, Part A, Sec. 301.) These formula grants are made to states largely on the basis of "relative population, financial needs, and need for more effective ...alcohol abuse and alcoholism programs".

Chiefly because of its comparatively small population, Maine is one of about 15 states to which the minimum appropriation of $200,000 has been tentatively allocated, whereas a state such as California will receive upwards of $2 million and Massachussetts approximately $750,000. On November 9, 1971, Maine learned informally of its tentative allotment to implement P.L. 91-616 for fiscal 1972. Later, in November 1971, under provisions of Title III, Sec. 302 (c) of P.L. 91-616 which permits states to utilize up to ten percent for the State allotment for payment of certain allowable administrative costs, among them the costs of compensating personnel who are directly involved in developing the plan, an arrangement was made to assist in drafting a plan with the Health Council, Inc., of Maine, a non-profit private

corporation representing 60 public and private health agencies in the State. The sum of $15,000 was tentatively earmarked for this consultative service in February of 1972. Funds were made available on March 15, 1972 by the State Department of Health and Welfare to the Health Council, according to terms of a contractual agreement. The intent is for this money to be reimbursed to the State Department when funds under the Hughes Bill are actually granted to Maine. Rather than having Hughes Bill funds available for developing the plan, the State must now qualify with a plan in order to get reimbursed.

The Health Council's involvement to date has consisted primarily of assembling and reviewing research documents, conducting field interviews, making arrangements for and conducting a series of regional workshops on alcoholism planning, and preparing the present draft of the State plan.

In addition to the State formula grants, an additional $20 million is authorized for project grants and contracts under Title III, Part B. This part amends Section 247 of Part C of the Community Mental Health Center Act to read as follows:

> "The Secretary, acting through the National Institute on Alcohol Abuse and Alcoholism, may make grants to public and private nonprofit agencies, organizations, and institutions and may enter into contracts with public and private agencies, organizations, and institutions, and individuals--
>
> "(1) to conduct demonstration, service and evaluation projects,
>
> (2) to provide education and training,
>
> (3) to provide programs and services in cooperation with schools, courts, penal institutions, and other public agencies, and
>
> (4) to provide counseling and education services on an individual or community basis for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics."

It is specified under this part that "projects for which grants or contracts are made shall, whenever possible, be community based, provide a comprehensive range of services and be integrated with and involve the active participation of a wide range of public and non-governmental agencies, organizations, institutions, and individuals".

Under this part, there is currently allocated $7 million for initiation and development grants, $4 million for state training grants, and $7 million for research grants.

B. Federal Mandate

As noted above, any state wishing to participate in the formula grant program must make application for its grant allocation by submitting a State plan for carrying out the purposes of Title III, Part A, of the Act. Such plan must:

1. Designate a single State agency, with authority for administering the plan.

2. Provide for the designation of a State advisory council on alcoholism, to include representatives of non-governmental organizations or groups, and of public agencies concerned with the prevention and treatment of alcohol abuse and alcoholism, to consult with the State agency in carrying out the plan, and

3. Set forth a survey of need for the prevention and treatment of alcohol abuse and alcoholism, including a survey of the facilities needed to provide services for alcohol abuse and alcoholism and a plan for the distribution of such facilities and programs throughout the State.

These criteria will be treated in the following section.

I. ADMINISTRATIVE ORGANIZATION

A. SINGLE STATE AGENCY

In compliance with this provision, Governor Curtis, on October 5, 1971, addressed a letter to the Honorable Elliot C. Richardson, Secretary of the Department of Health, Education and Welfare, designating Maine's single agency. In this letter he noted his awareness that the Hughes Act authorizes additional Federal assistance through the direct formula grant mechanism to states wishing to participate who establish their eligibility by submitting a comprehensive State plan for carrying out the purposes of the Act. Governor Curtis went on in his letter to say:

> We in Maine wish to participate in this program, with the Department of Health and Welfare designated by me as the official alcoholism agency; subsequently a State plan will be submitted to the new Institute of Alcohol Abuse and Alcoholism, subject to the provisions of P.L. 91-616, once final guidelines for writing such a plan have been furnished.

In subsequent correspondence, this time with Dr. Morris E. Chafetz, Governor Curtis again reiterated his designation of the Health and Welfare Department as the responsible agency. In this December 15 letter he reviewed his October correspondence with Secretary Richardson and added a further explanation:

> Maine still desires to participate in the program, and my earlier designation of our Department of Health and Welfare as the official State Alcoholism Agency to administer the plan still holds.
>
> As you have previously been informed... our current alcoholism program is specifically administered by a Division of Alcoholism Services, located within the Bureau of Rehabilitation, one of five bureaus which combine to make up our Department of Health and Welfare.

The single State agency designated for the administration of the plan, therefore, is:

1. Department of Health and Welfare
   State House
   Augusta, Maine 04330

   Commissioner: Dean Fisher, M.D.

   Director, Bureau of Rehabilitation: C. Owen Pollard

2. Director, Division of Alcoholism Services: Max P. Good

3. (See organization charts on following pages.)

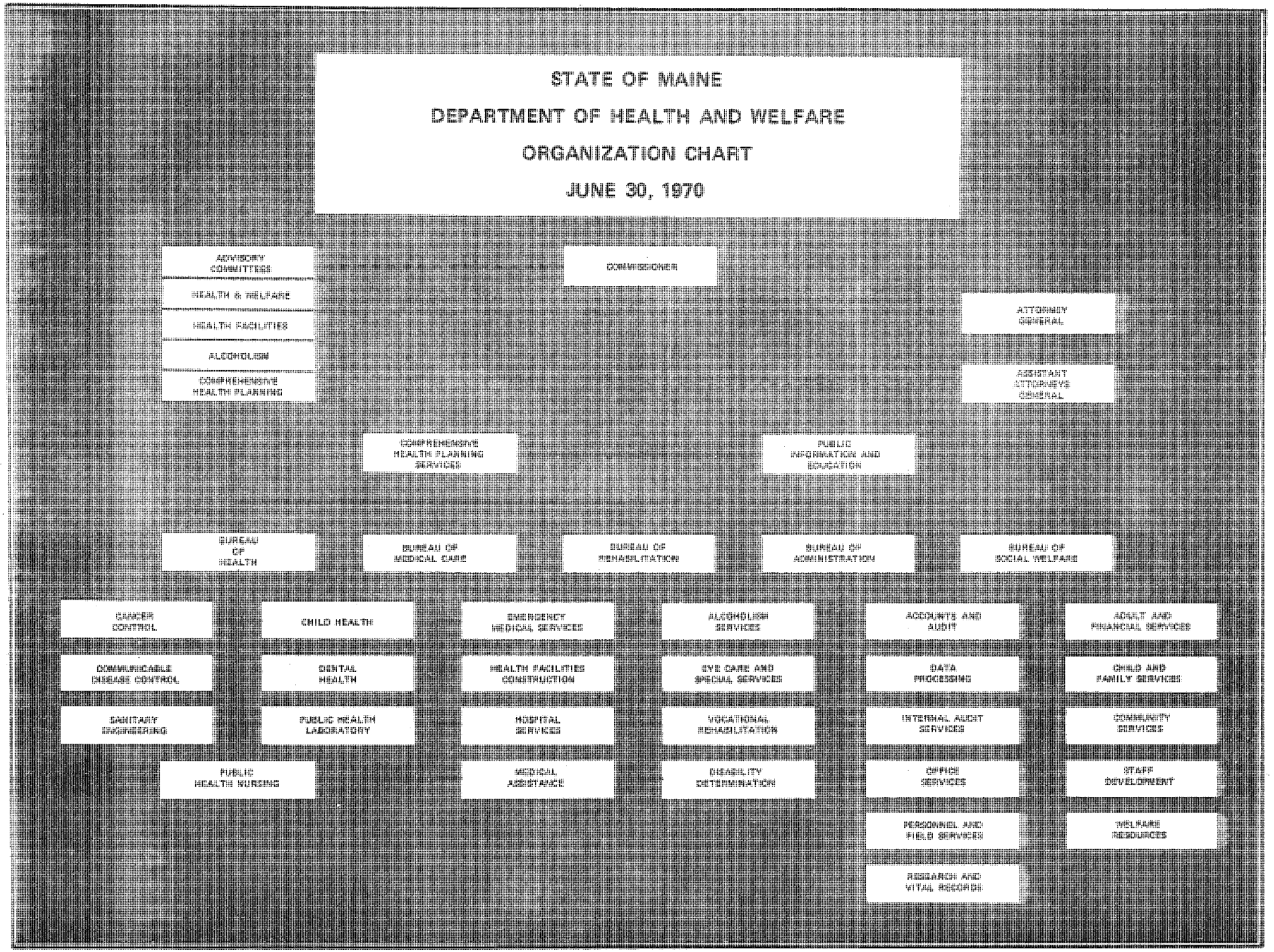
4. Functions of the Designated Agencies

   A. Alcoholism Services as a Component of the Health and Welfare Department

From its inception in 1953, alcoholism services was a component part of the Department's Bureau of Health until 1969, when the 104th Legislature created a new service structure within the Department which became designated as the Bureau of Rehabilitation.

This legislative restructuring of the Department was a direct outcome of a recommendation made during the course of a two-and-one-half year study (from February 1967 through June 1969) by the Maine Commission on Rehabilitation Needs, which gave first priority in its Statewide Plan for Comprehensive Rehabilitation Services to the "creation within the Department of Health and Welfare of a functional unit of Rehabilitation Services, which should be equal in administrative level and status with the other major administrative units within the Department".

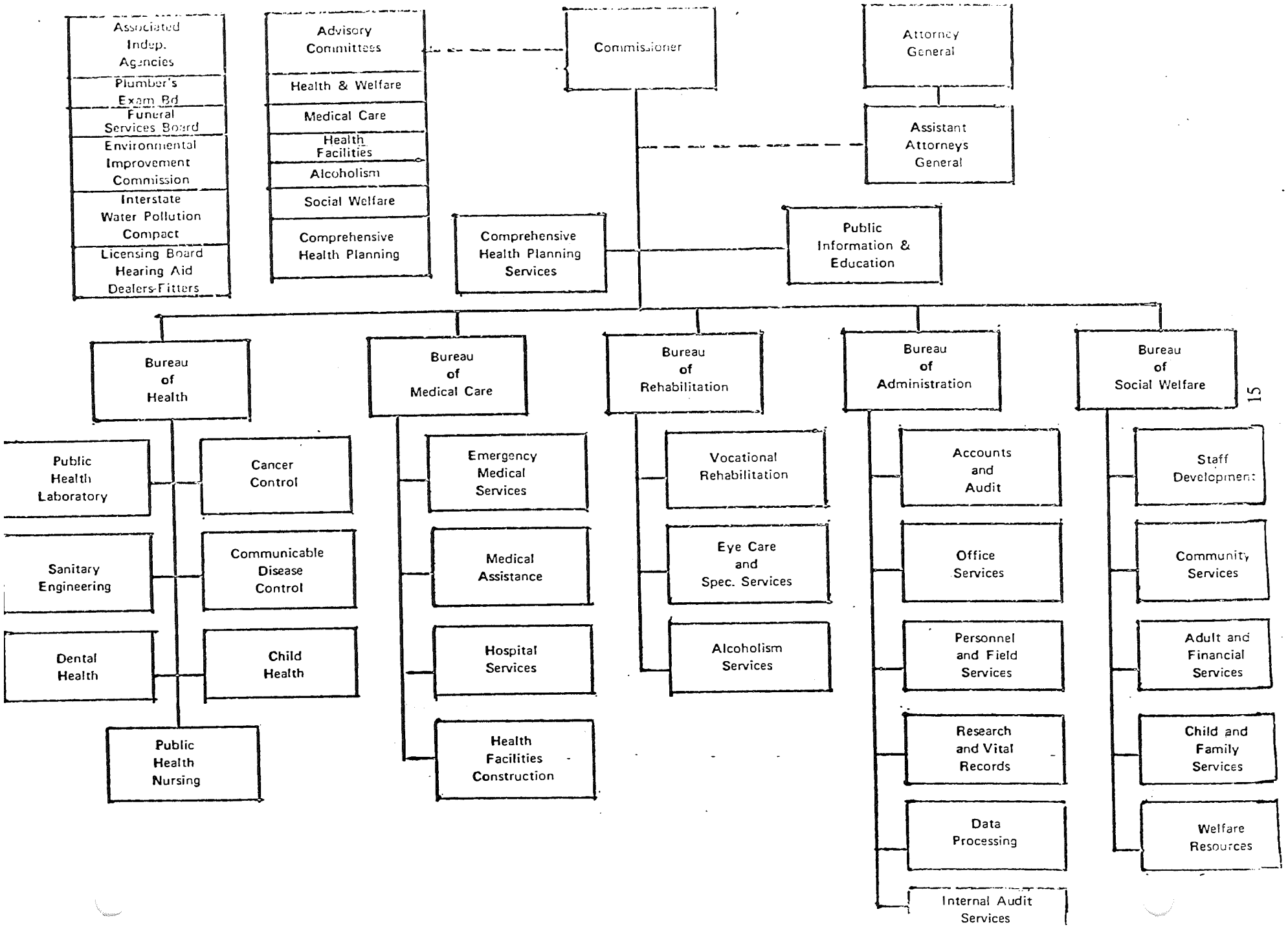
STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
ORGANIZATION CHART
JUNE 30, 1970



DEPARTMENT OF HEALTH AND WELFARE

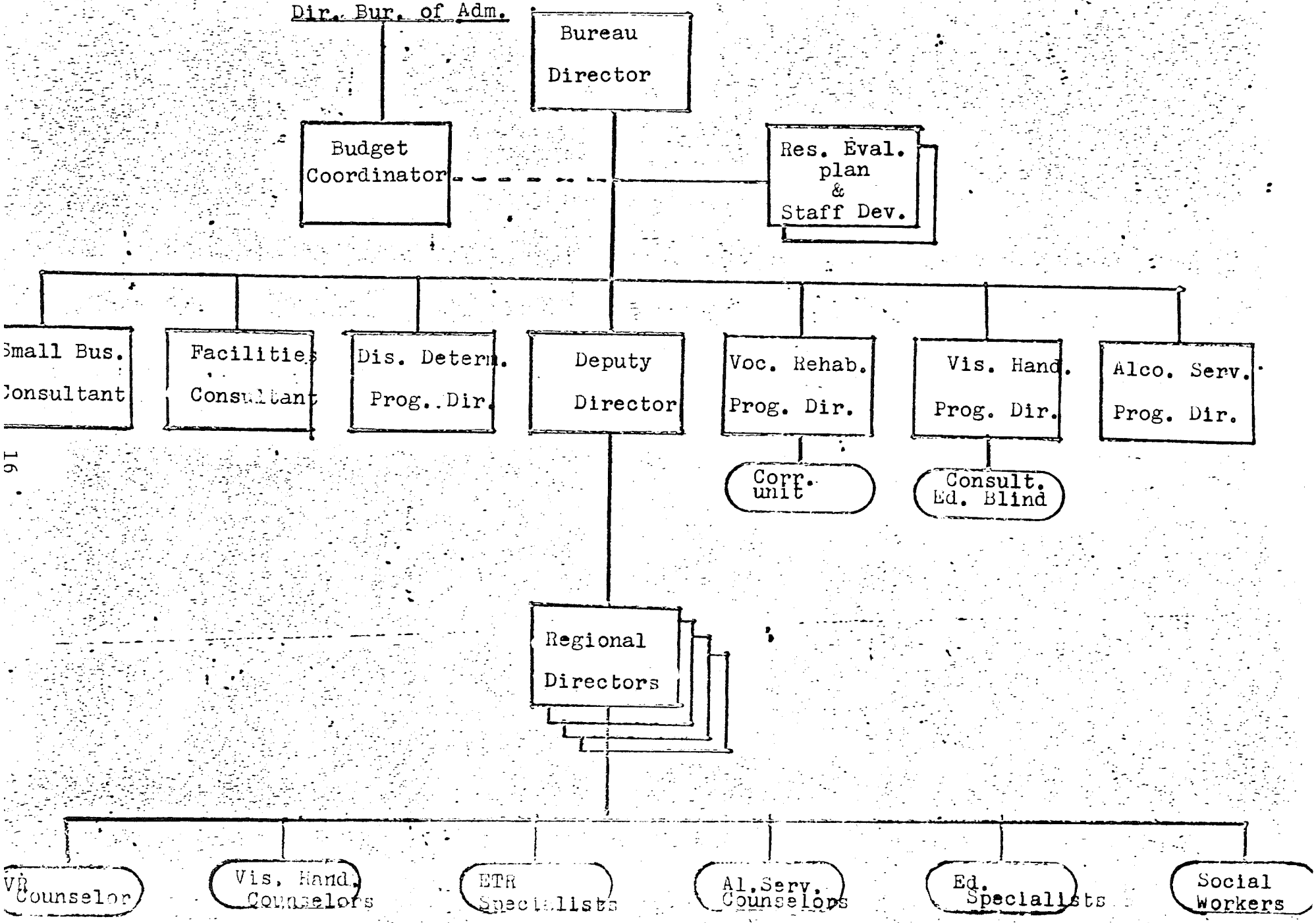
ORGANIZATION CHART

JANUARY 1, 1970



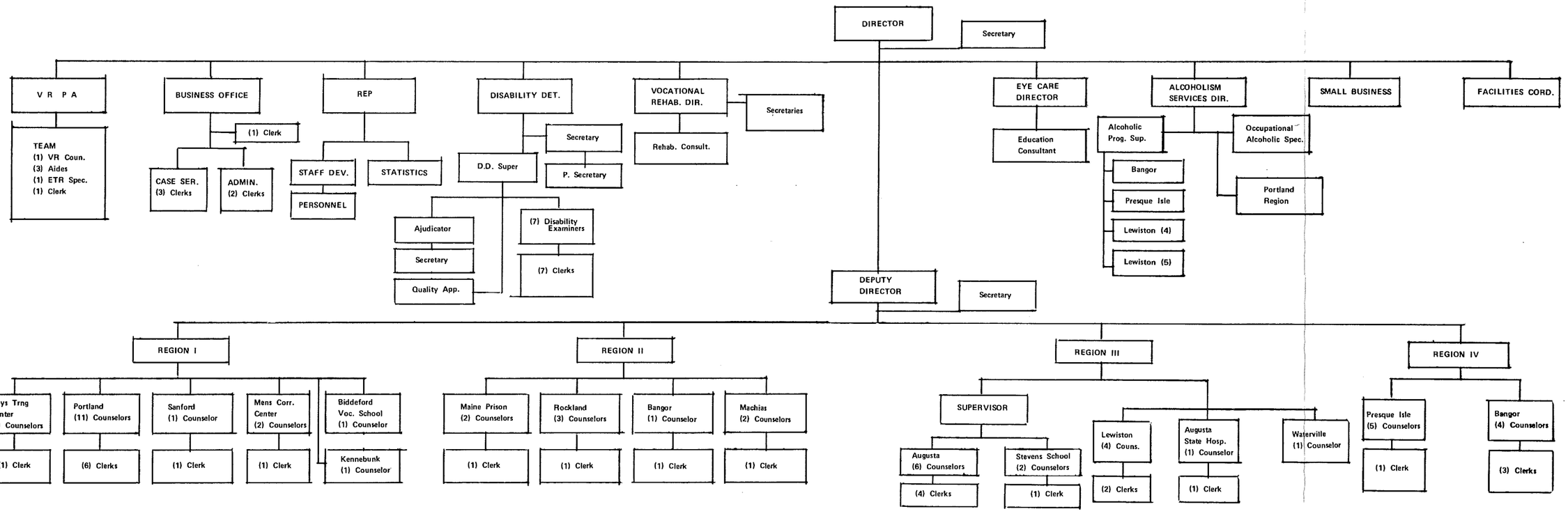
BUREAU OF REHABILITATION

12-14-71



BUREAU OF REHABILITATION

January 11, 1973



The recommendation stipulated further that "All functions of the Division of Vocational Rehabilitation...(should) be transferred from the Department of Education to the Department of Health and Welfare..." and that, as recommended by Governor Curtis in his February 1969 special message to the legislature on "Human Resources", that the new administrative structure for rehabilitation services should consist of that Division, together with "the Division of Eye Care and Special Services, the Division of Alcoholism Services, and any other rehabilitation programs that are developed".*

Subsequently the "Act Relating to Reorganization and Revision of Public Rehabilitation Services", introduced in February 1969 as LD-925, was enacted on April 30 of that year as the Rehabilitation Act, as a new Part 7, titled "Public Rehabilitation Services", of Title 22 of the Revised Statutes.

Thus, Chapter 713 under this new Part, gives as its first paragraph, § 3051, the short title, "Rehabilitation Act", and continues in the next,

> § There shall be created within the Department of Health and Welfare a functional unit of rehabilitation services, which shall be equal in administrative level and status with the other major administrative units within the department.
>
> § The Department of Health and Welfare is designated and established as the sole state agency to provide rehabilitation services, including but not limited to vocational rehabilitation services, and to provide evaluation and work adjustment services for purposes

*Final Report of Comprehensive Statewide Planning for Vocational Rehabilitation Services, Maine Commission on Rehabilitation Needs, Augusta, April 1969, pp. 242-243, p. 278; also, Special Message on Human Resources," to the 104th Legislature, Governor Kenneth M. Curtis, Augusta, February 4, 1969.

> of the Federal Vocational Rehabilitation Act and Social Security Act, and acts amendatory thereof and additional thereto. The Commissioner of Health and Welfare shall make such rules and regulations as he finds necessary and appropriate for the administration of a program of rehabilitation services and shall organize such a program within the Department of Health and Welfare in such a manner as shall be consistent with existing federal and state laws, rules and regulations.

This Rehabilitation Act, which consists of a number of other provisions, including the extension of eligibility for rehabilitation services to "disadvantaged individuals" and their families, as well as to the physically, mentally, and emotionally disabled and handicapped, represented the first comprehensive public rehabilitation services law to be enacted in Maine. Its major purposes, as stated, were to "improve the administrative structure and coordination of these services through a single, functional unit, and also to create a legal framework within which the liberalized federal provisions may be fully implemented".*

As a consequence of this legislation, the Maine Department of Health and Welfare is currently structured as shown on the previous organization chart. It is comprised of five Bureaus:

Administration
Rehabilitation
Health
Social Welfare
Medical Care

In addition to these, and also directly accountable to the Commissioner, are Comprehensive Health Planning Services and Public Information and Education Services.

*Ibid., p. 278

Components of the Bureau of Administration are Accounts and Audit, Office Services, Personnel and Field Services, Research and Vital Records, Data Processing, and Internal Audit Services.

Within the Bureau of Social Welfare are the Divisions of Adult and Financial Services, Child and Family Services, Community Services, Welfare Resources, and Staff Development.

The Bureau of Medical Care is responsible for Emergency Medical Services, Medical Assistance, Hospital Services, and Health Facilities Construction.

The Bureau of Health includes Public Health Nursing, Child Health, Communicable Disease Control, Cancer Control, Dental Health, Sanitary Engineering, and the Public Health Laboratory.

The Bureau of Rehabilitation, as shown on the preceding chart, is structured basically in terms of direct field services which are coordinated and supervised by four regional directors.

These direct client services, in turn, receive the guidance and support of a team of program specialists and administrative personnel whose function is to provide leadership and coordination for each of the generic areas with which the Bureau is concerned.

Thus, special disability problems arising from visual impairments, physical handicaps, alcoholism, and other dysfunctions are handled with the assistance of these highly technical consultants--the program directors, among others--who generally, because of the compound nature of clients' problems, function in the same fashion as do the regional workers.

These technical directors of the general Vocational Rehabilitation Division; Eye Care and Special Services Division; and Alcoholism Services Division; along with the director of the Bureau; his deputy; budget coordinator; the facilities consultant; small business enterprises consultant; the director of the Disability Determination Unit and his staff of disability claims examiners; staff training and development program; social services program and the research, evaluation and planning program, are now housed together in a central office at 32 Winthrop Street, Augusta, where the central office of the Vocational Rehabilitation Division was once located by itself.

As can be seen from the Bureau's organization chart, each region has a professional team made up of one or more of the following, depending on the population size of the region, its geographic location in the State, and other demographic and administrative considerations:

General vocational rehabilitation counselor
Counselor for the blind and visually handicapped adult
Visually handicapped child counselor
Work Education, Training, and Rehabilitation specialist
Alcoholism rehabilitation counselor
Social Worker.

In addition, a medical services supervisor for the blind and visually handicapped serves all regions, and two specialists in adult education for the blind, as well as two mobility instructors for the blind, serve more than one region in accordance with their geographic assignments.

It will be evident that the purpose of this regionalized service structure is to pool the talents of these specialized personnel in whatever way, or combination of ways, the particular needs of each individual client may dictate.

Since in many instances this rehabilitation team shares the same building space as the regional Health and Welfare District personnel, including those assigned to certain divisions of the Bureau of Health, such as the public health nurses, and personnel in the Bureau of Social Welfare; such as the community services workers, intake workers, social workers, assistance payment workers, and others, the combination of services that can be offered, and their effective integration, has been greatly enhanced. Not only do the social service and rehabilitation workers have the benefits that this close physical proximity provides, but so also, and perhaps even more importantly, do the people in the community who come to these field offices for help.

B. Service Functions of the Designated Agency

Maine's program of services for the alcoholic came about originally as the result of a comprehensive study done by the Liquor Research Committee which had been appointed by the Governor of the State in 1949. This commission's report led to the establishment of a Division of Alcoholism Services assigned to the Department of Health and Welfare through enactment of Chapter 270, Public Laws of 1953. In August of that year, the new division launched a program aimed at bringing about the reduction of alcohol abuse and alcoholism in the State as mandated in the legislative enactment.

Among the objectives of the program have been these:*

1. To secure general acceptance of the concept that alcoholism is an illness of such proportions that it reaches families or friends of almost every one of us.

2. To demonstrate that the alcoholic is a sick person who is worth helping, and can be helped by understanding and treatment.

3. To stimulate and help develop adequate services within the community for treating the alcoholic, using the facilities of general hospitals and other community resources to aid in rehabilitation.

4. Prevention through education, bringing to youth factual information about alcohol which will help them make wise decisions concerning the use of alcoholic beverages. (Ours is a culture in which there are many users of alcohol at the adult level, who do so within acceptable social and legal limits.)

The Division functions primarily through its five Alcoholism Counseling Centers:

Augusta:
32 Winthrop Street
Phone - Augusta 289-3706
By Appointment Only

Bangor:
117 Broadway
Phone - Bangor 942-6301
Monday thru Friday 9:00 am - 5:00 pm
Thursday Night - By Appointment

Lewiston:
179 Lisbon Street
Phone - Lewiston 783-9154
Monday thru Friday 9:00 am - 5:00 pm
Thursday Night By Appointment

*The Alcoholic Can Get Help In Maine, pamphlet currently available from the Division of Alcoholism Services, Augusta, or at regional Alcoholism Counseling Centers.

Portland:
509 Forest Avenue
Phone - Portland 774-4581
Monday thru Friday 9:00 am - 5:00 pm
Monday Night - By Appointment

Waterville:
Kennebec Mental Health Center
North Street, Waterville,
Phone - Waterville 872-8011
Monday thru Friday 9:00 am - 5:00 pm
Thursday Night - By Appointment

These centers offer essentially:

--Information and counseling for persons with alcohol problems and their families,

--Treatment and rehabilitation recommendations and arrangements,

--Information services for the general public and special interest groups on the nature and extent of alcoholism and alcohol abuse.

All counseling interviews are held in strict confidence and are furnished without charge. Each client is accepted as a person with a problem who needs help. This problem is approached with objective understanding by the counselor.

Where indicated, the patient is referred to a consultant physician for emergency treatment and/or a complete medical evaluation to determine total health in terms of organic and emotional function. After the results of the medical or psychiatric examination are known, the case is evaluated by the physician and counselor and a course of treatment is prescribed.

Treatment modalities consist, among others, of emergency services, hospitalization when indicated; both inpatient and outpatient services, including medical or psychiatric treatment, drug or vitamin therapy, group therapy, individual counseling, pastoral guidance, residence

in a halfway house or comparable facility, affiliation with the fellowship of Alcoholics Anonymous--any or all of these may be used in some combination to meet the needs of the particular individual.

Each plan of help, therefore, including follow-up treatment, vocational assistance, supportive family services, legal advice and assistance, and all the other forms of assistance necessary to help the individual come to terms with his particular life circumstances at this particular point in time, must of necessity be flexible and comprehensive. This involves calling upon many other community caregivers, public and private service representatives and authorities, and persons significant in the life of the individual client for their aid and support. In this sense, the Alcoholism Service Counselor is as much a coordinator of services, in his role of client advocate, as he is a direct provider of service.

In his educational role he brings factual information about alcoholism to schools and interested groups by giving talks, showing films, distributing literature, arranging for workshops and seminars, participating in conferences, and generally serving as spokesman, and frequently as omsbundsman, for his clients and within the community at large.

Consequently the five office counselors and two court counselors employed by the Division have established regular working relationships with the staffs at the community hospitals, state hospitals, community mental health centers, halfway houses and other intermediate care facilities, other Bureaus of the Department of Health and Welfare, as well as local welfare offices, sheriff's offices, courts, jails and State correctional centers, community action programs, schools and

colleges, business and industry, as well as direct participation in a number of related activities such as Project EXIT, ASAP, AA, Al-Anon and Al-Teen, and many more besides.

One concern to which the Division has been giving increasing attention is that of the "low visibility" problem drinker. Efforts are being made to reach out and contact him or her and to offer help before their deteriorating drinking behavior brings them to public notice. Additional effort is being made to develop measures that will help prevent the deteriorating social drinker from acceeding to the ranks of the "alcoholic group".

This will require a greater investment in information and preventive programs directed at alcohol abusers as well as potential alcohol abusers. Some specific high priority groups are young people, public and private employees, second or third-time court-connected intoxication offenders, drinking drivers, and others.

Special emphasis is also being given to better mobilization of existing community resources, particularly with regard to closer communication and coordination among agencies and other personnel who have responsibility toward the problems created by alcohol abuse and alcoholism.

5. Evidence of Authority

The authority ceded to the Department of Health and Welfare has been described in the account of Governor Curtis' designation of this agency in his correspondence with the responsible Federal officials.

Further evidence of this Department's statuatory authority is to be found in Chapter 270 of the Public Laws of Maine, and specifically

in Section I, Chapter 22 of the revised statutes pertaining to Health and Welfare services. These were amended by the State Legislature in 1953 by adding a new section to this part, numbered 73-A, entitled, "An Act to Repeal the Liquor Research Commission Law" (which had been enacted in May 1949 and funded during a subsequent legislative session in May 1951) and "Provide that the Department of Health and Welfare Assume Certain Responsibilities Relating to Alcoholism".

One of the provisions of this legislation giving the Department of Health and Welfare authority for alcoholism services in the State was the creation of a seven-member advisory committee, to be appointed by the Governor "to advise and consult with the Department of Health and Welfare in carrying out the provisions (of this Act)".

Though its membership, like that of any such group, has continually changed, this committee still serves in an advisory capacity to the Commissioner and the Division of Alcoholism Services. Persons currently serving on it are:

Senator Gerard P. Conley, Chairman
182 Clark Street, Portland

Donald DeCosta, M.D.
871 Court Street, Auburn

John Thurlow, D.O.
179 Maine Street, Waterville

Father John Feeney
St. Mary's Rectory
30 Cedar Street, Bangor

Rev. Robert Howes
North Street, Kennebunkport

Mr. Eaton Tarbell
198 Broadway, Bangor

Mrs. Edmund Socec
Winthrop Road, Augusta

B. SUPERVISED AGENCIES

With regard to administration of the State plan, there are no supervised agencies.

C. ADVISORY COUNCIL

In January 1972, at the request of Governor Curtis, Special Assistant Allen G. Pease invited public officials and private citizens throughout the State to submit names of persons who might be considered by the Governor to serve on a Statewide Advisory Council. Names were forwarded by the Department of Health and Welfare, Mental Health and Corrections, and a number of other sources. From the more than 175 nominees proposed, the Governor has selected 31 persons whom he has asked to serve. His intent is to confirm these appointments in the immediate future, with the chairman to be named by him at the time of the formal announcement. The Executive Order will also indicate that additional nominations will be entertained.

In his letter of invitation to the prospective Council members, the Governor outlined the following responsibilities and expectations:

> " The Council will be constituted to allow representation by a broad range of agencies and individuals in order that the interests of these agencies, individuals and groups will be a collective and strong advocate in assuring a comprehensive broad-based approach to the social, economic and medical problems of alcohol abuse and alcoholism. It will have the responsibility for advising the official agency, recommending and evaluating the effectiveness of the State Agency's Plan for combating alcoholism and the implementation of the plan, the responsibility for reviewing certain special project grant applications as they relate to the State plan and particularly as they relate to the provisions of the Alcoholism and Alcohol Abuse Act. It will be an ongoing committee and I shall recommend that each member agree to hold office for a term of either one, two, or three years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor, shall serve out the remainder of that term. The Council will be called to meet as frequently as the Chairman considers necessary. In view of the nature and importance of a

number of issues that must come before this group now and in the next few months, it may be necessary to meet monthly. It would be expected that as time goes on, meetings could be less frequent. Members of the Council will be entitled to receive actual and necessary travel expenses incidental to attendance at Council meetings."

As of this writing no by-laws have been officially structured for the Council, since it is the Governor's intent that these be formulated by the Council members themselves, consistent with his charge and the P.L. 91-616 guidelines, as a first order of business.

As soon as the final appointments are confirmed, the designated agency will notify NIAAA and regional officials. This membership roster will include each member's tenure dates, place of residence, position and/or pertinent interests, and organizational affiliations.

Thereafter, minutes of meetings, recommendations, and official actions taken by the Council will be recorded and will be made available on request to the Associate Regional Health Director and the National NIAAA, and will also be available to the public for inspection.

STATE ADVISORY COUNCIL
ON ALCOHOL ABUSE
AND ALCOHOLISM

Chairman -
Dr. Einar Olsen (3) President, University of Maine, Farmington 04938
Executive Secretary -
Max P. Good, Bureau of Rehabilitation, Division of Alcoholism Services,
32 Winthrop Street, Augusta 04330
Technical Assistant -
Edward C. Schlick, c/o ARCO Inc., 85 Cony Street, Augusta 04330

MEMBERS -
Paul Adams (3)
Southern Maine Comprehensive Health Association, 583 Forest Avenue, Portland 04101
Wallace L. Adams (3)
Personnel Supervisor, Great Northern Paper Co., East Millinocket 04430
Sister Mary Anastasia (3)
Chief Pharmacist, Mercy Hospital, Portland 04101
William Caldwell (1)
Maine Sunday Telegram, 390 Congress Street, Portland 04101
Carmen M. Celenza (2)
20 Johnson Heights, Waterville 04901
Kevin Concannon (2)
Diocesan Bureau of Human Relations, 519 Ocean Avenue, Portland 04101
Hon. Gerard P. Conley (3)
29 Taylor Street, Portland 04101
Rev. John J. Feeney (2)
St. Mary's Rectory, 30 Cedar Street, Bangor 04401
Merle P. Finley (2)
Director of Personnel, Guilford Industries, Inc., Guilford 04443
Ms. Gloria French (1)
Manning Mill Road, Bangor 04401
Rev. T. Lawrence Gilbert, Jr. (1)
Men's Correctional Center, South Windham 04082
Kenneth H. Goodwin (1)
Millinocket Community Hospital, 200 Somerset Street, Millinocket 04462
Edward J. Hanson (2)
Division of Probation-Parole, Department of Mental Health & Corrections,
State House, Augusta 04330
Keith Ingraham (2)
Director, Bureau of Alcoholic Beverages, State House, Augusta 04330
Kurt Johnson (1)
Maine Medical Center, 22 Bramhall Street, Portland 04101
Dr. Thomas Kane (3)
Chief, CMHS, Department of Mental Health & Corrections, State House, Augusta 04330
Edgar Kline, D.O. (3)
China 04926

John Leet (3)
Executive Director, Maine Law Enforcement Planning & Assistance Agency,
Old Federal Bldg., Augusta 04330

Hon. John Martin (1)
Eagle Lake 04739
Thurman A. Millett (2)
R.F.D., Medway 04460
Carl Mowatt (1)
Director, Drug Education Program, Department of Education, Augusta 04330
Dr. Robert Ohler (2)
Chief of Staff, Veterans Hospital, Togus 04330
William Ramsay (2)
Program Director, Waldo County Committee for Social Action,
67 Church Street, Belfast 04915
Dr. Charles Rothstein (1)
72 Parkwood Drive, Augusta 04330
James C. Schoenthaler (2)
Chairman, Maine Employment Security Commission, State House, Augusta 04330
Ms. Evelyn Scribner (3)
190 Alton Road, Augusta 04330
Charles Sharpe (2)
Sheriff's Office, 122 Federal Street, Portland 04101
Stephen P. Simonds (3)
Human Services Development Center, University of Maine, 96 Falmouth Street,
Portland 04101
John Stevens (2)
Commissioner, Department of Indian Affairs, State Office Bldg., Augusta 04330
Eaton W. Tarbell (3)
c/o Eaton W. Tarbell & Associates, Inc., 8 Harlow Street, Bangor 04401
Arnold Tobin (2)
Walker Hill, Wilton 04294
Melvin Tremper (1)
Department of Sociology, University of Maine, Portland-Gorham,
Bailey Hall, Gorham 04038
Arnold C. Wyndham (3)
43 Glen Street, Augusta 04330

EXECUTIVE ORDER

OFFICE OF
THE GOVERNOR

May 15, 1972

State Advisory Council on Alcohol Abuse and Alcoholism

WHEREAS, it is vital to the well-being of Maine citizens to have a wide range of diversified services and facilities provided to alcohol abusers and alcoholics; and

WHEREAS, comprehensive planning of needed alcoholism services and facilities must be accomplished in order to provide for more effective and efficient use of existing human and fiscal resources at all levels; and

WHEREAS, Public Law 91-616, The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, makes a formula grant available to the State of Maine to provide assistance for state and local alcoholism programs; and

WHEREAS, this formula grant is to be used for the implementation of a comprehensive plan for the delivery of alcoholism services under the purview of an Advisory Council;

NOW, THEREFORE, I, Kenneth M. Curtis, Governor of the State of Maine, create The Advisory Council on Alcohol Abuse and Alcoholism.

PURPOSE OF THE COUNCIL

To advise the official alcoholism agency in developing, implementing and evaluating the State Plan to combat alcohol abuse and alcoholism and to review grant applications as they relate to the provisions of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

MEMBERSHIP

The Advisory Council shall include representatives of non-governmental organizations or groups, and of public agencies and individuals concerned with the prevention and treatment of alcohol abuse and alcoholism, to assure a comprehensive broad based approach to the social, economic and medical problems of alcohol abuse and alcoholism.

This is a continuing Council consisting of 31 members, who will serve one, two and three year term appointments by the Governor, with the Chairman to be designated by the Governor. Additional members can be appointed if needed. A member is eligible for one reappointment.

DUTIES

A. To advise the Governor and to provide information to the Legislature concerning the effectiveness of programs serving alcohol abusers and alcoholics.

B. To assist in the coordination of all State government efforts dealing with the problems of alcohol abuse and alcoholism.

c. To assist Maine communities to mobilize their resources to combat alcoholism.

D. To review on-going governmental programs serving alcoholics, such as:

Vocational Rehabilitation
Public Assistance
Social Services
Medical Assistance
Mental Health
Comprehensive Health Planning

E. To participate in an on-going review of the State Plan, including the implementation of new and innovative programs to fill gaps in existing services.

ORGANIZATION

A. The Division of Alcoholism Services, Bureau of Rehabilitation, Department of Health and Welfare, is designated as the State Agency responsible for the administration of the State Plan for alcohol abusers and alcoholics. The Director, Division of Alcoholism Services, shall serve as the Executive Secretary of the Advisory Council.

B. Minutes of all Advisory Council meetings will be maintained, and copies will be provided to the Governor.

C. The Advisory Council shall meet as frequently as is necessary to fulfill the responsibilities outlined.

D. Insofar as possible the Comprehensive State Plan for alcohol abuse and alcoholism should conform to the planning regions as set forth in Executive Order No. 6 of January 26, 1972.

POWERS AND PROCEDURES

The Advisory Council will have the necessary authority to carry out the purpose of the Order and to hold public meetings if deemed necessary. State departments and their employees are directed to cooperate fully in carrying out the purpose of this Council.

COMPENSATION

For their services, members of the Council shall be compensated for meals, lodging and travel incurred in the performance of their duties. This expense will be borne by the Division of Alcoholism Services through the mechanisms set up for that purpose by The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

Kenneth M. Curtis
Governor

NOTE: These By-laws were adopted by unanimous vote of the members of the Council present at the October 31, 1972 meeting at Portland.

STATE ADVISORY COUNCIL ON ALCOHOL ABUSE AND ALCOHOLISM

BY–LAWS

ARTICLE I: NAME

The name of this Council shall be the State Advisory Council on Alcohol Abuse and Alcoholism, hereinafter referred to as the Council, and established in accordance with the provisions of Section 303 (a) (3) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, (P.L. 91-616) commonly known as the Hughes Act.

ARTICLE II: PURPOSES

The purposes of this Council are:

1. To advise the official alcoholism agency in developing, implementing and evaluating the State Plan;
2. To combat alcohol abuse and alcoholism;
3. To review grant applications as they relate to the provisions of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

ARTICLE III: DUTIES

The duties of the Council are:

1. To advise the Governor and to provide information to the Legislature concerning the effectiveness of programs serving alcohol abusers and alcoholics;
2. To assist in the coordination of all State government efforts dealing with the problems of alcohol abuse and alcoholism;
3. To assist Maine communities in mobilizing their resources to combat alcoholism and alcohol abuse;

4. To review on-going governmental programs serving alcoholics, such as (but not limited to):

   Vocational Rehabilitation

   Public Assistance

   Social Services

   Medical Assistance

   Mental Health

   Comprehensive Health Planning

5. To participate in an on-going review of the State Alcoholism Plan, including implementation of new and innovative programs to fill gaps in existing services;
6. To review grant and project applications for alcoholism and alcohol abuse programs, and recommend priorities for approval and funding to the designated State Agency.

ARTICLE IV: ORGANIZATION

1. The Division of Alcoholism Services, Bureau of Rehabilitation, Department of Health and Welfare, is designated as the State Agency responsible for the administration of the State Plan for alcohol abuse and alcoholism. The Director, Division of Alcoholism Services, shall serve as the Executive Secretary of the Advisory Council, and as a non-voting ex-officio member of the Executive Committee.
2. Minutes of all Advisory Council meetings will be maintained and copies will be provided to the Governor and to all members of the Council.
3. The Advisory Council shall meet as frequently as is necessary to fulfill the responsibilities outlined, but not less than quarterly.
4. The Chairman of the Advisory Council shall be designated annually by the Governor.
5. The planning staff within the Bureau of Rehabilitation will serve as principal staff support for the Council.

ARTICLE V: POWERS AND PROCEDURES

The Advisory Council will have the necessary authority to carry out the purpose of the Order from the Governor dated May 15, 1972, and to hold public meetings if deemed necessary.

ARTICLE VI: MEMBERSHIP

The Advisory Council shall include representatives of non-governmental organizations or groups, and of public agencies and individuals concerned with the prevention and treatment of alcohol abuse and alcoholism, to assure a comprehensive broad based approach to the social, economic and health problems of alcohol abuse and alcoholism.

ARTICLE VII: MEETINGS

The Council shall meet as often as necessary, as determined by the Chairman, or at the request of any five (5) members, and at least quarterly. Notice of regular and special meetings of the Council shall be mailed at least ten (10) days in advance.

Each member of the Council shall have one vote.

A quorum of the Council shall consist of one-third of the voting members. A quorum shall be required for the affirmative transaction of any Council business.

The annual meeting for the election of officers of the Council shall be held in October of each year beginning in 1973.

ARTICLE VIII: OFFICERS

There shall be a Chairman and a Vice-Chairman.

The Chairman shall serve at the pleasure of the Governor, and shall conduct meetings of the Council and the Executive Committee in accordance with these by-laws. He shall select standing committee members, other than the Nominating Committee, and appoint such ad hoc committees and task forces as are deemed necessary. The Chairman shall serve as official spokesman for the Council and prepare agendas for Council business meetings.

The Vice-Chairman shall be nominated annually and elected by a majority vote of the Council. The Vice-Chairman shall assume responsibilities of the Chairman in his absence.

The immediate past Chairman shall be an officer of the Council and serve on the Executive Committee.

ARTICLE IX: COMMITTEES

The Council may establish such standing committees as it deems necessary or desirable to carry out its responsibilities.

The standing committees of the Council shall be:

1. Nominating Committee: This committee, consisting of a minimum of five (5) members, shall be elected annually by the Council at large during the first meeting following the annual meeting. The nominating committee shall elect a chairman from the five (5) members. The committee shall present a slate of candidates for consideration by the membership at the annual meeting, and at least two persons shall be presented as candidates for each position, to include the Vice-Chairman of the Council, the Chairman of the Review Committee and the Chairman of the Legislative Committee.
2. Executive Committee: This committee shall consist of a minimum of seven (7) members, to include the Council Chairman, Vice-Chairman and immediate past Chairman, Review Committee Chairman, the Legislative Committee Chairman and two at-large members of the Council to be nominated by the Nominating Committee and elected by the Council. The Executive Secretary shall serve as an ex-officio member. The committee shall meet at the request of the Council Chairman to develop recommendations for the Council concerning policy formulation and interpretation.
3. Review Committee: This committee shall consist of a minimum of five (5) members. The committee members other than the Chairman, shall be selected by the Council Chairman, subject to final approval by the Council at large. The committee shall meet at least quarterly to

review applications for Federal funds under P. L. 91-616. The committee shall make recommendations for priorities of project and grant applications based upon the comprehensive state plan, subject to consideration and approval by the Council.

4. Legislative Committee: This committee shall consist of a minimum of three members. The committee members, other than the Chairman, shall be selected by the Council Chairman, subject to final approval by the Council at large. This committee shall review both current and pending Federal and State legislation in terms of the effect that the legislation may have on programs dealing with alcohol abuse and alcoholism. The committee shall be responsible for making recommendations to the Council regarding new legislation as well as proposed changes in existing legislation.

ARTICLE X: AMENDMENTS

These by-laws may be amended by two-thirds vote of the Council present, provided that the proposed amendment shall have been presented in writing to each Council member at least ten (10) days prior to an official meeting.

ARTICLE XI EFFECTIVE DATE OF BY-LAWS

These by-laws shall take effect immediately upon approval by two-thirds vote of the Council at an official meeting.

II. STATE SURVEY

Overview

Nostalgia for the country life and particularly for the family homestead with its real or imagined promise of economic and social independence has been a real and living part of our American cultural inheritance, and within this idealized frame, Maine has held a special place. In the hearts and minds of large numbers of rural romantics, Maine for a long time has come to symbolize a kind of haven of rest, a refuge from the unpleasant and unhealthful living conditions that have come to typify rapidly encroaching urban sprawl.

The penonmenon of rural idealism however, antedates this more recent one. For generations Maine's idealized image has been that of a place where one can touch base with the fundamentals of life, where the air and water are abundant and still relatively clean and one can even have a plot of land to "farm". Equally important, the growing threat of social breakdown, in thelarge cities, as illustrated by a power failure in New York, for example, seems very remote.

Sociologists have cited a number of reasons for our continuing rural romanticism. Among them, for example, is the fact that three of every four Americans are second generation rural. In Maine and the states immediately neighboring it, the percentage is of course higher.

1. Population Changes

The reason for pointing to this phenomenon is that it contains an important paradox. Instead of attracting a flood of refugees from

the congested, stressful urban areas, Maine has in fact experienced a net outmigration for at least the past two decades. For the 1950-60 decade it was 67,000 persons. During the next decade, 1960-70, this exodus of principally young people for the most part, many of them from low income families, increased to over 70,000. In this regard it is worth noting that during the 1960-70 decade, Maine was the only state in New England that experienced a net loss in population due to migration out of state. Not that this net loss due to outmigration means that the total state population is lower. What it does mean, though, is that a great many more people moved out than moved in during the period.

Similarly, in the last decade Maine was by far the slowest growing state in New England in terms of population and one of the seven slowest growing states in the nation. During the time the population increased only 2.5%, substantially less than the increases of the previous two decades. In other words, the rate of Maine's population growth has declined from decade to decade.

More specifically, whereas the population of New England increased by 12.7% from 1960 to 1970, from 10,510,106 to 11,847,186 or 1,337,080 men, women and children, the population gain for the State of Maine during that 10 year period was 969,265 in 1960 to 993,663 in 1970, or only 24,398.*

This slow rate of growth and sparsity of population is particularly significant when one considers that Maine is not only the largest

*After the U.S. Census Bureau had compiled its data and published several statistical documents based on its 1970 population count for Maine, it was discovered that an additional 1,615 servicemen stationed at Loring Air Force Base in Limestone had not been included.

of the New England states but that its 33,215 square miles encompasses an area almost as large as all the other five states put together. When flying over it in a plane, one has an overwhelming impression of a vast tract of timberland and is not surprised to learn that these 17 million acres of forest cover more than 87% of the total land area, and that another 10% of the total area is water.

Rural and Urban

The 1970 census defines as urban, any area of more than 2,500. By this index, the proportion of people living in the urban areas of Maine decreased from 51.3% in 1960 to 50.9% in 1970, while the rural population increased from 48.7% to 49.1%. Of Maine's 22 cities, one experienced growth, 10 remained stable, and 11 declined. Of the 16 county seats, two saw more than 5% growth, 7 were stable, and 7 declined.

This, however, is not so much an indication that there has been an outmovement of residents from the cities to the country. What it does reflect is a trend, common nationwide, for people to move out of central cities to nearby "bedroom communities". Portland, for instance, has experienced a decrease in population during the 1960's, whereas nearby towns such as Gorham, Scarborough, Cape Elizabeth, Falmouth, Yarmouth, and Freeport have all had population increases. Two other examples of bedroom community growth are Manchester, near Augusta, which increased its population by 24.6%, and Eddington, near Bangor, 41.8%.

It should be noted that demographically, the distinction made by the Census Bureau between rural and urban is quite arbitrary.

There are those who consider all of Maine as "rural". The University of Maine at Orono uses that broad definition, but makes exceptions for Portland and Lewiston-Auburn, both of which are Standard Metropolitan Statistical Areas, while giving due recognition to the Census Bureau's "urbanized area" category of towns and places of 10,000 or more, of which there are 17, including the two mentioned above, in the State.

An example of the arbitrariness of the 2,500 definition is that of Dover-Foxcroft, which in 1950 was classified as "urban" by the Census Bureau, but after losing a score or more of people during the decade, was given a "rural" classification in 1960.

A more significant trend, and one that will be dealt with in the following section, is the shift in population from north to south, a trend which has also been characteristic for all of New England. This shift represents a dispersal from areas of low economic opportunity to those where the income potential is more favorable.

Age-Sex Ratios

Important changes in the age distribution of Maine's population are evident in the census data. The median age of Maine people dropped from 29.3 years in 1960 to at least 28.8 years in 1970. But there were many other changes in age groups that have more apparant significance.

One was a significant drop in the number of children under 5 years, over 24,000 or 22%. Elementary age children increased about 9,000, but almost all of the increase was in the 10-14 age group.

Another one of the major changes was in the high school and college age group, with an increase of over 25% or 35,000 in the years 15-24.

The younger work force (25-44) decreased 16,000 while the older work force (45-64) increased about 9,000.

Retirement age groups (65 and over) increased about 8,000, all women, as there were fewer men over 65 in 1970 than in 1960.

The number of males per 100 females in Maine in 1970 was about the same as that for the country as a whole, but it had decreased from 97.7 in 1960 to 94.8 in 1970. The ratio remains above 100 only through the 15-19 age group. From 20-24 and in each succeeding group there are increasingly more females than males.

As noted above, however, these census data are based on the original 992,048 count. If allowance were to be made for the "found" group of males at Loring Air Force Base, this would substantially increase the number of males in the 20-30 age group. Even when this adjustment is included, we find that of Maine's total increase of 24,400 persons, only about 6,600 were males compared with over 19,000 females.

Dependency Ratios

Dependency ratio is generally considered to be that proportion of the population under 15 years of age and over 65, relative to the number in the 15-64 group. In Maine the number of dependents per 1000 working age group increased from 1950 to 1960 from 612 to 725, and then decreased to 677 in 1970.

The component "over 65" increased in both decades, from 165 (compared with 125 for the U.S.) in 1950 to 194 (compared with the

nation's 160) in 1970. The 0-14 component increased from 447 in 1950 to 536 in 1960, then decreased to 483 in 1970. This was still higher than the 454 ratio for New England and 463 for the nation.

The burden this "under 14" component places upon the State's ability to support an adequate public school system is obvious.*

Traditionally, in terms of dollars spent, rural areas have been worse off than urban areas. One reason has been that rural areas generally have more children to educate per adult than urban areas. Thus the amount of money available for education in rural areas is seriously restricted. Also, in most town or township school districts, the school board or school committee has no taxing or fund-raising power. School needs are voted upon by the people at town meeting. If the area is moderately well off, it has moderately well off schools. Being less well off in terms of economic base, rural areas, if they are to support schools at anything like an urban level, they must put in a much higher proportional amount of their financial resources. Since they cannot, there is much lower support in terms of dollars.

Maine's State Board of Education has been assisting rural areas under an equal educational opportunitites provision, and legislation has recently been enacted that will continue to aid rural areas at a higher level of support.

*On the elementary and secondary school level, there are 77 School Administrative Districts in Maine. In addition there are 36 school unions of towns, 24 cities and towns with individual supervision, 24 school units under district superintendents and agents of the Commissioner of Education. According to the State Department of Education Directory for 1970-71, some 262,369 pupils were enrolled in Maine's public schools. Of this number, 169,453 were in elementary schools, 28,182 in public junior high school, and 64,734 in public high schools. Enrollment in private junior and senior high schools totalled 7,918.

Population by Race

The 1970 census counted 2,800 blacks and 2,195 Indians among the Maine population, along with 1,202 persons of other non-Caucasian ethnic groups such as Japanese, Chinese, Filipine, Hawaiian, and Korean.

Concentrations of blacks are found in Cumberland County, 680; Aroostook, 760;* York, 459, and Penobscot, 427. Highest concentrations of Maine Indians are in Washington County, where there are two

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* Does not include 1,615 persons at Loring Airforce Base and town of Limestone.

Passamaquoddy reservations in the extreme eastern part of the State: Pleasant Point, a settlement of some 350 residents, not far from Eastport, and Indian Township, near Princeton and some 40 miles to the north, and in Penobscot County, where there is a reservation for Penobscots on Indian Island near Old Town. The census lists 630 Indians in Washington County and 538 in Penobscot County. (And 436 in Aroostook.)

2. Socioeconomic Data

Economically, Maine may be considered a hinterland standing at the edge of the region of the United States. This Northeast region has lagged behind the national average for over a decade. During the years 1967-1971, Massachussetts lost more than 110,000 manufacturing jobs. Farther away, New York and Pennsylvania have had similar experiences reflecting their low competitiveness in retaining andmodernizing

traditional industries such as textiles, leather products, and so on. Only the growth of service industries and their favorable, concentrated mixes of high-technology industries have kept the net downward shifts in employment in these states from being greater than they were.

The farther one proceeds into the northeast region, the more is this the case, until one reaches Maine where investment in plant equipment was one-third less than the national average for each production worker in the decade of the 1960's, and manufacturing wages in 1969 were one-fourth less than the national average as a result.

The Maine Turnpike, (Route 95), and the townships adjacent to it may be considered an axis or "corridor" that extends from Kittery to Bangor, connecting Maine to the rest of the nation by this transportation link. Towns in this industrial urban belt have tended to gain population, partly due to the suburbanization movement, but chiefly because it is in this corridor, some 10 to 20 miles wide on both sides) of the Turnpike, that the largest share of Maine's economic productivity occurs.

In 1970 this corridor area contained 65.4% of the State's population, or almost two-thirds. Yet 76.3%, or more than three-quarters of all the production jobs created in Maine in the growth period 1967-1970 were in that "job belt". Moreover, of the jobs created in new plants as opposed to existing plant expansions, fully four out of every five were within the corridor area.

The "upland" area containing 17.7% of the population had only 12.6% of the jobs created by growth, and only 5% of the new ones. And the "coastal" area, with 16.9% of the people, had but 11.1% of all the jobs created. The net effect has been serious depopulation of Maine's more remote counties during the decade of the 60's; Washington County, population down 9.3%; Aroostook, 11.3%; Piscataquis, 6.3%, and so on.

Counties that showed the greatest population growth during the 1960's were York, 12.2%; Franklin, 11,8%; Lincoln, 11.0%; Hancock, 6.8%; Androscoggin, 5.8%; and Cumberland, 5.4%.

These population shifts within the State, as well as the net loss due to outmigration, provide an idea of the limited nature of economic opportunity within the State.

The following table indicates Maine's rank among the New England states and the nation in terms of income and taxes:*

	Population		Income Per Capita		Households Under $5,000		Households Over $10,000		Tax Burden Per Capita	
	000's	#	$	#	%	#	%	#	%	# **
United States	203,185		3,921		28.4		35.1		1,059	
New England	11,847		4,277		19.7		39.6		1,187	
MAINE	994	3	3,257	6	28.1	5	28.7	6	865	6

** # indicates rank among the six New England states.

A recent survey that addressed itself to Maine's income gap during the decade of the 60's included the following summary of its findings.

*Used by permission of the Allagash group, Bath, Maine, from A Maine Manifest, p. 6.

1. Maine's per capita income is the lowest in New England and 36th in the nation. Not only has there been no significant progress during the past decade in closing the "income gap" between Maine and the other states; in terms of actual dollars, this income gap has substantially increased.

2. Maine received a lower share of total New England personal income in 1970 than it did in 1960, continuing a declining trend that has existed for more than 20 years. Total personal income in Maine during the 1960's increased at a rate about 20% slower than the region and the nation.

3. Current Production Income, which represents earnings by individuals, both employees and self-employed for their efforts in current production, increased about 20% slower in Maine during the 1960's than in New England and the nation, and slower than that of any other New England state.

4. Maine trails substantially behind most New England states in growth in virtually every area of Current Production Income including manufacturing, trade, services, government, construction, finance and transportation.

Maine's Department of Economic Development has pointed out that "The current, nationwide recession has caused serious problems for manufacturing industries in Maine as well as the rest of the nation.. Although the 1970 value of manufactured products in current dollars showed an increase over 1969, the adjusted value (to 1967 dollars) exhibited a 2% decrease in this period. Essentially then, although the aggregate dollar income of Maine manufacturers increased, actual production of goods decreased..."

"This decrease in Maine's manufacturing production is the first since 1961. Total employment in manufacturing has been decreasing in Maine since 1967... The recession, however, has amplified this employment decrease; where 3,100 jobs were lost in '68 combined, over 5,600 jobs were lost in 1970 alone."

It has been already cited here that Maine's manufacturing plant and equipment expenditures were lower than those of the U.S., every year but one during the 1960's. (The reason Maine exceeded the U.S. expansion expenditure per worker in 1965 was the massive expenditure in that year for one large paper manufacturing facility in Jay, Maine.) "This means... in still other terms, that Maine manufacturing is labor-intensive; new capital equipment, with the resulting benefits, has been slow in coming to Maine. Thus the State's production capability is a smallerpercentage of the total U.S. capacity year by year."

The Department of Economic Development cites three major factors effecting employment change:

1. Introduction of successful new products (e.g., the computer and television in the 40's.
2. Population growth, resulting in increased demand of goods and services and eventually bringing about new jobs to fill this demand.
3. The business cycle, determined by such factors as inflationary or recession periods, political happenings, and the aggregate mood of consumers to spend or to save.

Between 1960 and 1970 total employment grew at substantially lower rates in both Maine and New England than in the U.S. It will be

seen from the following chart that employment growth rates in most non-manufacturing sectors are significantly higher than in the manufacturing sector. Service, government, and finance, insurance and real estate are among the fastest growing sources of employment in all three geographic areas.

EMPLOYMENT GROWTH RATES,
MAINE, NEW ENGLAND, AND UNITED STATES, 1960-1970 **
(percent per Year)*

AREA	Total Employment	Manufacturing	Transportation	Trade	Finance R.E. Ins.	Service	Govt.
U.S.	2.67%	1.43%	1.18%	2.74%	3.29%	4.59%	4.19%
N.E.	2.01	-.02	1.20	2.73	3.00	4.60	3.16
Maine	1.79	.51	-.28	2.03	3.17	3.51	3.25

*Compound growth rates computed from the average monthly employment for 1960-1970.

**Maine Pocket Data Book, 1971, Maine Department of Economic Development, November 1971, Table I, Yellow pages.

3. Alcohol Abuse and Alcoholism and Related Social Problems

Despite its high visibility for people who are in daily contact with it, such as law enforcement officers, court judges, social workers, alcoholism counselors, and so on, the extent of Maine's alcohol problem is difficult to assess because of the limited statistics available, the lack of any standardized system of reporting, and--more commonly-- of any reporting system at all.

Agencies and facilities that work directly with alcoholics and problem drinkers do, however, keep records and these are enlightening. But they tell only part of the story. The following chart, for example, is a tabulation of the numbers of clients in both referral and active status who were served by the five office counselors and two court counselors of the State Division of Alcoholism Services during the past biennium and the first 6 months of the current one. It includes also the number of client-related persons who were seen by these counselors, such as their spouses, employers, or friends; total number of interviews held during the two and one-half year period, and the outcome of both accepted and non-accepted cases.

Similarly, after its first full year of operation, the Alcohol Rehabilitation Center in Bangor, which is a function of The Counseling Center, Eastern Maine's Comprehensive Mental Health Center, developed a statistical profile of the 210 resident patients it served during 1971. The charts on the next three pages, used here by permission of the Counseling Center, summarize these data and contain the following observations:

STATE DIVISION OF ALCOHOLISM SERVICES

Cases served in Fiscal 1969-70 and 1st half of 1971

Fiscal 1969-70	Total Interviews	Non-Alcoholics	Old Cases* Alcoholics	New Cases Alcoholics	Complete Sobriety	Partial Sobriety	No change- Left service or Died
5 Regional Offices	8,988	1,931	1,102	310	282	424	706
Court Counselor Bangor	872	250	150	82	93	70	69
Court Counselor Portland	1,680	498	123	133	102	77	77
Totals Fiscal 1969-70	11,540	2,679	1,375	525	477	571	222
First Half - 1971							
5 Regional Offices	4,107	821	1,130	189	263	396	660
Court Counselor Bangor	430	129	139	31	68	51	51
Court Counselor Portland	937	314	154	68	89	67	66
Totals First Half 1971	5,474	1,264	1,423	288	420	514	777

*Clients carried over from the previous year who were still in some stage of treatment, rehabilitation, or referral.

ALCOHOL REHABILITATION CENTER

Table 1

Admission Statistics

Total 210

	Age Group				
	15-19	20-24	25-44	45-64	65+
Males	1	2	92	74	1
Females			23	17	
	1	2	115	91	1
Married	1	2	48	19	
Never Married			5	23	
Separated/Divorced			59	31	1
Unknown			2	8	
Widowed			1	10	
	1	2	115	91	1
None					
Some Grade School			16	17	
Completed Grade School			18	18	
Some High School	1	2	33	17	
Completed High School			26	23	1
Some College			7	8	
Completed College			4	5	
Graduate School			1		
V.B.T.			5	2	
Special Education					
Unknown			5	1	
	1	2	115	91	1
No Income					
50 or Welfare			38	25	
50-99			37	35	1
100-49			14	11	
150-199			7	3	
200-299			1	2	
300 and over					
Unknown	1	2	18	15	
	1	2	115	91	1

Table 1 presents patient characteristics by age. The income section of Table 1 represents weekly income prior to admission.

COMPARISON OF CATCHMENT POPULATION

1971 ADMISSIONS AND 1971 ADMISSIONS TO ARC

	1970 CATCHMENT POPULATION		1971 ADMISSIONS		210 ADMISSIONS TO ALCOHOL REHABILITATION CENTER	
	No.	%	No.	%	No.	%
TOTAL	206,127	100.0	2428	100	210	100
SEX						
MALE	101,263	49.1	1248	51	170	80
FEMALE	104,864	50.9	1180	49	40	19
TOTAL	206.217	100.0	2428	100	210	*99
AGE						
0-15	61,527	29.8	519	21	0	0
16-20	20,643	10.0	334	13	3	1
21-64	100,049	48.5	1531	63	206	98
65 +	23,908	11.6	44	1	1	0
TOTAL	206,127	99.9	2428	*98	210	*99
RACE						
WHITE	204,048	99.0	2329	95	205	97
NEGRO	479	.2	2	.01	0	0
INDIAN	1,232	.6	26	1	5	2
OTHER	368	.2	71	2	0	0
SUBTOTAL	206,127	100.0	2428	*98.01	210	*99
MARITAL STATUS (PERSONS AGED 14+)						
NEVER MARRIED	40,052	26.2	1037	42	39	18
MARRIED	93,045	60.9	996	41	70	33
DIVORCED	5,135	3.4	184	7	48	22
SEPARATED	1,443	.9	155	6	42	20
WIDOWED	12,998	8.5	56	2	11	5
TOTAL	152,673	99.9	2428	*98	210	*98

* UNADJUSTED

COMPARISON

1971 ADMISSIONS TO 1971 ADMISSIONS ARC

EDUCATION

	NO.	%	NO.	%
NONE	67	2	0	0
SOME GRADE	436	17	33	15
COMP GRADE	193	7	36	17
SOME HIGH	408	16	53	25
COMP HIGH	494	20	50	23
SOME COLL	138	5	15	7
COMP COLL	62	2	9	4
GRAD SCH	27	1	1	0
VOC, BUS, TECH	39	1	7	0
SPEC ED	62	2	0	0
UNKNOWN	502	20	6	2
	2428	*93	210	*96

WEEKLY INCOME

	NO.	%	NO.	%
NO INCOME				
50 or WELFARE	563	23	63	30
50-99	463	19	73	34
100-149	454	18	25	11
150-199	117	4	10	4
200-299	65	2	3	1
300 and OVER	25	1	0	0
UNKNOWN	741	30	36	17
	2428	*97	210	*97

*UNADJUSTED

--Males represented 80% of admissions for the year,

--Only 5 persons were non-Caucasians (Maine Indians),

--Prior to admission, slightly more than one third had been earning between $50 and $100 per week; a somewhat smaller number were either earning less than $50 per week or were receiving public assistance, while only 16 persons, or less than 8%, had been earning $100 a week or more.

--Only 33% were still married, whereas 42% were either separated or divorced, and 18% had never married.

Somewhat comparable records are kept by other facilities, including Serenity House and the 24-Hour Club in Portland, Milestone Foundation in Scarboro, Bangor Halfway House, the two State Hospitals, Togus VA Center, and the area mental health centers.

A project data report of the 24-Hour Club, prepared for the calendar year 1971 contains a considerably more detailed description of the 181 clients served at this emergency shelter during the 12-month period. Of the total number of persons using the facility, only 92, or 50%, were from the Model Cities neighborhood; many of the others were homeless, transient, or both. Shelter was provided to 112 of these, 65 were referred to a hospital, and 47 to the Division of Vocational Rehabilitation. Meals served during the period totaled 1,572. In addition, 285 hours were spent counseling 207 persons; and 302 hours were spent answering 1,152 phone calls to the answering service.

Considerable data is available from the Alcoholism Treatment Program which is part of the Neuropsychiatric Section of the Togus Veterans Administration Center. This treatment facility consists of a 90-bed ward, including a 10-bed detoxification room. Since its official opening on January 1, 1971, the Alcoholic Treatment Program has operated at maximum capacity, and has averaged 55 discharges per

month. During its first 6 months of operation, Ward 20 discharged 332 patients, of which 278 were different individuals, and the remaining 54 had one or more discharges. Only nine of these 54 had more than two admissions and discharges, and accounted for more than half of the readmissions that were discharged. None of the nine that had multiple discharges exceeded four such actions in the six months period.

The director of the VA Center Alcoholism Treatment Program has commented on the September 1971 report of this program as follows:

> These statistics, while interesting, tell us only that there is "action" in the form of turnover resulting from the Alcohol Treatment Program. However, it does not allow us to make statements of "cure" or other changes in symptoms. Neither does it allow us to infer treatment success in terms of hospital, home, work, or community adjustments. To make statements of the type usually made to justify such a program, the experience must be placed in a research framework. Such research would establish symptom criteria for admission, provide for psychological and social analysis for admission, program evaluation, analysis of hospital behavior, psychosocial evaluation at discharge, follow-up in community, etc.

The same need for ongoing research and evaluation could be cited in the instance of these September 1971 tabulations of patients with alcohol problems served by the Department of Mental Health and Corrections. The first chart (p.48) represents admissions by primary diagnosis to the two State Hospitals during fiscal 1970-71.

This chart shows that 286 (out of a total 1,315) admissions at the Augusta State Hospital were alcohol related, and that 222 (out of 983) admissions to the Bangor State Hospital were alcohol related.

Additional data is presented in this next chart (p.49) which summarizes admissions to the Mental Health Centers during calendar year 1971 for alcohol related problems. A total of 1,119 are noted here.

Admissions: Augusta State and Bangor State Hospitals

Fiscal 1970-71

Patients with an Alcoholic Problem

	Augusta State Hospital				Bangor State Hospital		
	Male	Female	Total		Male	Female	Total
Organic Brain Syndrome Associated with Alcoholism	60	15	75		42	10	52
Alcohol Addiction	23	9	32		16	4	20
Other Alcoholism	146	33	179		130	20	150
Total Admissions for Alcoholic Problems			286				222

Residents: Augusta State and Bangor State Hospitals

As of 6-30-71

Patients with an Alcoholic Problem

	Augusta State Hospital				Bangor State Hospital		
	Male	Female	Total		Male	Female	Total
Organic Brain Syndrome Associated with Alcoholism	28	15	43		11	6	17
Alcohol Addiction	2	4	6		1	-	1
Other Alcoholism	17	6	23		2	-	2
Total Number of Residents with an Alcoholic Problem			72				20

Admissions; Community Mental Health Centers - Calendar Year 1971

Patients Reported Having Alcohol Problems

Mental Health Area	Alcoholism Planning Region	Name of Mental Health Agency	Number	Percent of total Admissions
I	V	Aroostook Mental Health Center	159	13%
II	IV	The Counseling Center*	373	15%
III	III	Kennebec Valley Mental Health Center	30	5%
IV	II	Child and Family Mental Health Services	155	10%
V	I	Maine Medical Center	336	13%
VI	I	York County Counseling Services	26	4%
VII	I	Bath-Brunswick Mental Health Clinic	18	4%
VIII	I	Mid-Coast Mental Health Clinic	22	8%

*These are cases of alcohol related problems seen in general mental health services and does not include clients in the Counseling Center's Comprehensive Alcoholism Services Program.

A valuable indicator of the incidence and prevalence of alcohol abuse and alcoholism in the State would be one obtained from clinical impressions and subsequent diagnoses of patients seen or admitted to Maine's 55 community hospitals. At the present time a tabulation of this kind would be exceedingly difficult if not impossible to obtain. One of the reasons for this is that large numbers of patients in the acute phase of alcoholism illness are admitted under some other diagnosis. Medical insurance programs have been reluctant to provide coverage to such persons, and have excluded not only acute alcoholism as a disease entity in itself, but also the recognizable sequelae of alcohol abuse, such as gastritis or liver damage. However, staff physicians can and do admit their patients if they believe, after examining the individual, that this action is indicated. And quite often in such cases he will be found to have a physical condition which is acceptable to the patient's insurance carrier.

Another parameter for research and evaluation is provided by a tabulation of calendar year 1970 criminal offenses compiled by the Maine Law Enforcement Planning and Assistance agency:

Offense	Reported Complaints	Number of Offenses Cleared by Arrest, 1970	
		Total Offenses Cleared	By arrest of Persons Under 18 years of Age
Driving intoxicated	2,307	1,920	54
Drunkenness	3,517	4,255	130
Liquor laws	2,136	1,135	624
SUBTOTAL:	7,960	7,310	808
Family and Children	2,137	1,313	44
	10,097	8,623	852

While such isolated statistics as these may be revealing to a limited extent, they have little relevance when made to stand alone outside their particular context, as they have here, and when it is not shown for what particular purpose they were extracted. Certainly they have no "common data base", or anything much else in common, for that matter. For example, the gross statistics on numbers of alcohol related criminal offenses tell us nothing about the person who committed the offense. Was it his first conviction for public intoxication or his 20th? Neither is recidivism reflected in admissions to community mental health centers and state hospitals.

Variations among age groups, ethnic groups, socioeconomic groups, and other specific populations with specific problems and needs are not indicated by such lumpings of data.

Since this plan addresses itself to a spectrum of alcohol related problems as well as to chronic alcoholism, a practically insurmountable complication arises in the area of statistical assessment. The effects of alcohol abuse shade off into and complement a wide variety of other psychological, social and medical problems which affect the family and community.

However, before attempting a more pertinent and refined presentation of the limited data currently available for this study, a word needs to be said about statewide incidence and prevalence and the way in which these have commonly been cited.

In a 1970 publication by Rutgers Center of Alcohol Studies, Maine was ranked 14th among the states in estimated number of alcoholics, based on 1960 population figures; also in rate per 100,000 adult population, i.e., 20 years and over.

Total number of alcoholics in the State's 1960 population was estimated as 24,200 of which 19,600 were thought to be men and 4,600 women. Rates per 100,000 (on which the ranking by states was computed) was given as 6,812 for men and 150 for women.*

The authors, Efron and Keller, explain that the estimates are derived by the original Jellinek formula. The rates on which the numerical figures are based are those of the year 1945, with R (presumed ratio of alcoholics to alcoholics-with-complications in a given place at a given time) having a factorial value of 5 and applied to the 1960 population.

In the original equation, developed by the late E. M. Jellinek in the early 1940's, R was given a value of 4; that is, three alcoholics without complications for each alcoholic with complications.

They note that "These estimates should be considered as very rough approximations. Numbers are rounded to nearest hundreds... Calculations for later years should allow for changes in population and factor R should be given a value of 5.3"

They also point out in the monograph cited here that the original Jellinek formula "is thought not to have worked reliably after 1945. But if the rate of the 1940-45 period has remained substantially the same, then, with a further necessary correction of R to 5.3, the numbers of alcoholics and rates of alcoholism in recent years can be calculated."**

*Selected Statistics on Consumption of Alcohol (1850-1968) and on Alcoholism, (1930-1968), Vera Efron and Mark Keller, RCAS, New Brunswick, N.J., 1970, p. 12.

**Ibid, p. 11.

In order to obtain some rough approximations of the number of alcoholics (according to Jellinek's definition) for our five regional alcoholism planning areas, we have used the commonly cited 25,000 figure and by means of it have made a simple computation of each region's percentage share of the State's total 1970 population of 993,663. This simplified method of computation of course implies the questionable assumption that Maine's alcoholic population is evenly distributed from one end of the state to the other.

For what they are worth, however, these regional computations of alcoholism incidence are shown in the following table:

Table I

REGION I
York, Cumberland, Sagadahoc, Lincoln, Waldo, Knox 10,075

REGION II
Androscoggin, Franklin, Oxford..... 3,975

REGION III
Kennebec, Somerset..... 3,425

REGION IV
Hancock, Washington, Penobscot, Piscataquis..... 5,175

REGION V
Aroostook..... 2,375

Admittedly, such oversimplified abstractions as these have little value as a base on which to build programs. It is only when speaking of specific target populations that estimates of incidence and prevalence can have any real meaning.

If the target population in a particular instance is that of the chronic inebriate or the alcoholic who habitually exhibits socially unacceptable behavior, then there would be little question about including the man who has been jailed for public intoxication not just once or

a few times, but many. Or again, the man or woman who periodically and perhaps frequently drinks to thepoint of needing emergency treatment and hospitalization for acute alcoholism could no doubt by all accepted definitions be safely classified as "alcoholic".

But how is one to label the drinking driver who has never before been apprehended? Or the teenager who goes on occasional, perhaps fairly frequent, binges? Or another youngster with a six-pack of beer in his car?

The familiar stereotype of the "alcoholic" as a man in his 40's, whose family ties, if he still has any, are, if not broken, at least badly ruptured. He is in serious financial straits, a condition brought on mainly by his spending money for alcohol that should have gone to pay bills. Recognized also as a "type" is the "closet drinker". This may be a woman, also in her 40's or 50's, with a grown family and nothing much to occupy her time, who now feels useless and frustrated and consequently assuages these feelings by "nipping" in the daytime. There is also the aging man who has outlived all his other acquaintances and who can now find the companionship he craves only in his neighborhood bars.

Not surprisingly, the general consensus in each of the five regions has been that the variety of individuals who can be helped through intelligently conceived and skillfully conducted programs of integrated and appropriate services include all these "types" and many others besides.

The crux of the matter would seem to be, first of all, that so-called "alcohol problems" are in actuality <u>people problems</u>. As such, they are not only difficult to categorize; there is also some question about how useful such categorizing of "populations" really is.

problem that ranges in degree from the early, incipient, low-visibility or unknown kind of "alcoholism" to the moderately severe or severe, known, visible type with full blown complications. The Division of Alcoholism Services estimates that about 1,500 new people move into this alcoholic group each year.

In terms of a comprehensive alcoholism services network, a high priority must necessarily be given to the visible alcoholic whose problem is not only more acute, but represents a considerable economic and social drain on the community. At the same time it is essential to develop program resources aimed at those groups from which the visible alcoholic can be expected to arise.

The Deteriorating Social Drinker

Ours is a culture in which it is socially acceptable to drink alcoholic beverages in a sane and responsible manner for relaxation, for dietary reasons, to be convivial, to celebrate special and festive occasions, to seal business transactions, etc. Assuredly most every person who drinks socially intends to adhere to the ground rules, but because of underlying personality disruptions or other causes may not be able to do so. On a statistical basis, 1 out of every 15 of these "social" drinkers aceedes to the group of clinically evident alcoholics eventually.

Jay N. Cross* notes that it may take a number of years to progress from the early stages of nonconforming drinking to the late stage in which persons are easily recognized as alcoholics. "The progression may be rapid, but on the average it takes at least seven to 12 years for men to proceed through the phases. There is some

*Guide to the Community Control of Alcoholism, by Jay N. Cross, M.P.H., American Public Health Association, New York, 1968.

evidence that the course of the disease is more rapid for women."

In the absence of a long history of deviant and disruptive drinking behavior, it is usually assumed that the early deteriorating social drinker will not have to be singularly exposed to a routing of intensive or complicated treatment to correct his problem. It may be sufficient to focus on educational measures of a primary preventive nature. On the other hand, this may be a highly crucial point in the total life experience of the individual, when the precipitating causes of his sometimes excessive and otherwise nonconforming drinking behavior should be sought out and attempts made to help him solve his personal and interpersonal problems.

The Currently Unknown or Non-Visible Problem Drinker or Alcoholic

In this early-middle stage it usually becomes more and more difficult for the individual to abstain. This is often evidenced by his increasingly frequent loss of control over alcohol intake after the first one or two drinks. Also, at this stage he usually is encountering some degree of difficulty with his associates and family.

In other respects the currently unknown or non-visible drinker or alcoholic may have the same fundamental peculiarities as the visible alcoholic. The major characteristic that sets him apart, however, is his low visibility in the community. This stems partly from his tendency to conceal his drinking, his tendency also to become an "excessive rationalizer," quite often coupled with a kind of social existence and style of life that provides a protective environment. He is most often identified with the middle or upper layers of society, and may own or control more than the average share of the world's goods and services. In this group may be found skilled workers,

semi-professionals, professionals, company executives, private business owners, non-working housewifes, divorcees, widowers, and others who could be so classified.

The low-visible or non-visible problem drinker or alcoholic gives no indication that he has a drinking problem and seems quite unaware of what is happening to him, despite the frequency and intensity of hangovers that only "a hair of the dog" can alleviate. When approached on the matter he is most reluctant to even consider the possibility, although members of his family circle and certain close associates know or suspect that he is in trouble.

Little or nothing is known about the frequency of this distribution, but it is clear that a large part of the annual accession to the "visible" group must come from the "invisible".

The obvious need here is in some way to provide therapeutic intervention before the outward physical, social, or emotional signs of his deterioration can no longer be hidden and the separations from jobs and arrests by the police occur.

The Visible Alcoholic

Death rates in this group are high. (It is to be noted here that the Jellinek equation is based upon an observed relationship between the number of alcoholic-with -complications and statistics on deaths from cirrhosis of the liver.) Prolonged excessive drinking has usually led to considerable physical and neurological deterioration. Again quoting Cross: "Liver cirrhosis, chronic gastritis, and tremor are common symptoms. Peripheral polyneuropathy and temporary psychoses such as delirium tremens and alcoholic hallucinosis may develop."

"Chronic alcoholics often manifest withdrawal symptoms when their intake of alcohol is interrupted. Among these are tremors, extreme anxiety, insomnia, inability to concentrate, restlessness, and a feeling of weakness. Delirium tremens is a severe withdrawal state... characterized by acute tremulousness, disorientation, and hallucinosis. It is considered to be a medical emergency and is usually easily managed with proper medical care."*

Therefore, in this acute phase, at least, alcoholism is an undisputed illness, usually requiring emergency hospitalization, and characterized by the physiological concommitants of alcohol overuse cited above. The sequelae of chronic alcoholism are also distinct disease entities, and require medical treatment as urgently as do any other physical disorders.

But these medical aspects are only part of a "multidimensional problem", as Eva and Richard Blum, in their standard text on alcoholism, explain:

> Whether considered as a disease, a reaction, an acting-out or a learned addiction, alcoholism in each patient will be a multidimensional problem which can be defined in a variety of ways; that is, economically, criminologically, educationally, socially, or in terms of public health or psychiatric disease.**

*Ibid., p. 52.

**Alcoholism: Modern Psychological Approaches to Treatment, Eva Maria Blum and Richard H. Blum, Josey-Bass Inc., San Francisco, 1969, pp. 46-47.

B. OTHER SIGNIFICANT INFORMATION

1. Definition of the Problem

In Maine as elsewhere there is considerable debate and divergence of opinion about what "alcoholism" is and is not; what "causes" it; and how it can be "treated" or "arrested". Describing or defining the problem in terms that would be satisfactory to everyone concerned with it would seem to be an impossible task.

There is common tendency to apply the term "alcoholism" to any kind of excessive, inappropriate, or socially unacceptable drinking behavior. There is at least one good reason for this: it eliminates the need of having to explain precisely what kind or problem drinking one is talking about in any particular context. Many authors,* after noting their awareness of the many different kinds of drinking andthe circumstances connected with each, adopt this kind of shorthand for the sake of literary economy. For them to do this, once they have made the distinction clear, is of course perfectly acceptable. But for the layman and practitioner to resort to this misapplication of the label "alcoholism" leads only to confusion and misunderstanding. It also represents a considerable barrier to the thinking through and subsequent development of appropriate goals and programs in the area of alcohol abuse and alcoholism.

One of the speakers at a regional workshop held in connection with the present study commented on this by saying:

> One of the methods people use to solve problems is to apply labels. You simply label this person and that one (as a problem drinker or an alcoholic) and that solves the problem. Well, it doesn't.**

*Eva and Richard Blum, Jay N. Cross, etc., Ibid.

**Dr. Einer Olsen, at Tri-County Alcoholism Workshop, March 18, 1972.

This points, again, to the widely recognized phenomenon that the way a particular set of circumstances is viewed, whether or not it is seen as a problem and if so, what particular kinds of recommendations are proposed to deal with it, stem largely from the standpoint of the observer.

Thus from a medical standpoint, especially during the acute illness phase, excessive, uncontrolled and uncontrollable drinking is seen as a disease entity.

From a psychological standpoint it may be regarded principally as a psychosocial disorder. When viewed in this context, there is considerable reluctance to apply the label, since the assumption here is that asocial or antisocial drinking behavior is a symptom of an underlying disorder.

Law enforcement officers, the court justice system, and others who have responsibility for enforcing social controls, necessarily take their cues from the legal statutes by which they operate and both consider and treat deviant drinking behavior as a criminal offense. This is not to imply that these agents of social control are by any means unaware of the vast ramifications of the problems with which they are called upon to deal. A succinct expression of their recognition of the problem's complexities is to be found in the York County HRS-ASAP application for a drinking driver's pilot project:

> Behind this is the deeper need of solving the problems of family disintegration, unemployment, and poverty which breed the drives that create problem drinkers. Treating alcoholics is just one segment in a whole effort to help York County people develop a more meaningful life style.

2. The Disease Concept

While it may be that these confusions of definition have led to an overextension of the disease concept of alcoholism, and consequently to the misapplication of both terms, there can be no doubt in anyone's mind that at certain stages at least, such as the acute illness phase, and also in terms of the physiological concomitants of alcohol over-use--the acute tremors, liver damage, chronic gastritis, etc.--the effects of excessive ethanol intake are distinct disease entities and should be treated as such. While it may be an oversimplification to claim, as some do, that "it isn't any different from cancer, or heart disease, or tuberculosis, or anything else",* in a great number of cases a medical emergency exists requiring immediate treatment, a period of in hospital care, and a program of follow-up.

Consequently most national health organizations term chronic alcoholism at least, as a disease. The American Public Health Association, the National Council on Alcoholism, and the U.S. Department of Health, Education and Welfare have done so. Similarly, in 1956 the American Medical Association and in 1957 the American Hospital Association have recognized alcoholism as a disease entity.

The problem remains, however, of convincing large numbers of practicing physicians that excessive alcohol use is in many important respects "legitimate", a treatable illness, to be considered the same as any other illness for which hospitalization and subsequent aftercare is indicated; that, in other words, it should be accorded the same consideration given any other illness which some other family member might have.

*A speaker at the Southern Maine Alcoholism Workshop, April 28, 1972.

3. Socioeconomic Aspects

While it is true that alcohol abuse and alcoholism are no respector of persons, and that the highly paid executive is as prone as the welfare recipient, it has been demonstrated that socioeconomic factors have a strong bearing on incidence of alcohol abuse, as they do on other kinds of psychosocial dysfunctioning. The Blums comment on this as follows:

> As one reviews the characteristics of the 'typical' alcoholic and finds the profound relationship between alcoholism and the other social and physical disorders that affect people in disadvantaged groups, one concludes that alcoholism is indeed but a symptom--not only of individual psychological distress or an addictive disease process, but of disordered social backgrounds and painful interpersonal experiences as well.

It is believed by some, on the other hand, that problems with alcohol are not more prevalent among the drinking poor, but are only of a different kind and characterized by different, possibly less socially acceptable drinking patterns. It is evidently much more visible among the low income population, who can least afford to support their drinking habits. Whereas the still employed middle class drinker can afford to drink frequently and to excess and to pay for the periodic medical attention which his "self-indulgence" requires, the already impoverished only become more so and must rely on public agencies both for treatment and for the financial support of their families. To those who are already unemployed, either because they have been unable to find work where none is available, or because of a physical or mental disability, the problem--and hence the visibility--becomes that much more evident. This socioeconomic aspect of the program is again stressed by the Blums when they write:

> One also sees not only that the groups from whom the 'typical' alcoholic comes share a wide number of distressing characteristics--disease, unemployment, powerlessness, addiction, criminality--in proportion far beyond their due, but also that the individual patient is likely to demonstrate these same correlative disorders in his life.

4. Criminological Aspects-The Need for a Uniform Law

The high incidence of public intoxication and other alcohol related offenses on court dockets in Maine, as elsewhere in the country, has been a subject of increasing concern.

The statistic brought out earlier in this report, of nearly 9,000 arrests for such offenses in Maine during 1970, provides some insight into the scope of the problem, but only a partial one. We have no way of knowing, for example, how many other criminal acts were committed under the influence of alcohol, or how many of the alcohol related offenses were committed by chronic alcoholics.

Two separate but still closely associated issues arise from what evidence is available. One is the need for early detection and and therapeutic intervention when it becomes known that pathological drinking is at least a concommitant of other forms of socially deviant behavior. The other is that many thousands of taxpayers' dollars are being spent annually to arrest, convict, and incarcerate persons whose only offense is socially unacceptable drinking.

Since it has been demonstrated that the persons most likely to be arrested, fined and/or confined are those least able to afford it, not only from the standpoint of paying the fine but of serving time in lieu of payment and risking the loss of their jobs, leaving their families destitute, and the rest, this procedure appears to

be not only wasteful and ineffective in terms of the drain on the State's already overburdened and costly law enforcement and judiciary system, but represents a degree of punishment greatly in excess of the crime.

State and Federal funds spent to enforce public intoxication laws have not been available for other uses. Or to put it differently, although taxpayers continue to invest considerable sums of money in alcohol "control", they have realized no return on their investment.

As mentioned here earlier, although there have been several significant actions taken at both the national and local levels to change attitudes concerning alcohol abuse and alcoholism, it was not until the mid-1960's that these began to be formally structured. One of the most recent and innovative reforms has been the drafting of a "Uniform Alcoholism and Intoxication Treatment Act" by the National Conference of Commissioners on Uniform State Laws. This model legislation has been endorsed by the U.S. Department of Health, Education, and Welfare and recommended by the NIMH-NIAAA for enactment in all the states. From the time it was first made public at the Commissioners' annual conference in August, 1971, it has been adopted either in its original or modified form by the legislatures of at least six states, including Massachussetts.

This model law, which draws heavily on the authoritative recommendations of the U.S. and Washington, D.C. Crime Commissions, on the District of Columbia statutes, and on model laws drafted by the Legislative Drafting Research Fund of Columbia University and the Joint Committee of the American Bar Association and the American Medical Association, has had an interesting history.

The first landmark decisions, issued in the District of Columbia in 1966, held that because alcoholism is an illness, a homeless alcoholic could not avoid being drunk in public and therefore could not be punished for his public intoxication. Although two years later the U.S. Supreme Court declined to extend this holding to include an alcoholic who has a home and family, a majority of the court indicated that the punishment of a homeless alcoholic for public intoxication would violate the Eighth Amendment to the U.S. Constitution. The decision also documented the Court's unanimous recognition that current facilities, procedures, and legislative responses to the problem of public intoxication were wholly inadequate.

Reports of the three commissions cited above found that the criminal law was "an ineffective, inhumane, and costly device for the prevention and control of alcoholism and public drunkenness". All recommended that a public health approach be substituted for current criminal procedures. The "Joint Statement of Principles Concerning Alcoholism" issued by the American Bar Association and the American Medical Association urged State governments to adopt new comprehensive legislation in which alcoholism would be viewed as an illness and public intoxication would no longer be handled as a criminal offense.

Within four years after initiative taken by Congress in enacting the District of Columbia Alcoholism Rehabilitation Act of 1968 (P.L. 90-452), Hawaii, Maryland, North Dakota, Florida, and Massachussetts have since followed suit.

This growing awareness and concern on the part of the states brought a Federal response. In 1968 Congress passed the Alcoholic Rehabilitation Act (P.L. 90-574), the first Federal law dealing

specifically with the treatment of alcoholism on a national basis. Congress declared in the Act that "the handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism, whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public". In December 1970 this Federal initiative was substantially expanded with the enactment of the Hughes Act and the establishment of the National Institute on Alcohol Abuse and Alcoholism.

The model law proposes as a declaration of policy "that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages, but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society". This policy statement is intended to preclude the handling of drunkenness under any of the wide variety of petty criminal offense statutes such as loitering, vagrancy, disturbing the peace, and so forth. As the Crime Commissions pointed out, drunkenness by itself does not constitute disorderly conduct.

For purposes of the Act, "alcoholic" is defined as "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 disrupted." The National Conference of Commissioners points out in its supportive rationale for the proposed model law that "The

term 'alcoholic' is defined in two alternative ways for two different purposes". The first alternative is a relatively narrow definition based on lack of self control...(which) may be manifested either by inability to abstain from drinking for any significant time period, or by the ability to remain sober between drinking episodes but an inability to refrain from drinking to intoxication whenever drinking an alcoholic beverage. This relatively narrow definition has been the basis for the court decisions holding an alcoholic not criminally responsible for his intoxication.

"The second alternative definition adopts the World Health Organization's broad approach, that alcoholism can be defined as the use of alcoholic beverages to the extent that health or economic or social functioning, are substantially impaired. The purpose of this definition is to make as large a group as possible eligible for treatment for alcoholism and related problems. This broad definition is useful in making <u>voluntary</u> treatment available to as large a group as possible, but would be wholly inappropriate to define those alcoholics who justify civil commitment for <u>involuntary</u> treatment.

"The Act defines 'treatment' broadly to include a wide range of types and kinds of services to reflect the fact that there is no single or uniform method of treatment that will be effective for all alcoholics. The Act provides a flexible approach with a variety of kinds of medical, social, rehabilitative, and psychological services according to the individual's particular needs."

The Model Law, which reinforces and explicates the Hughes Act in several important respects, defines the functions and specific duties of the designated State agency under the Hughes Act. It also outlines the duties of the State Advisory Council on Alcoholism whose members, appointed by the Governor, are to serve overlapping terms of three years each. In addition, it provides for an Interdepartmental Coordinating Committee to ensure the coordination of , and exchange of information on, all programs relating to alcohol abuse and alcoholism.

A requirement of the Model Law as drafted is the development of a comprehensive statewide program of treatment services that will include:

(1) Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) Inpatient treatment;

(3) Intermediate treatment; and

(4) Out-patient and follow-up treatment.

The commentary to this section notes that "Whether or not the director divides the State into regional units for purposes of administration, it is desirable that all treatment services be community based. Alcoholics and other ill persons are treated more effectively through treatment services in their own communities, located conveniently to population centers so as to be quickly and easily accessible to patients and their families, rather than in large institutional settings...

"...Emergency services should be available 24 hours a day and readily accessible to those who need this assistance. In addition to

medical services, emergency social services and appropriate diagnostic and referral services should be included.

"Inpatient treatment' refers to full time residential treatment in an institution. Although alcoholics and intoxicated persons ordinarily do not require full time inpatient treatment services, such care must be available for those who do need it. Since long-term inpatient services are inappropriate for (most) alcoholics, inpatient treatment should be designed to facilitate the patient's return to his family and the community or to other appropriate care services as rapidly as possible.

"'Intermediate treatment' refers to residential treatment that is less than full time and that can be provided in a variety of community facilities, such as halfway houses, day or night hospitals, or foster homes.

"'Outpatient and follow-up treatment' includes the same wide range of treatment services and modalities offered in inpatient or intermediate service settings, but in outpatient treatment, the client is not a full or part-time resident of the treatment facility. Such services may be offered in a wide variety of settings in the community, such as clinics and social centers and even in the patient's own home.

This section also "requires the department to provide adequate and appropriate treatment for all alcoholics and intoxicated persons, including both the vast majority of persons who will come to these facilities voluntarily and the small minority who may be involuntarily committed..." (Section 14 of the Act makes it clear that involuntary treatment is permitted only in exceptional and very clearly prescribed circumstances. The Act stipulates that the

patient must not be required to agree to "voluntarily" commit himself for a specified length of time or to accept any of the other restrictions that apply to involuntarily committed persons. The involuntary commitment provision "is meant to be utilized only in true emergency situations where immediate action is essential..." This section also prohibits "mere custodial care by providing that a person may not be committed unless the Division is able to provide "adequate and appropriate treatment for him and the treatment is likely to be beneficial".)

Two sections of the Model Law provide for the repeal of State laws that are inconsistent with the Act. Under Section 37, States would be expected to repeal all the relevant portions of their criminal statutes under which drunkenness is the gravamen of the offense with the exception of part (c) of Section 19, which states:

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

The Model Law has been quoted here at length for the benefit of readers who may not have had access to copies of it, and also to point out the similarities between this Uniform Law and the requirements of the Hughes Act.

A major step towards implementing the intent of this Model Law was taken by the 105th Legislature, in June 1971, when it enacted Public Law 460, "An ACT Relating to Public Intoxication", which amended

Title 17 of the Revised Statutes of 1971. In its first draft, it amended Section 2001 of this title by deleting "is found intoxicated in any street, highway, or other public place, or" to read as follows:

> Whoever is found intoxicated in a motor vehicle while said motor vehicle is in any street, highway, or other public place, shall be punished for the first offense by a fine of not more than $20 or by imprisonment for not more than 30 days, or by both...(etc).

The supporting Statement of Fact accompanying the bill, presented as L.D. 584, and referred to the Committee on Judiciary in February, 1971, noted:

> This amendment will eliminate simple public intoxication as a crime in Maine. The enactment of this law will help relieve law enforcement officers and the judiciary of a considerable amount of work and expense in connection with the arrest, conviction and commitment of inebriates. It will have the societal benefit of emphasizing the health and rehabilitation of alcoholism and the recognition of alcoholism as fundamentally a disease.

This bill was later reported from the Committee on Judiciary in May, and printed under the joint rules as L.D. 1786. The committee restored the words that had been deleted from the original statute, but amended the original statute by adding the following new paragraph:

> Within 18 hours after an accused is taken into custody, if it appears that the accused is not a danger to himself or others, with the written consent of the accused, the accused may be released from custody and no complaint shall issue. After such release the arresting officer or the officer in charge may, with the written consent of the accused, make such arrangements to transport the accused to his home or some other suitable place as may be reasonable under the curcumstances.

This amended version was signed into law by Governor Curtis on June 17, 1971, and went into effect 90 days later.

It is recognized that full implementation of the Model Law in anything like its present form will need to be phased in over a period of time, since the extensive treatment and rehabilitation facilities called for in the Uniform Alcoholism and Intoxication Treatment Act are a long way from being accessible to the entire population of the State at this point in time.

C. EXISTING RESOURCES

Statewide Services

Until quite recently, services to alcoholics and their families have been limited almost entirely to those provided by the Division of Alcoholism Services and the Division of Vocational Rehabilitation in the Department of Health and Welfare; counseling and therapy services provided through the eight community mental health areas and, to a more limited extent, the two State Hospitals; Alcoholics Anonymous, Al-Anon and Al-Ateen; the Salvation Army in two urban areas of the State; Model Cities in Portland and Lewiston-Auburn; Diosecan Bureau of Human Relations Services, Inc., and the Alcohol Safety Action Program.

With the increasing attention being given to the coordination of health and other human services, additional State and private agencies have entered this field. These include the State Comprehensive Health Planning 314 (a) Agency, and the five regional 314 (b) agencies. More recently the State Planning Office now has jurisdiction for a statewide system of eight planning and development districts, established by executive order of the Governor in January 1972, for the purpose of encouraging Federal, State and local comprehensive planning and coordinated development.

1. STATE DEPARTMENT OF HEALTH AND WELFARE

(a) Division of Alcoholism Services

The client services function ofthis agency has already been described under the State agency section of the first part (Administrative Organization) of this State plan. It was noted that current operations are channeled through five area Alcoholism Counseling Centers located in Portland, Lewsiton, Augusta, Waterville, and Bangor. Anyone with a drinking problem can request help at any of these offices, and referrals are accepted for all sources--industry, labor, government, the professional community, and from the public at large. In addition, the Division provides services to the district courts; consultation to all court personnel about alcoholism, and special liaison between court judges and drinking offenders brought before them.

Direct services consist of a first interview, a screening procedure, a diagnosis, the formulation of a personal recovery plan, and counseling for as long as needed. Also, information and counseling are made available to the alcoholic's family, his employer, or other sponsor. A similar procedure is followed with court referrals, except patients have to be interviewed within the custody of the court. Those sentenced to jail or other penal insitutions are visited while incarcerated to initiate a program to be activated upon their release.

(b) Division of Vocational Rehabilitation

This Division administers a program of rehabilitative services to men and women handicapped by physical, mental, or psychosocial impairments to prepare for and achieve suitable employment. It is concerned with all types of disabilities except those due to visual impairment, which are the concern of the Division of Eye Care. It

is a State-Federal grant-in-aid program, funded on the basis of $4 Federal for each State dollar.

Referrals to this Division increased from 3,319 during 1967-68 to 4,408 in 1969-70. Cases closed as "employed" increased from 795 to 1,134. Total caseload at the end of the 1968-70 biennium included 1,240 clients who had been found eligible and were recieving services, plus 1,700 who had been referred and were receiving services, including medical and psychiatric evaluation, to determine eligibility.

Interestingly--and here again is an instance of the inadequacies of the State's present reporting system--out of a total of 1,134 clients reported "rehabilitated" by the Division for the 1968-70 biennium, in a listing by disability category, only 9 are reported as having a primary diagnosis of alcoholism. This may be comparable to the general hospital's practice of admitting a much higher number of both rehabilitated clients and those 1,240 still in active status were known to their counselors as problem drinkers or alcoholics. The same inadequacy of case reporting applies to other operational components within the Bureau of Rehabilitation, including its Division of Eye Care; Education, Training and Rehabilitation specialists, and Social Work program. Although known alcoholics have never been specifically excluded from the Vocational Rehabilitation program, neither was the referral of such persons encouraged. It was not until the passage of the 1965 and 1968 Vocational Rehabilitation Act amendments cited earlier, and their incorporation as policy by the Rehabilitation Services Administration of the Department

of Health, Education and Welfare, that alcoholics became officially "recognized" as a medically and psychologically eligible "disability group".

Prior to that time, also, there were no intermediate care facilities for homeless, jobless problem drinkers and alcoholics. Three of the currently existing residential facilities were then only in the planning state. Although Milestone, a private facility for recovering alcoholics located at Old Orchard Beach had begun accepting clients as early as June 1967, it did not meet requirements for State licensing until March of 1969.

The first major commitment made by the Division to alcoholics came in October 1968 with the opening of the State-Federal accredited Bangor Halfway House. It was at this time that the federal grant, which the Division had been instrumental inmaking application for, was awarded under the Laird amendment of the national Vocational Rehabilitation Act. The Division continued to give both direct and indirect assistance to this program, principally by assigning one of its regional counselors to it part-time. Since then DVR has sponsored, for periods of time ranging from a few days to six months, some 130 clients at this facility, by paying all or part of their room and board, and providing other kinds of vocational rehabilitation assistance, including physical restoration, psychological counseling, job training and help in placement, along with other services to return them to steady employment. With the opening of the Serenity House in Portland a short time later, as well as other facilities for treatment,

the number of DVR-sponsored clients has increased accordingly.

The Division has given strong backing to the halfway house concept of treatment, with its rationale of utilizing a multi-disciplinary team approach in helping the individual solve his various and complex problems, and the advantages this has over a less integrated one-and-one counseling relationship.

The Division has three basic criteria of eligibility which it applies not only to alcoholics but to any handicapped individual: (1) there must be a medically or psychologically identifiable handicap, (2) the handicap must be a barrier to obtaining and retaining employment for this particular individual, and (3) there must be reasonable expectation that the individual will benefit from the services available through the Division to the extent that he can be fitted for suitable employment.

Although the individual's ability to obtain suitable employment is the objective of the VR program, it can in some instances be interpreted as part-time or even sheltered employment, depending upon whatever is reasonable, practical and suitable according to the individual's capabilities and limitations.

Services provided by the Division are wide-ranging and include a complete diagnostic evaluation to determine both abilities and disabilities. Eligibility is then largely determined on the basis of this medical, psychological and vocational evaluation. Upon acceptance into active status, an individual action plan is formulated jointly by the client and counselor, and a goal--either a firm goal or a tentative goal--is agreed upon that will then determine what services should be provided. These generally include counseling and

guidance; physical restoration which may involve surgery, if necessary, to remove or ameliorate a physical disability; other kinds of medical treatment including medication; purchase of prosthetic devices such as artifical limbs, wheelchairs, braces, hearing aids, dentures, etc. Individual or group therapy, physical therapy, speech therapy, are also some of the types of services included in the broad use of the term "restoration".

The Division is able to arrange and pay for any type of training that seems reasonable for the individual to reach his goal. This could run the gamut from four years of college to vocational school training, business school training, or on-the-job training. In conjunction with these, the Division is able to provide a reasonable amount of weekly maintenance to allow the client to subsist while undergoing restoration or training or while seeking employment or waiting for this first paycheck.

The same broad range of services is provided to clients of the Division of Eye Care, whose primary disability is blindness or a visual handicap.

2. DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

This State agency was established in 1939 as the Department of Institutional Services, thus removing institutional programs from the Department ofHealth and Welfare. In 1957 it was given its present name, and in 1959 the Bureau of Mental Health was created within the department. Until that time the mental health services had been restricted to those provided in the institutions, with limited mental health services available in communities through two hospital outpatient clinics.

The Department now has three operating Bureaus: (1) Mental Health, (2) Mental Retardation, and (3) Corrections. The most recent of these is the Bureau of Mental Retardation which was established with its own director in April, 1970.

(a) The Bureau of Mental Health is responsible for the direction of mental health programs in the institutions as well as the promotion and guidance of mental health programs within the several communities of the state. Its mission is to provide directly or indirectly, a comprehensive and coordinated system for care of those with mental health or mental health related problems of which alcoholism has long been dealt with. Through its Division of Community Services, begun as the result of statewide mental health planning and established with its own chief in September of 1970, it provides consultation and coordination to community mental health clinics and centers throughout the State. A nine-member Mental Health Advisory Board appointed by the Governor assists the Bureau in the development ofpolicy for institutional and community mental health programs.

The Bureau has administrative responsibility for the State's two mental hospitals, the Augusta State Hospital and the Bangor State Hospital, as well as a unit for emotionally disturbed children in the single State retardation facility, Pineland Hospital and Training Center in Pownal. These institutions offer short term as well as long term care.

Division of Community Services. References to the eight community mental health areas and discussion of their current programs has been made in Section I of this report under "Purposes of the Study". These will be treated more comprehensively in the regional sections of the "Action Plan".

(b) The Bureau of Corrections has responsibility for the four correctional institutions in the State, as well as the Division of Probation and Parole.

3. ALCOHOLICS ANONYMOUS

This loosely knit organization of more than 500,000 members and 16,000 groups in more than 90 countries, has been notable for the success it has had with those who have been willing to follow its program. According the the World Directory of AA members there are 75 local groups in Maine. Actually, since there are no dues or fees for AA membership, nor is there any way of "signing up," it would be extremely difficult to get even an approximate count. Members are asked to contribute $2 annually to the General Service Office of AA in New York City, and each group's membership is estimated on the basis of these contributions. However, some members may not contribute anything, while others may give considerably more than the annual assessment asked for. Also, there is no definition of "membership" in the ordinary sense. No "attendance" is taken, and no distinction is made between those who have relapsed and begin the road to recovery anew, and those who have maintained an extended length of uninterrupted sobriety.

The organization is described in its basic text, Alcoholics Anonymous--nicknamed "The Big Book" by its members--as follows:

> Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

> The only requirement for membership is a desire to stop drinking. AA is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

Although having no formal connection with Alcoholics Anonymous, the Al-Anon and Al-Ateen groups work in close accord with them through their own group membership, both to improve their own understanding of the problem as individuals who have a drinking husband, wife, parent, relative or friend. By sharing their "experience, strength and hope with each other" they not only find needed support for their own lives, but in doing so are able to effect an improvement in the home environment which in turn increases the recovering alcoholic's chances of staying sober.

4. SALVATION ARMY

As one of the early temperance and social reform movements, the Salvation Army has traditionally been recognized for its efforts to rehabilitate, as well as provide food and shelter, for the homeless alcoholic. In Maine the central office is located in Portland at 88 Preble Street where the Men's Social Service Center is also.

5. MODEL CITIES

Portland Model Cities was approved and funded in November 1967 and includes an area of the peninsula known as Portland West inhabited by approximately 15,000 people. This and its more recent counterpart in Lewiston-Auburn, which got underway in 1969, are the only cities to be authorized in Maine under the Federal legislation known as the "Demonstration Cities and Metropolitan Development Act of 1966".

Both planning efforts have sought and promoted unified action by public and private agencies in their respective areas. Among their objectives have been to:

--Combat poverty and low income,

--Provide better education and proper child development,

--Improve and expand preventive and rehabilitative social services,

--Improve the health of the community, and

--Reduce the incidence of crime and delinquency.

More detailed descriptions of these programs will be treated under the Southern Maine (Region I) and Tri-County (Region II) sections of this State plan.

6. HUMAN RELATIONS SERVICES, INC.

Formerly called the Diocesan Bureau of Human Relations, Human Relations Services, Inc., is a private, non-profit charitable institution incorporated under the State statutes. Its services are offered throughout the State and is, in fact, the only voluntary statewide health and welfare agency in Maine.

It is organized geographically into four "divisions". The districts correspond to the major geographical divisions of the State planning agencies, with offices in the following locations:

District I - 317 Congress Street, Portland

District II - 1180 Lisbon Street, Lewiston

District III - 44 Main Street, Waterville

District IV - 53 Illinois Street, Bangor

District V - 15 Vaughn Street, Caribou

District VI - 9 Alfred Street, Biddeford

The four divisions are Homemaker Services, Indian Services, Camping Services, and Diocesan Child Development Services. Their main function is to serve the districts in their area of expertise.

The agency is governed by a statewide board of directors, and has a central office for administration, business management, and program development at the Chancery Annex, 519 Ocean Street, Portland. Each of the six districts is guided in its operations by a locally recruited board of advisors which assists the district directors and the Diocesan Director in policy formulation, identification of regional needs, and implementation of district programs.

Statewide operations are governed by a 15-member Executive Committee which meets quarterly.

Since it was first inaugurated in 1967 on a statewide basis, its staff has grown to include over 200 persons. Programs vary from region to region depending on district needs as identified by staff and district board members. The basic staff in each district office is a District Director (MSW or equivalent) and a professional counselor. Other staff is determined by the number and size of programs in the region. Funding for services is generated by a variety of sources including the Catholic Community of Maine, United Fund, Model Cities, Health and Welfare (IV-A Funds), and endowment resources.

All district staffs spend a considerable portion of their time working with persons whose problems, family or otherwise, are related in some way to alcohol use and abuse. The District V office in Caribou, for example, has reported that of "our total counseling caseload of 70 within the past year, 14 (or 20%) have been directly concerned with the problem of alcoholism. Within our Homemaker Services caseloads of 377 cases serviced in the past 12 months, 99 cases have been directly concerned with an alcoholic family member."*

District I involvement in the problem is reflected in its grant application for a special demonstration project to provide comprehensive services for alcoholics in conjunction with the Department of Transportation's Alcohol Safety Action Program in Cumberland County. This proposed project is described in the regional profiles section of this present State plan.

*Letter from the District V director to the Aroostook Mental Health Center director, August 23, 1971.

7. ALCOHOL SAFETY ACTION PROGRAM

An ASAP program, funded in Maine for a three and one-half year period under a grant from the Office of Alcohol Countermeasures, National Highway Transportation Safety Agency, U.S. Department of Transportation, is now operating in Maine under the supervision of the State Motor Vehicle Division. At the present time this effort is being conducted only in York andCumberland Counties. This project and its proposed development is dealt with in the regional profile section of the plan.

8. STATE COMPREHENSIVE HEALTH PLANNING

This agency's major activities are primarily in the area of organizational development and coordination of all health program components, in order to bring them together within the framework of a comprehensive statewide health services plan. The 314 (a) agency staff consists of a director, three full time professional staff, a part-time education consultant, part-time health services consultant, and a secretary.

During its initial phase of activity, priority was given to an education program for health service providers by means of organized workshops and conferences, and to developing lines of communication between the public and private agencies that have responsibility for health and health related activities. The ultimate goal of this statewide planning mechanism is the "development of an efficient, acceptable, accessible, and economical delivery system of high quality comprehensive health services to the state's population... an immediate goal is to eliminate the wasteful and ineffectual duplication of health

services and competitiveness among health service providers from which the health care system has been suffering".*

The State Comprehensive Health Planning Agency provides its services to health or related organizations concerned with developing operational service programs for their respective client populations.

Comprehensive Health Planning 314 (b) agencies concerned with area wide planning are:

Region I - Southern Maine Comprenensive Health Planning Agency, Portland (includes 4 Community Mental Health Areas)

Region Ia - Pen-Bay Regional Medical Agency, Rockport, (a component of Southern Maine Comprehensive Health)

Region II - Tri-County Health PlanninglAgency, Lewiston

Region III - Kennebec Valley Regional Health Agency, Waterville

Region IV - Penobscot Valley Regional Health Agency, Bangor

Region V - Aroostook Health Services Development, Presque Isle

Current activities of these 314 (b) agencies as contributing to comprehensive statewide planning for alcohol abuse and alcoholism are described in the regional profiles.

*1968-1970 Biennial Report, Maine Department of Health and Welfare, p. 6.

9. STATE PLANNING OFFICE, EXECUTIVE DEPARTMENT

The State system of planning and development districts referred to in an earlier part of this narrative and established by Executive Order of the Governor in January, 1972, has its legal basis in the Act Relating to Regional Planning and the Establishment of Regional Councils of Governments as codified in Title 30, Chapter 239, Sections 4501-4503, Maine Revised Statutes. In accordance with this Act, and the requirement by the Federal Government that states use, insofar as possible, coterminous boundaries for planning the various federally assisted programs within the states, the eight planning and development districts were delineated by the State Planning Office on the basis of the physical, economic and human resources relationships existing within the State.

The present State plan for comprehensive alcohol abuse and alcoholism programs in Maine, with its firm commitment to the principles of both community based services, and to community responsibility through direct involvement in the planning and implementation of these services, is consistent both with the Planning and Development District system and with the eight area system which has been adopted by Community Mental Health Services of the Department of Mental Health and Corrections. At this intitial stage of planning, however, a regional pattern coterminous with that of the State Comprehensive Health Planning with its five 314 (b) agencies offered distinct advantages. In the first place, though fewer in number, these "B" agencies are not inconsistent in their boundaries, designation of population centers, etc. with the State organizational structure. Although at the present

time the staffs of these regional "B" agencies are small, they are set up expressly to provide consultative and operational services to just such health planning efforts as this present one. (Similarly, although they encompass larger land areas, the four service Regions of the Bureau of Rehabilitation are each comprised of two State Planning and Development Districts.)

Despite the fewer number of planning regions at this present stage of alcohol abuse and alcoholism program planning and development, the overall regional organization of this project conforms to the requirements of both Executive Order issued by the Governor of Maine, and revised Circular No. A-95 of the U.S. Office of Management and Budget, issued February 9, 1971. A preliminary draft of the current State plan for comprehensive programs of alcohol abuse and alcoholism services is now being reviewed by the State Planning Office and other State agencies as requested by that Office in accordance with the Circular A-95 provisions.

The eleven planning commissions, their planning jurisdictions, office addresses, and executive directors, are as follows:

Regional Planning Commissions in Maine - March, 1972

ANDROSCOGGIN VALLEY REGIONAL PLANNING COMMISSION James O. Nesbitt, Executive Director 181 Russell Street Lewsiton, Maine 04240 - Tel. 784-0151	Androscoggin District Benjamin E. Blackmore, Chairman
BATH-BRUNSWICK REGIONAL PLANNING COMMISSION Dana A. Little, Executive Director 98 Maine Street Brunswick, Maine 04011 Tel. 725-4233	Southern part of Mid-Coastal District Harold Leeman, Chairman

GREATER PORTLAND COUNCIL OF GOVERNMENTS William Rogers, Jr., Executive Director 169 A Ocean Street South Portland, Maine --Tel. 799-6695	Cumberland District Harold G. Loring Chairman
HANCOCK COUNTY REGIONAL PLANNING COMMISSION Jackson L. Koon, Executive Director Box 608 Ellsworth, Maine 04605--Tel. 667-5729	Hancock County section of Eastern Maine District Peter L. Young Chairman
KNOX COUNTY REGIONAL PLANNING COMMISSION Mrs. Paul Fay, Executive Director PO Box 664 Rockland, Maine 04841--Tel. 594-5693	Eastern Section of Mid-Coastal District Raymond D. Smith Chairman
NORTH KENNEBEC REGIONAL PLANNING COMMISSION Elery Keene, Executive Director 173 Main Street Waterville, Maine 04901--Tel. 873-0711	Northern part of the Kennebec District George A. Vigue, Jr. Chairman
NORTHERN MAINE REGIONAL PLANNING COMMISSION James A. Barresi, Executive Director PO Box 911 Presque Isle, Maine 04769--Tel. 768-5511	Northern Maine District Robert G. Soucy Chairman
PENOBSCOT VALLEY REGIONAL PLANNING COMMISSION Talbot Averill, Planning Director Bangor City Hall Bangor, Maine 04401--Tel. 945-5769	Penobscot District Richard Stratton Chairman
SOUTHERN KENNEBEC VALLEY REGIONAL PLANNING COMMISSION John B. Forster, Executive Director 154 State Street Augusta, Maine 04330--Tel. 622-7707	Southern part of the Kennebec District Paul Hermann Chairman
WASHINGTON COUNTY REGIONAL PLANNING COMMISSION Donald J. Bushey, Director PO Box 273 Machias, Maine 04654--Tel. 255-3971	Washington County section of Eastern Maine District Edwin Hamm Chairman

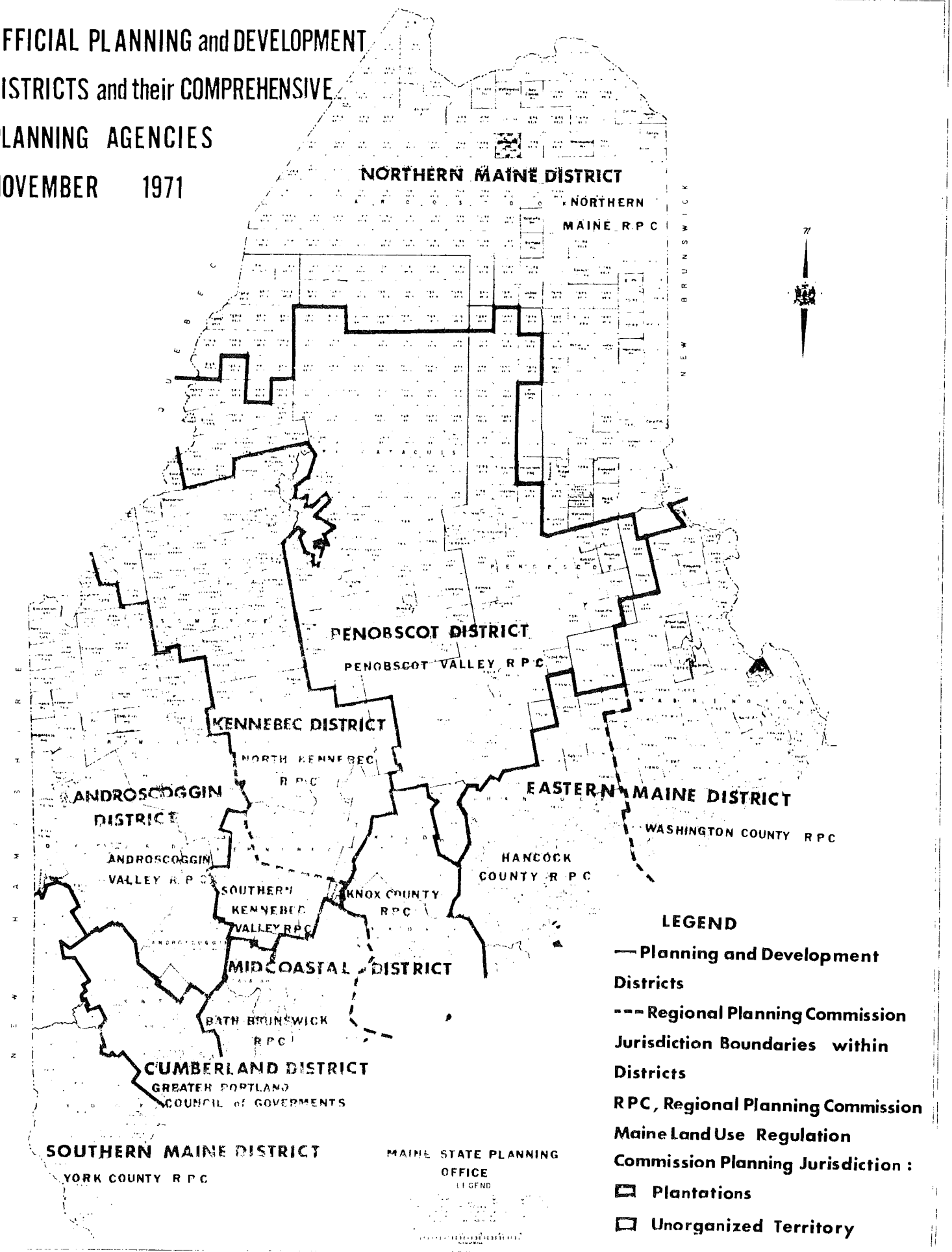
YORK COUNTY REGIONAL PLANNING COMMISSION
Arthur T. Lougee, Executive Director
County Court House
Alfred, Maine 04002--Tel. 324-5780

Southern Maine District

Fred R. Lane
Chairman

The eight planning and development districts as now constituted are shown on the following map.

OFFICIAL PLANNING and DEVELOPMENT DISTRICTS and their COMPREHENSIVE PLANNING AGENCIES NOVEMBER 1971



LEGEND

—Planning and Development Districts

---Regional Planning Commission Jurisdiction Boundaries within Districts

RPC, Regional Planning Commission

Maine Land Use Regulation Commission Planning Jurisdiction :

- Plantations
- Unorganized Territory

2. Facilities

For purposes of this part, facilities are defined very narrowly to include only those residential facilities currently in operation that offer not only food and shelter but also focus primarily on the needs of alcoholics. They are described here in their chronological sequence of establishment, and will be referred to again in the regional descriptions of facilities, services and needs.

Bangor Halfway House

Incorporated with its own board of directors in 1965, this facility at 98 Cumberland Street in Bangor took in its first seven resident clients on October 30, 1968, soon after receiving a VRA grant of $37,000. This three-year Federal operating grant was supplemented by a required $4,200 in local matching funds.

Accomodations are for 15 men, and for some months now the House has been operating at full capacity. Prior to that, the client count had been down to as few as 3 or 4, particularly after the Counseling Center opened its Alcohol Rehabilitation Center at about the same time the three-year grant period expired in October, 1971. The facility then experienced a financial crisis, but due to community fund raising efforts, personnel service contributions from both the Community Mental Health Center (The Counseling Center) and the Division of Alcoholism Services, weekly maintenance paid by the Division of Vocational Rehabilitation for its own clients, and room and board charges based on weekly earnings, paid by the working residents, the House has been able to remain solvent.

Serenity House

The Serenity House, now located at 30 Mellen Street, Portland, began its community organizing activity in 1967. Following its incorporation as a private, non-profit organization, its board of directors launched a fund-raising drive in June 1968 to raise $15,500, or the 15% required in local effort to qualify for a requested VRA grant of $46,000. This drive was successful, and the live-in facility with accomodations for 15 men opened at its original location at 127 Spring Street, the building now occupied by the 24-Hour Club.

Since moving into the larger building on Mellen Street, it has a present capacity of 30 clients, of which less than one-third are females. The staff consists of a director, assistant director, secretary and chef on a full time basis. A psychiatrist, psychologist, and a social worker are employed as part-time consultants. Residents are requested to stay a minimum of 90 days, during which time a program of testing and evaluation, individual and group therapy, and occupational counseling and assistance are provided. Residents are expected to pay all or part of their board and room on a pro-rated basis, if employed. Normally about 12 of the individuals in residence are Vocational Rehabilitation clients.

Milestone Foundation

Incorporated in July, 1968, this facility at Old Orchard Beach has living accomodations for 32 men and women. Average census is 25, and most clients remain from ten days to two weeks. In 1971, 6,020 patient-days of residential care and treatment were provided. Services include those of a general practitioner who visits daily to attend to clients' physical problems. Thereare six other paid staff members, some of whom have been trained at Rutgers Center of Alcohol Studies in techniques of alcoholism counseling.

General recovery services, including education and instruction regarding the nature of alcoholism and means by which the individual can control it; individual and group therapy; as well as family counseling, are component parts of the program.

AA cooperates with Milestone by holding weekly meetings, and pastoral counseling is also available.

Clients, many of whom have been able to retain their jobs and whose families are still intact, pay for resident services, and both outpatient and drop-in services are available.

The 24-Hour Club

Located in an old building at 127 Spring Street in downtown Portland, this relatively short-term facility has been incorporated since 1964. The only agency of its kind in the area with a 24-hour "hot line" and a cadre of crisis volunteers ready to serve countywide, it can accomodate 12 men, with a current average daily census of 7. Along with food and shelter, group and individual counseling and various supportive services are provided. There are rooms available on the first floor for 24-hour rap sessions, dining facilities, and drop-in counseling. AA participation is encouraged. Average length of stay in the facility is three to ten days. During the recovery period, families are welcomed and group work is available. The population served is for the most part the chronic alcoholic whose family and employment status has deteriorated. The staff consists of a director, cook, and three stewards. The stewards assist in a number of ways, such as providing transportation to or from hospitals. During January - November, 1971, the Club responded to the call for

help of 908 persons who made 6,836 visits to the Club. 491 persons remained overnight 1,375 times. Referrals of 60 cases were accepted from hospitals, and 36 persons were released from jail custody.

Salvation Army Social Service Center

Located at 88 Preble Street, this is the only Salvation Army Men's Social Service Center in Maine. It provides resident care, activity therapy, personal counseling, and leisure time activities for 48 unattached and homeless men, nearly all of whom are alcoholics. This facility has referral and other cooperative contacts with numerous agencies and facilities in the Portland area, including the Maine Medical Center for both acute emergency care and other forms of medical treatment; the Maine Medical Mental Health Center, and other agencies that can assist in the program of physical, mental, and spiritual regeneration.

The Social Service Center has become in many respects a long-term facility, and most of the present population have been in residence from one to two years.

Work therapy entails operating the fleet of trucks, salvaging or renovating the donated articles in the carpenter shop and other work rooms for sale in the Salvation Army operated stores.

The program has been inducive to a comparatively high recovery rate, and "old timers" assist the staff in establishing a therapeutic environment for the recovery of newcomers. An AA group on the premises has been temporarily discontinued, but the men are encouraged to attend other group meetings in the neighborhood. Other spiritual opportunities are offered through religious meetings, instructional classes and personal interviews.

Some statistics for the year 1971 are as follows:

Center occupancy	48
Percentage of occupancy	89.3%
Meals served	46,230
Lodgings given	15,644
Material assistance	2,479
Chapel services	87
Chapel attendances	3,510
Group activities attendances	5,455
Men released to outside employment	27
Trucks operated	7
Thrift stores	3
Turnover of men	244

3. Financial

Traditionally, legislative spending for alcoholism programs in Maine has been modest, to say the least. Evidence of this low priority dates back to the inception of these services, when the 96th Legislature abolished the State Liquor Research Commission and transferred responsibilities of this to the Department of Health and Welfare, an action that became effective in August, 1953. Significantly, the fiscal transaction that accompanied this transfer repealed Chapter 218 of the Private and Special Laws of 1951 which had authorized $25,000 appropriation to the Commission. Instead of transferring the unexpended balance of $24,300 to the Department along with the responsibility, a new Section was amended to the Private and Special Laws of 1953, lapsing this quite considerable sum back into the General Fund. An additional Section appropriated $9,000 from the General Fund to cover operating costs of the new alcoholism program for fiscal 1953-54, and an equal amount for fiscal 1954-55. The remaining $6,600 thus became working capital which could then be expended from the general fund for other uses.

The transfer of the program to the Department of Health and Welfare and the minimal appropriation that accompanied it did, though, permit the hiring of a full time alcoholism specialist, who worked alone in this capacity for the next two years.

Then in 1955 the appropriation to the Department of Health and Welfare for alcoholism services was increased to approximately $35,000 for the biennium and an additional person was hired.

Two years later the appropriation was again increased to approximately $70,000 for the biennium. This permitted the hiring of additional counselors, the same number as now, incidentally, and one technical-clerical position. It also extended the agency's geographical coverage by providing funds to increase the number of regional counseling offices from two to five.

At each of the past sessions of the Legislature, a supplemental Part II budget for Alcoholism Services has been submitted to the Appropriations Committee, along with the regular Part I budget for funds to maintain the Division's current level of operation. Each time the Part II budget requests for a moderate extension of services, and three additional positions to help implement them, have been denied.

One of the positions that has been requested repeatedly has been for a full time alcoholism counselor for Aroostook County, which has been without one for several years. Requested also have been an education consultant to be responsible for information and preventive programs directed at alcohol abusers as well as potential alcohol abusers, consultant to develop and implement programs in connection with industry and labor, and a court counselor for the Central Maine area.

Contractual services requested have included those in connection with an outpatient clinic in the Greater Portland area; a training seminar for physicians to be held in the Portland area, and scholarship grants to enable selected candidates to attend one-week training sessions at the New England School of Alcohol Studies at the University of New

Hampshire and the six-week training programs at the Rutgers Center of Alcohol Studies in New Brunswick, N.J.

Operating expenditures appropriated to the Division for each year of the 1968-1970 biennium were, for 1968-69, $71,507, and for 1969-70, $78,278. Operating costs for the first year of the current biennium were increased to $81,220, and $81,393 for the second, an increase of $173.

As noted earlier, however, the appropriation to the Division of Alcoholism Services represents only a portion of total expenditures for alcoholism programs in the State.

The Department of Mental Health and Corrections, especially through its Community Mental Health program and state hospitals spend considerable funds annually for services to alcoholics and their families. As noted in a previous chart, upwards of 1,200 patients with alcohol problems were treated at the Bureau of Mental Health's eight Community Mental Health Centers and Clinics during calendar year 1971. This does not include the wives, husbands, children , and other significant individuals who may or may not have been associates of the alcoholic patients but who also received counseling and related services.

More than 500 patients with primary diagnoses of chronic alcoholism in some form were admitted to the two state hospitals during fiscal 1970-71. In addition, it is certain that a large proportion of the Bureau of Corrections' current fiscal budget of $650,000 is expended for both direct and indirect client services to ex-offenders who have problems with alcohol. Each year one officer from the Division of Probation and Parole attends the six-weeks training

session at the Rutgers Center of Alcohol Studies in New Jersey. General psychological counseling at both the Mens and the Womens Correctional Centers, as well as at the State Prison at Thomaston is carried on by staff members who are trained and experienced in psychosocial problems related to alcohol abuse and alcoholism.

In summary, these direct and supportive services related to problems of alcohol use and abuse have claimed an increasingly larger share of the Department's total fiscal 1971-72 budget of $24,166,040, of which $10,813,966 is being expended for the state hospitals while $266,000 is being expended for community services. In addition to these expenditures, the department has shown its commitment to community mental health services by using an additional $101,100 in 314D funds and $523,794 from the Mental Health Improvement Fund (MHIF) to improve community services.

Federal support for community mental health services in Maine totalled nearly $1,600,000 in fiscal 1971. Of this, $1,382,015 was awarded for staffing grants and $217,923 for construction grants. The largest single Community Mental Health Center staffing by NIMH for a comprehensive alcoholism program in theState of Maine was made in that year in the amount of $360,514 to The Counseling Center in Bangor.

Involvement of the Bureau of Rehabilitation in treatment and restorative services for alcoholics has been described. An analysis, however, of expenditures by other Bureaus within the Department of Health and Welfare would reflect proportionate amounts expended for the families of persons whose problems include excessive or pathological drinking behavior. As an example, Aid to the Aged, Blind and Disabled rose from $9,110,000 in 1968 to $12,308,900 in 1969 and rose again to $12,766,000 in 1970.

4. Personnel

Because of the present time limitation and particularly in the absence of any standardized or reliable system of case reporting, it would be extremely difficult if not impossible to obtain valid estimates of the numbers of persons even directly involved in the development and implementation of service delivery systems for problem drinkers and alcoholics,- together with family members and others in the State of Maine. For one thing, current role definitions and responsibilities at this stage reflect principally the great variability in adequacy and scope of current delivery systems. They provide only limited information about percentages of time spent by individuals in this particular activity.

On the one hand the State has a five-county geographic area of some 12,000 square miles, inhabited by some 209,000 persons and designated as Area II of the State Mental Health Plan, in which there is now a comprehensive community alcoholism services program that employs more than 60 professional and technical personnel. To the west of that region is a tri-county area of some 3,700 square miles, inhabited by 151,000 persons, where there are only two full time alcoholism workers, one of whom is a counselor for the Division of Alcoholism Services, and the other a full time alcoholism counselor employed by one of the community mental health area clinics.

Again to the north is Aroostook County, a land mass of 6,500 square miles and 106,000 people, where there are no full time professional alcoholism personnel at the present time, although considerable interdisciplinary cooperation has been evidenced in the region's necessarily limited attempts to serve this handicapped group.

Considering the variety of disciplines involved in some way in delivering services to this segment of the population, under the sponsorship of a variety of governmental agencies as well as private, non-profit organizations, an assesment of actual "man hours" devoted to problems of alcohol abuse and alcoholism and expressed in terms of "workers" will be a considerable undertaking. However, it will also be an essential one. This kind of analysis will be necessary to identify the kinds of services being provided, in which areas they are and are not available, how comprehensive or superficial they are at present, and what and where are the major areas of unmet need. It will also be of prime importance in defining roles and areas of responsibility as well as determining personnel needs regionally and statewide.

Much of this has already been done and has been made available to the present statewide study in the form of local and regional grant applications, community sponsored studies, and other printed materials developed prior to this current planning effort. Information pertaining to staffing needs, along with documented needs for specific kinds of facilities and services, have been abstracted from these documents and incorporated in the regional descriptions to be found in the following section of this report.

D. SURVEY OF NEED

1. Determining Extent of the Problem and Needs by Region

During the course of this planning a number of approaches have been utilized in arriving at a preliminary assessment of regional and statewide needs for alcohol abuse and alcoholism problems. These were seen to include needs for the continuance and development of existing programs, as well as the establishment of new programs where none now exist.

Many of the needs that have been identified are in some respects the problems that created them. They exist in varying degrees; as for example, among certain segments of the population which are recognized as more vulnerable than others.

The needs vary most noticeably by region. Not that it has been shown, at least not at this present stage of planning, that some localities have more numerous or more severe problems than do others. Only that some localities in Maine have taken the initiative to launch programs for the amelioration of alcohol and alcohol related problems, while others have not. Or at least not at this point in time.

Areas of need are therefore both geographic and generic. Among the latter are the universally expressed needs for new and/or expanded services and facilities; for new and/or additional personnel; and, most emphatically of all, for new and more adequate and more reliable funding mechanisms.

The methods used to obtain a consensus of universally expressed needs, as well as to identify and describe the particular needs of specific regions, were essentially these:

1. Review of programs in progress, especially as these are documented in written reports, including grant applications for continuance and/or expansion.

2. Review of planning studies, surveys, task force reports, etc., containing proposals not yet initiated or funded but addressed either directly or indirectly to problems in which alcohol abuse or alcoholism were seen as contributing, or, in some instances, as precipitating factors. Documents such as Initiation and Development grant applications and similar requests for funding of programs having a specific or implied alcoholism component, were reviewed with particular interest.

3. Personal interviews and small group meetings with a number of community care givers who represented a cross section of disciplines and viewpoints. These key individuals provided valuable information concerning present and projected programs and needs.

4. First priority was given to a means of obtaining community involvement and early planning input. It was felt that here, at the local level, is where the most knowledgeable, realistic, and concerned participation in human services development and implementation takes place.

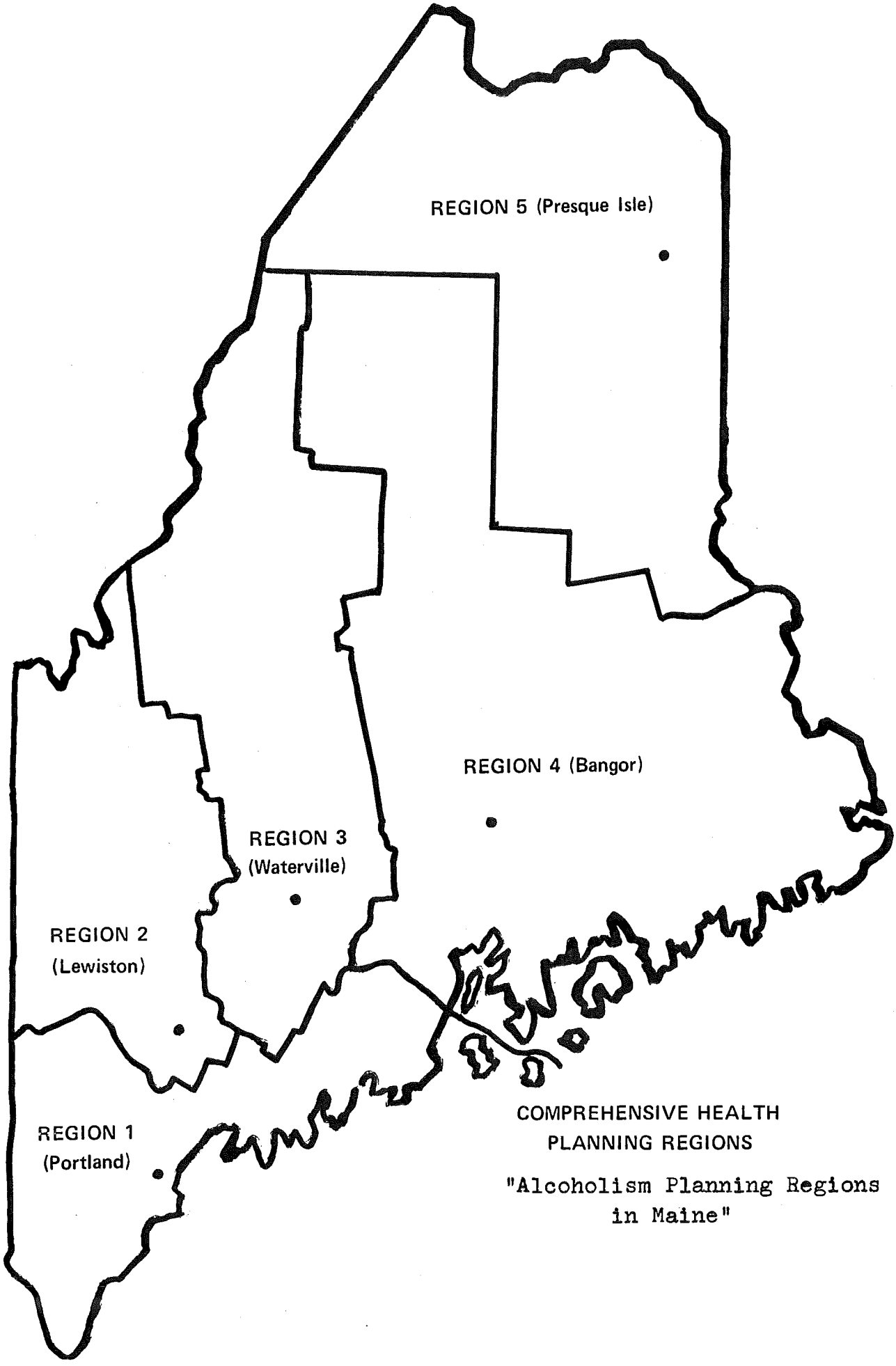
While the language of the Hughes Law and the guidelines for planning furnished by the National Institute of Alcohol Abuse and Alcoholism do not suggest exactly how the planning process must be conducted, whether emphasis should be on a statewide program regarded as a total entity, or on regional or even more local components, it is very clear and precise in its community emphasis. This is consistent with all state planning

in Maine for health and other services, and a framework for planning had already been developed both by the Comprehensive Health Planning Agency and the State Planning Office. For technical planning purposes we are using the approved State Planning scheme which delineates 8 districts.

As explained in an earlier section, it was decided at the outset that the Comprehensive Health Planning system, with its five major population areas, was the one most suitable for practical needs assessment in alcoholism and accordingly was adopted for this purpose.(see map on next page)

a) Regional Workshops

Within this framework, a series of five regional workshops were held during the month of March, 1972, in each of the key population centers of these regions. With one exception, when a severe blizzard made attendance impossible for almost everyone except those in the immediate neighborhood, each of the workshops was attended by upwards of 40 people. They included not only persons working directly in alcohol related fields, but also a variety of other community representatives and laymen. Among them were representatives of labor and industry; law enforcement and the court justice system: medical, paramedical, and mental health specialists; clergymen; educators; members of Alcoholics Anonymous recovering alcoholics with no particular identification with any organized treatment approach; members of Al-Anon and Al-teen; officials of State and private agencies, including elected office-holders; students; housewives; and other interested laymen.



COMPREHENSIVE HEALTH
PLANNING REGIONS

"Alcoholism Planning Regions
in Maine"

The revised schedule and dates of the regional Alcoholism Planning workshops were as follows:

Tri-County Alcoholism Control Planning Workshop (Region II)	Holy Family Church Sabattus St., Lewiston	Sat., March 18, 9:00 a.m.
Aroostook County (Region V)	Northeastland Hotel Presque Isle	Thurs., March 23, 8:30 a.m.
Penobscot and Eastern Maine (Region IV)	Baldacci's Restaurant Bangor	Fri., March 24, 8:30 a.m.
Kennebec Valley (Region III)	Silent Woman Waterville	Monday, March 27, 8:30 a.m.
Southern and Mid-Coastal Region (Region I)	Eastland Hotel Portland	Tuesday, March 28, 8:30 a.m.

Each session began with an explanation and general discussion of the Hughes Act provisions, particularly in regard to developing a State plan for comprehensive alcohol abuse and alcoholism services.* Attendees then chose which of four work groups they wished to take part in, making their decision on the basis of their particular interest or discipline. In these special interest groups, as well as in the general reporting and open discussion session that followed later in the day, each participant had an opportunity to express his or her own opinions and recommendations, and to project these within a group setting.

The four special interest or "work groups" at each regional workshop were:

1. Education, prevention, and early intervention,
2. Treatment functions of hospitals, mental health clinics, and other medical and paramedical personnel.

* See letter of invitation and workshop agenda in Appendix.

3. Rehabilitation functions of mental health clinics, private efforts, Alcoholism Services, other counseling services including local employment offices, employers and personnel managers, etc.

4. Management, administration, and planning for alcohol abuse and alcoholism programs, either directly or indirectly.

The current methodology for the State plan itself emerged primarily through these regional meetings, and the recommendations and priorities which, despite a considerable amount of variation in detail, were nonetheless characterized primarily by their commonality of concern, and an unmistakable consensus regarding which areas of need should be given most emphasis in the ongoing process of planning. These can be summarized as follows:

1. A formally structured regional system for ongoing planning, implementation, and evaluation.

2. Establishment of a comprehensive and coordinated alcoholism services program within each region to include at least these essential components:

    (a) 24-hour emergency treatment affiliated with or part of the medical service of a general hospital,

    (b) Inpatient treatment,

    (c) Intermediate treatment,

    (d) Outpatient services,

    (e) Vocational services,

    (f) Follow-up and aftercare treatment

3. A skillfully organized and implemented community education program to bring about urgently needed attitudinal changes on the part of virtually every element of society including taxpayers, service providers, community guardians, lawmakers and opinion moulders, families and associates of problem drinkers and alcoholics, and, by no means least, problem drinkers and alcoholics themselves.

A more detailed description of these general priorities, along with the more specific ones, will be found in section III of this report, the Action Plan.

2. DEMOGRAPHIC CONTEXT: REGIONAL PROFILES

In outlining services which deal with alcoholism in a particular area, it is impossible to make a sharp demarcation between those agencies that deal directly with the problem and those on the periphery that are effected by various consequences of alcohol abuse. This situation is an aspect of the ubiquitous effects of the problem on society as a whole, from the social dirnker involved in a traffic accident to the skid-row derelict. When the far-reaching effects of alcohol abuse are considered, as they must be, there are few organizations or professions that are not touched by the problem in some way.

In the following descriptions of regional characteristics and available services dealing with alcohol abuse and alcoholism we have had to be somewhat arbitrary in including some agencies and not mentioning others specifically. The reason is that these descriptions are intended to give some indication of the demographic differences which pertain among the different regions, and describe some of the unique local circumstances out of which a truly comprehensive service delivery system must necessarily evolve.

ALCOHOLISM PLANNING REGION I

Southern Maine Region

This region corresponds with Comprehensive Health Planning Region I and the State Planning and Development Districts for Southern Maine. (York County, Cumberland County and the Mid-Coastal area)* It encompasses the Rehabilitation Bureau's Region I (Cumberland and York Counties) and the southeastern portion of the Bureau's Region II, which corresponds to the Mid-Coastal area.

This planning region is quite diverse, both in its demographic and socioeconomic characteristics. For the sake of clarity, the following description of the region is comprised of three subsections:

1. York County, the southern most end of the State
2. The Portland-Cumberland County area, which also contains a small segment of Oxford County, and
3. The Mid-Coast area, which includes the northeastern corner of Cumberland County, all of Sagadahoc, Lincoln and Knox Counties, and most of Waldo County.

*See map

YORK COUNTY*

A. Descriptive Statistics

1. Demographic Data

Although in land area York County is the sixth smallest in the state, its 1970 population of 11,576 was the third highest. Also, its population growth between 1960-1970 of 12.2% topped that of any other county in Maine and was in marked contrast with Maine's overall increase of 2.4% for the period.**

The county contains two cities - Saco and Biddeford - and 26 towns covering an area of 989 square miles. Rural non-farm residents comprise 41.0% of all inhabitants. The Maine Turnpike enters the state at Kittery. The area is most heavily populated in summer, when tourists flock to the coastal communities for antiques, art, summer theatre and aquatic recreation.

Persons of French-Canadian descent comprise the major cultural group, and the Catholic faith is the one most strongly represented. Bilingual residents are estimated at about 80 percent for Biddeford and 60 percent for Sanford.

Persons aged 65 years and over comprise 25.4% of the county's total population, compared with 27.4% for the State as a whole.

*Adapted by permission from an alcoholism grant application submitted by the York County Community Counseling Service, under Section 246 of P.L. 91-211, on February 16, 1972.

**Calculated by the Maine State Planning Office from 1970 census figures.

Median school years completed by York County residents 25 years and older was 12.1, which is identical with that for the State.

2. Socioeconomic Data

A large proportion of the work force are in manufacturing, with transportation equipment, leather, and textiles being the largest employers.

Median family income is $8,495 per year, which is somewhat higher than Maine's family median of $8,205, but much less than Cumberland County's $9,289.

The Biddeford-Saco area was formerly an important textile manufacturing center. In recent years, however, it has been seriously affected by the shifts of this industry to the South. Although this shift was especially felt during the 1940's and 1950's, the community has recovered somewhat. Currently, the major economic contributors are the Saco-Lowell Division of Maramount Corporation, and Pepperell Mills, a textile plant.

Until recently, the Portsmouth-Kittery Navy Yard has played a vital role in the region's economy--so much so that few attempts were made to broaden the area's industrial resources. With the declining importance of shipbuilding as a government-sponsored industrial activity, the industrial future of this area appears to be somewhat uncertain.

Sanford, as well as Saco-Biddeford, was affected badly by the shift of the textile industry to the South. However, it rallied its forces and now has a varied industrial complex of plastics and light industry.

B. Existing Resources

1. Services

York County Counseling Service

Following the approval of a mental health staffing grant to the Maine Medical Center three years ago, York County was designated a separate Mental Health Catchment area, and plans were developed for the York area to have a Center program of its own. These plans are nearing completion; York County Counseling Service, Inc., is now operating a clinic in a separate facility adjacent to Webber Hospital in Biddeford, with branches in Kittery and Sanford.

At present the clinic has working arrangements with local police, other jurisdictional and social agencies concerned with problems of alcoholism, and with local A.A. members who serve as referral sources and provide supportive services.

At this writing, York County Counseling Service has just received the first allottment of NIMH staffing funds for development of comprehensive community mental health services. In addition, York County Counseling Service has pending a grant application to NIAAA for staff personnel to handle the treatment phase of the York County Alcohol Safety Action Program (ASAP).This proposal provides for a staff of 9 professionals to deal with alcoholism and related problems. The staff would function as a regular part of York County Counseling Center's mental health services, but would carry a priority commitment for treating persons referred from ASAP.

Alcohol Safety Action Program

During the past initial three months of operation the ASAP program in York County has been run as an extension of the Cumberland County ASAP program. (See description in following subsection)

Police officers from York County have been included in the ASAP training program and a few individuals now receiving counseling services are from this area.

Development of a local ASAP unit in York County is primarily contingent upon implementation of treatment services through York County Counseling Center.

Diocesan Bureau of Human Relations Services

The Diocesan Bureau of Human Relations Services in Biddeford offers counseling and assistance to individuals and families in problem situations. The two principal components of existing services are a counseling unit for individual and family problems and a homemaker assistance program for disrupted families. Present staff includes one director, 2 caseworkers, 12 homemakers who directly assist troubled families, and one mental health aide. The Diocesan Human Relations Bureau coordinates services closely with York County Counseling Services. The Human Relations Bureau will staff two programs as part of the Mental Health Center's comprehensive community services.

1. A community outreach program which will focus particularly on identification and delivery of services to underpriviledged families.
2. A consultation and education assistance program for community service groups such as police and teachers.

The latter program should be a particularly effective vehicle for disseminating information on alcoholism and how these service groups can relate to the problem.

Division of Alcoholism Services

Alcoholism counselors from this State agency serve the York County area from a Portland office. For a description of services offered, refer to Portland-Cumberland County subsection.

2. Facilities

	General Hospitals	
Biddeford	Webber Hospital Association	(202 beds)
Kittery	Tri-County Hospital	(40 beds)
Sanford	Henrietta D. Goodall Hospital	(82 beds)
York	York Community Hospital	(39 beds)

Private physicians can admit their patients with alcohol problems to these hospitals at their discretion.

Milestone Foundation in Old Orchard Beach is an intermediate care residential facility, drawing clients from throughout the State as well as the immediate area. For a more detailed description of this facility refer to the section on Facilities under State Survey.

PORTLAND - CUMBERLAND COUNTY AREA

A. Descriptive Statistics*

1. Population Data

Cumberland County extends from Scarboro in the southwest to Brunswick in the northeast and to Bridgton in the northwest. The distance from Scarboro to Brunswick (the easterly border of the County along the coast) is approximately 40 miles. The distance inland from Portland to Bridgton (the northwestern border) is 45 miles.

*Adapted from the narrative section of a Demonstration Grant application submitted to the National Institute of Alcohol Abuse and Alcoholism by the Bureau of Human Relations, Inc., Portland. The grant request is for a three-year pilot project, proposed for September 1, 1972 through October 31, 1975, which was submitted to NIAAA for its consideration on January 31, 1972. The project would provide comprehensive services for problem drinking drivers in conjunction with Cumberland County's Alcohol Safety Action Program.

The northwestern end of this area includes a small section of Oxford County which in turn is adjacent to the New Hampshire border. Although it is geographically within Cumberland County, Brunswick is included in the next area subsection called the Mid-Coast Area.

The population of Cumberland County in 1960 was 182,800 and increased in 1970 to 192,528. The City of Portland decreased in population in the same period, but the adjacent municipalities increased: Gorham, Scarboro, Cape Elizabeth, Falmouth, Yarmouth, and Freeport.

Public transportation is available by bus from north to south; but is less available as you travel west. The area to be described includes the heaviest concentration of the population of the State and has the greatest potential for economic growth. There are two major population groupings in this area: the Greater Portland area and the Bridgton-Fryeburg area.

The Greater Portland area is also the largest of Maine's two Standard Metropolitan Statistical Areas. (The other is Lewiston-Auburn.) Although this Metropolitan area reflects the State's highest income per capita and per household, according to 1970 census data, it also has the highest concentration in numbers of people who are below the poverty level.

Similarly, while the area's median of school years completed is 11.9, well above the State level, it also has the largest number of school dropouts.

The Greater Portland area is the most densely populated in the State. It has the largest shopping center north of Boston and additional major ones distributed throughout the County. It offers essential services to most of Cumberland County, the northern part of York County, and the southern part of Oxford County. It is a major seaport serving primarily ocean tankers which discharge large

quantities of crude oil to the Portland Pipeline Corporation, a major supplier of crude oil to eastern Canada.

2. Socioeconomic Data

A substantial portionof the population earns its living from fishing and the processing of sea products. Recently there has been an expansion of industry with major national firms establishing themselves in the area. Both Sylvania and Fairchild have developed semiconductor plants and the General Electric Corporation is conducting a major expansion program. The American Can Company has had a large plant as well as several steel fabricating organizations. The S.D. Warren Company is a major employer, and other processors of paper products are notable in the economy.

The Bridgton-Fryeburg area is primarily known for and dependent upon recreation, both summer and winter. The area has a large number of lakes, and its rolling hills are ideally suited for skiing. In addition, there is some light industry, as well as lumbering and agriculture. Much of this area supplies the Boston market with a variety of agricultural products.

Statistical data prepared by the U.S. Census Bureau show Cumberland County as having the highest divorce rate in the State: in 1969, there were 721 divorce and annulments for 1,949 marriages, a ratio of 37%. The Maine Department of Mental Health and Corrections has reported that in fiscal 1969 there were 333 admissions to the state hospitals, and that 213 teenagers and youths were committed to the juvenile institutions or placed on probation.

For some years now, Portland has been in the process of developing an extensive urban renewal program, with prime focus on the "inner city".

Approved and funded in November 1967, Portland's Model Cities project, the first to be funded in Maine (later followed by a second Model Cities in Lewiston), has succeeded in bringing about many social improvements in an area of the peninsula inhabited by some 15,000 generally low-income people.

Model Cities has addressed itself to a score of objectives and programs aimed at combatting the depressive effects of poverty and low income on individuals and families, improving and expanding preventive and rehabilitative social service, improving the physical and mental health of the West-End community, and reducing its incidence of crime and delinquency.

B. Existing Resources

Compared with other parts of the state, (with the exception of the Bangor-Brewer area, where the Counseling Center is already conducting a comprehensive alcoholism services program) the Southern Maine alcoholism planning region would seem to be quite well endowed with most of the components necessary for an effective and areawide prevention, treatment and rehabilitation service network.

1. Services

The Western Maine Counseling Service began operating in July 1969. It provides mental health services to 19 towns with a total population of over 16,000 people. WMCS is located in Bridgton, 45 miles from Portland. Staff consists of three full time counselors and a psychiatrist hired for two days a week. The range of services

includes evaluations, counseling, and psychotherapy with individuals, couples, and families. Mental health consultations are available to school, clergy, law enforcement officers, and other agencies.

Maine Medical Center Mental Health Center

A full range of routine and specialized health care services are available in Portland at the Maine Medical Center which houses the Mental Health Center. This is a comprehensive Community Mental Health Center with NIMH funds for staffing and construction. Services include psychiatric evaluation, medication, therapeutic counseling for clients and their families, and involvement in the partial hospitalization program when the primary problem is psychiatric. In addition, a psychiatric internship program at the Center provides an extra resource of skilled professionals.

The direct working relationship between mental health and general medical services at Maine Medical Center allows for flexibility in treating patients with alcohol related problems. Emergency inpatient care may be handled in either a medical or psychiatric ward, depending upon the individual's condition.

At the other end of the treatment spectrum, Maine Medical engages a vocational rehabilitation counselor with responsibilities for liaison and referral and follow-up of cases as well as direct counseling.

Maine Medical Center Mental Health Center is currently negotiating to assume responsibility of the Western Maine Counseling Service in Bridgton.

The Community Counseling Center

The Community Counseling Center is an independent non-profit social casework agency located in Portland, serving the Greater Portland area. There are ten professional (MSW) staff members who counsel those who come to the Center in individual, marital, family, or group modalities. Recently a merger was accomplished with the Traveler's Aid Bureau and the Unmarried Parents Service.

Division of Alcoholism Services

The two full time Alcoholism Counselors who serve Portland and the Southern Maine area maintain a close working relationship with other area agencies concerned with problems relating to alcoholism, particularly the Community Counseling Center. In addition to direct counseling services, duties include interagency referral contacts and court counseling for alcohol related offenses.

Southern Maine Comprehensive Health Planning Agency

This agency, located in Portland, includes all of Alcoholism Planning Region I in its catchment area.

Within the past year, SMCH commissioned a study on alcoholism services in Southern Maine.* The study was a survey of existing resources with some recommendations for service development. This agency has recently taken the initiative in the formation of a Southern Maine Coordinating Council for alcoholism services.

The Diocesan Bureau of Human Relations Services, Portland office, runs a number of community service projects in the Greater Portland and Cumberland County area. Among these are a troubled families homemaker service and a community outreach program coupled with an

* "Alcoholism in Southern Maine", 1971. A study by N.C.A.

information and referral service. These community based programs are of particular note in relating to persons and families with alcohol problems. The Homemaker Program is the largest in the state with a staff of 36.

The Portland office of the Bureau of Human Relations has developed a grant proposal to NIMH-NIAAA to provide comprehensive services for alcoholics in conjunction with the Alcohol Safety Action Program in Cumberland County. This proposal is a reflection on a local level of an agreement between the Federal Department of Transportation and the Department of Health, Education, and Welfare whereby H.E.W., through its institutes of mental health and alcoholism, would provide funding for the treatment component of Alcohol Safety Action Programs. As mentioned above, this grant proposal is intended to be comprehensive, providing for interagency coordination and liaison. In some instances direct staffing assistance for other agencies will be provided. The program will utilize existing local facilities for treatment as much as possible. The administrative and counseling staff of the proposed project will be composed of 12 professionals and para-professionals.

The Alcohol Safety Action Program for Cumberland County has been operating in its initial phase since February, 1972. This first phase of the program has focused on initiating a training program in alcoholism countermeasures for 25 police officers in Southern Maine. Although this phase is primarily concerned with law enforcement as related to traffic alcohol offenses there has been an initiative to assist in the treatment of alcohol offenders following court action. At present two ASAP court counselors are working within the judicial system, plus conducting counseling sessions for 15 clients now inthe treatment phase of the program. The treatment component of ASAP in

the Cumberland County area cannot be fully implemented until more personnel are added through the staffing proposal submitted by the Diocesan Bureau of Human Relations Services.

There is a provision for ongoing evaluation of both the Cumberland and York County ASAP programs over a three year period. This evaluation project is being conducted by Social Systems Research Inc. of Bangor.

2. Facilities

Medical Facilities
Portland - Cumberland County Area

Portland	-	Maine Medical Center	(565 Beds)
Portland	-	Mercy Hospital	(180 Beds)
Portland	-	Portland City Hospital	(162 Beds)
Bridgton	-	Northern Cumberland Memorial Hospital	(34 Beds)
Westbrook	-	Community Hospital	(30 Beds)

Within the past year, Mercy Hospital has conducted a training program for hospital professionals and para-professionals to increase knowledge of alcoholism control and treatment.

Westbrook Community Hospital has an emergency treatment program with a special follow-up component for alcoholics who are still in a viable position in the community.

At Maine Medical Center, emergency care fits in with treatment services for alcoholics offered through the Maine Medical Center Mental Health Center. (See description of Mental Health Center in this section.)

Portland has two intermediate care facilities for alcoholics--Serenity House and the 24 Hour Club. In addition, it has the only Salvation Army Social Service Center in Maine. These live-in facilities are described under the State Survey section of this report.

MID-COASTAL AREA

A. Descriptive Statistics

The Mid-Coastal Area is treated here as a subsection comprising the eastern half of Alcoholism Planning Region I. It extends from Brunswick which is 26 miles from Portland northeast to Belfast, located on Penobscot Bay 35 miles south of Bangor. The area is essentially the same as the Mid-Coastal District for State Planning and Development. It incorporates the Bath-Brunswick and Mid-Coastal catchment areas (Areas 7 and 8) for Community Mental Health Services. The Mid-Coastal Area which is described in the following account includes a small piece of Cumberland County, all of Sagadahoc, Lincoln and Knox Counties and most of Waldo County, excepting a quadrant that lies near Bangor.

1. Demographic Data

Viewing the State as a whole, the Mid-Coastal Area is indeed in the center of Maine's long coastline. It divides the thickly settled and commercialized southern beaches from the more isolated stretches of the coast in Hancock and Washington Counties.

The population of this Mid-Coastal Area is approximately 113,000.

There are three centers of population concentration: Bath, Brunswick and Topsham - 31,732; Rockland, Thomaston, Rockport and Camden - 17,333; and Belfast - 5,957. Offshore islands in the area have a permanent population of 2,134. The remaining residents in the area are spread quite evenly between inland rural communities and small coastal towns, During the summer months, particularly July and August, many of the coastal and island communities experience an influx of tourists and summer residents that multiplies their population twice to several fold.

The population of the Mid-Coastal Area is primarily white and Protestant. The French-speaking population makes up only 2% of the total, which is the lowest percentage for any area in the state. Most of the small non-white resident population is composed of servicemen and their families at the Brunswick Naval Air Station.

Median school years completed in the entire area is 12.2, compared to a statewide median of 12.1. This figure does not reflect the fact that opportunities for continuing education within the area are extremely limited. Bowdoin College in Brunswick is a liberal arts school with a long tradition, but it is not the type of institution that can be expected to include a proportionately larger enrollment from its immediate area. In Knox and Waldo counties the University of Maine offers some extension courses at local high schools.

2. Socioeconomic Factors

The economic picture of the Mid-Coastal Area can be broken down into four basic components:

1. Manufacturing industry in and near the three sections of population concentration mentioned previously.
2. Fishing, lobstering, and summer tourism along the immediate coast.
3. Farming, dairying and poultry raising in inland rural areas, and
4. Commuter jobs in Portland, Augusta, Waterville, and Bangor.

Recently the Mid-Coastal Area has had two major economic setbacks. The Bath Iron Works, a shipyard which for some years has been Bath's principal employer, lost a bid for a lucrative defense contract to build destroyers. A more subtle but potentially damaging development has been the steady decrease in lobster catches over the past decade. Lobstering is a direct means of livelihood for many Mid-Coastal residents and is an important factor in maintaining the tourist trade.

Within the area, the percentages of families living below the poverty level are: Sagadahoc County, 10.8%; Lincoln County, 12.0%; Knox County, 11.3%; Waldo County, 12.1%; and 10.6% for the town of Brunswick in Cumberland County.

Although it is located in a geographically central portion of the state, the Mid-Coastal Area is off to the south of Maine's population and industrial corridor, which runs up from Portland to Lewiston, Augusta, Waterville, and Bangor, roughly paralleling Interstate Route 95. Consequently, area residents have had to travel to one of these

five urban areas for many specialized social and health care services.

B. Existing Resources

1. Services

The Bath-Brunswick Mental Health Clinic, located at the Bath Memorial Hospital, has a full time staff consisting of an executive director, and a counseling psychologist.

In addition, the Mental Health Center and its affiliate branches in the outlying Wiscasset-Boothbay-Damariscotta area, which is comprised of 14 communities, have the part-time services of three social workers, a psychiatric consultant, and a clinical psychologist.

During the past year, the Center has supplied treatment to 26 problem drinkers and alcoholics, 16 of which were subsequently admitted to the Augusta State Hospital. It is recognized, however, that deviant drinking behavior is a significant problem for many other patients who come tothe clinics for help.

Although it is usually not possible for the clinic to provide direct service to military personnel, the Bath-Brunswick Mental Health Association has noted the high incidence of problem drinking among the military stationed at the Brunswick Naval Air Station and has made overtures toward assisting in setting up an AA group at the base or developing some program of direct service through the clinic.

There had been a conspicuous lack of referrals from the courts and local law enforcement officials of persons with alcohol related offenses. Similarly, few contacts with the Alcoholism Services counselor for the Region or with Southern Maine Comprehensive Health Planning personnel.

The Mid-Coast Mental Health Clinic in Rockland offers individual counseling to area residents. Alcoholism is reported as a primary disability in at least 8% of cases seen, and is a related problem in a number of other cases. Psychiatric bed space will soon be available to the Clinic at Knox County Hospital in Rockland. This inpatient capability will give the Mental Health Clinic more flexibility in treating cases of alcoholism and alcohol abuse.

Close working relationships have been established between the clinic and the various Health and Welfare services in the area. Two persons on the staff of the Rockland Health and Welfare office work with the Mid-Coast Mental Health Clinic on referrals and interagency treatment programs.

On an individual case basis, the clinic has contacted local employers for job placement of clients with alcohol abuse problems. The Division of Vocational Rehabilitation has worked closely with the Mid-Coast Mental Health Clinic toward this end, although no special employee alcoholism program exists as such in the area.

The Mid-Coast Mental Health Clinic has developed a staffing grant application to NIMH. Funding would allow the clinic to expand into comprehensive mental health services.

Information and Referral

The Pine Tree Society for Crippled Children and Adults, Inc., also in Bath, provides service to all inquiries for information with concern for health and welfare problems and related services on a statewide basis.

State Health and Welfare Programs

The Department of Health and Welfare maintains district offices in Bath and Rockland which includes both a social service unit and income maintenance unit. Alcoholism, general vocational rehabilitation, eye care, and social worker services are offered through the Bureau of Rehabilitation, and come within the province of the Bureau's Region II rehabilitation team structure, which currently has its Region II headquarters in the Bangor Health and Welfare building.

Alcoholics Anonymous

Weekly AA meetings in the Knox and Waldo County area are held at Belfast, Rockland and Thomaston State Prison.

The Waldo County Social Action Committee, a Community Action Program based in Belfast, has recently become involved with the problems of alcohol abuse within Waldo and Knox counties. The program at present is aimed at identifying and contacting persons with alcohol problems within the community and offering consultation and referral services. Contacts are usually made through an outreach staff who serve on the agency's other Community Action projects and have a close working knowledge of area social problems. This program also concentrates on working with police, courts and parole counselors in the special problem area of the alcoholic offender.

Two overall goals are community acceptance of the problem of alcoholism and follow-up with job placement for the recovering alcoholic.

The Waldo County Social Action Committee is concerned with developing interagency coordination in the area and has scheduled a preliminary meeting to bring in various disciplines that deal with the problems of alcoholism.

2. Facilities

General Hospitals

Bath	- Bath Memorial Hospital	(96 beds)
Damariscotta	- Miles Memorial Hospital	(42 beds)
Rockland	- Knox County General Hospital	(89 beds)
Belfast	- Waldo County General Hospital	(60 beds)
Camden	- Community Hospital	(33 beds)

Knox County General Hospital and Camden Community Hospital are now affiliated in the Penobscot Bay Medical Center. The Medical Center will be building a new centralized facility in Rockport within one and a half to two years.

ALCOHOLISM PLANNING REGION II

Tri-County Region

The area and boundaries of this three county region are identical with those of the Androscoggin Valley State Planning District, and also of Comprehensive Health Planning District II.

A. Descriptive Statistics

1. Population Data

Situated in the southwestern part of the State, the Tri-County Region of Androscoggin, Franklin and Oxford Counties represents an area of 4,263 square miles (approximately 13% of Maine's total land mass of 30,920 square miles). It is bounded on the north by the Canadian province of Quebec, on the east and south by the Maine counties of Somerset, Kennebec, Sagadahoc and Cumberland, and on the west by New Hampshire.

Its combined 1970 population of 157,180 is about 16% of the State total. This represents a modest 5.2% increase over the 1960 census figures.

Within the region is one Standard Metropolitan Statistical Area which includes the cities of Lewiston-Auburn plus the satellite town of Lisbon. Together these communities had a 1970 population of 72,474 or nearly 50% of the people living in the entire region. They account for Androscoggin County's comparatively high population density of 192.6 per mile, second highest in the State and exceeded only by Cumberland County to the south.

While no significant percentage of racial minority groups reside within the region, there is an exceedingly high percentage of poor people who, indeed, constitute a significant minority group.

2. Socioeconomic Data

According to the Maine Office of Economic Opportunity, families with less than $3,000 annual income in 1970 were Androscoggin, 18.5%; Franklin, 19.6%; and Oxford, 19.6%. Each of these was considerably higher than the Maine average of 16.4%, which in turn was higher than all other New England states except Vermont.

The economy of the area has depended for many years on the textile, leather and wood products industries. This narrow economic base and the low wages traditionally paid by these industries have contributed to the unusually high ratio of women in the work force. The ratio of production workers in these manufacturing industries is 46% male to 54% female, while the national ratio is 62% male to 38% female.

The twin cities of Lewiston-Auburn, located in the southernmost part of the region on opposite banks of the Androscoggin River, serve as the region's major urban center and provide a number of significant regional functions. Overall the area is 120 miles north to south and 60 miles east to west. This dispersement of people, coupled with inadequate public transportation, represents a major barrier to the accessibility to adequate medical care as well as other important services.

In the early 1960's the region faced a serious threat when several of the major textile operations closed down, and again in the late 1960's when many of the shoe factories did likewise. Since then a number of new industries, including chemicals, rubber, plastics,

and food processing, have made their appearance and it is hoped that these will expand and serve to diversify the economic base. Outside the metropolitan area, a large paper processing plant in Franklin County has improved the economic picture. However, the development of highly mechanized processes in manufacturing have made drastic reductions in employment. For example, the large paper mill in Rumford, representing that town's only industrial mainstay, has automated so extensively that an alarmingly high unemployment rate has resulted and population has plummeted since 1960. Further evidence of this continuing decline is to be found in a comparison of revised estimates of non-agricultural employment in the Lewiston-Auburn Standard Metropolitan Statistical Area for 1970 and 1971. These annual summary tables show a decline in employment of 1,400 industrial and manufacturing workers during the 12-month period from December 1970 to December 1971, and an overall decline for both manufacturing and non-manufacturing of 1,000 workers.

B. Existing Resources

1. Services

The Tri-County Mental Health catchment area is identified geographically with the Tri-County Health Planning Region and the Tri-County Regional Planning and Development District.

Until recently, the Mental Health centers in this region, while devoting a large percent of their efforts to cases in which alcoholism is a prominent factor, have not been equipped to provide alcoholism counseling per se. However, in December 1971 the Franklin County Counseling Service, utilizing the Emergency Employment Act, employed a full time alcoholism counselor.

Construction of the building in Lewiston which now houses the regional planning staff as well as the clinic of Child and Family Mental Health Services, Inc., was begun in 1966 under a Community Mental Health Center construction grant, and was completed in 1967. A NIMH staffing grant was awarded in 1967 and the center became operational in November of that year.

Child and Family Services in Lewiston serves as the core agency for mental health services in the Tri-County Area. Although no specific alcoholism program exists at Child and Family Services at this time, several particular service components facilitate treatment of clients presenting alcoholism or alcohol related problems.

Child and Family Services staffs a psychiatric ward at St. Mary's hospital in Lewiston. Over the past year admissions for alcoholism as a primary or secondary problem have constituted 40 to 50% of the total. This in-patient psychiatric unit is presently designed for short term care and deals mainly with emergency treatment and any acute psychological symptoms that may be presented by the alcoholic patient. Following discharge, follow-up is provided through outpatient counseling at Child and Family Services.

Contact between Child and Family Services and the local police has been good. Alcholics apprehended intoxicated are usually brought either to the C.F.S. offices or direct to the psychiatric unit at St. Mary's in more severe cases.

Child and Family Services would like to expand into more comprehensive services for alcoholism including a system whereby the courts could refer certain alcoholic offenders to the Mental Health Center.

Child and Family Services maintains close contact with other agencies dealing with the problem of alcoholism. In particular, there is an ongoing consultation program with the Bureau of Social Welfare, Department of Health and Welfare. Initiative has been taken to include the Division of Vocational Rehabilitation in this consultation program. A counselor from Child and Family Services meets regularly with the Rural Community Action Ministry.

Health and WelfareServices - Division of Alcoholism Services

The Bureau of Social Welfare, and the Division of Vocational Rehabilitation maintain district offices in Lewiston. DVR has three counselors in this office who serve the Western Maine Tri-County Area. The Division of Alcoholism Services has one. Consultation linkage with Child and Family Mental Health Services should provide increased potential for identification and intake of recovering alcoholics needing vocational rehabilitation services.

Alcoholics Anonymous chapters meet regularly in Auburn, Farmington, Norway, Wilton, Rumford and Rangeley. Al-Anon groups in the Tri-County Area meet in Auburn, Farmington and Rumford. A number of AA and Al-Anon members serve on the newly formed Tri-County Alcoholism Control Council. It should be noted that they serve on this council as interested individuals and not as direct representatives of AA or Al-Anon.

The Rural Community Action Ministry, an interdenominational council of rural parishes, is concerned with various social problems within the eastern half ofthe Tri-County Region. Alcoholism is a significant factor in so many instances where ministers do counseling for family and individual troubles that Rural Community Action Ministry has placed particular emphasis on this problem.

Tri-County Alcoholism Control, Inc.

In February, 1972, this non-profit interdisciplinary committee incorporated to coordinate the activities of various agencies dealing with alcoholism and plan development of services in the region. T.A.C. is an independant organization but it is also intended to function as the alcoholism planning arm of the Tri-County Health Planning "B" Agency.

Some of the projected activities of T.A.C. relating to planning and development of services are:

--A survey utilizing questionnaires and personal interviews to elicit both objective and subjective information on alcoholism from a cross-section of the Tri-County community.

--Compiling a detailed profile of area needs for alcoholism services,

--Fostering coordination and involvement between professionals and lay groups that deal directly with or are interested in problems relating to alcoholism, and

--Optimal utilization of existing resources.

The Tri-County Health Planning Agency serves the Tri-County Region from a headquarters in Lewiston. This agency has been instrumental in the formation of Tri-County Alcoholism Control Inc. Affiliation of T.A.C. with Tri-County Health Planning Agency is intended to allow T.A.C., which represents both consumer and health care interests, extra flexibility in planning for and assisting in the development of alcoholism services. Tri-County Health Planning is now in the process of submitting a grant proposal for planning funds to NIMH-NIAAA on behalf of T.A.C.

2. Facilities

General Hospitals

Farmington	-	Franklin County Memorial Hospital	(50 beds)
Lewiston	-	Central Maine General Hospital	(269 beds)
		St. Mary's General Hospital	(233 beds)
Norway	-	Stephens Memorial Hospital	(41 beds)
Rumford	-	Rumford Community Hospital	(97 beds)

ALCOHOLISM PLANNING REGION III

Kennebec Valley Region

Comprised of two counties, Kennebec and Somerset, this Kennebec Valley Region is coterminous with the Kennebec State Planning and Development District and Comprehensive Health Planning's Region III.

A. DESCRIPTIVE STATISTICS

1. Population Data

With a population of 95,247, Kennebec County ranks fifth among the 16 counties. Somerset ranks eighth with a population of 40,597. Kennebec, in the southern part of the region, is largely urban, with population concentrations inthe Waterville-Fairfield-Winslow area (31,175), Augusta-Hallowell-Farmingdale area (27,182), and the Gardiner-Randolph compact (8,426).

Skowhegan, with a population of 7,601, is the largest community in Somerset County. It has one shopping center and a general hospital.

Of the 135,844 inhabitants of the two counties, 135,401 are whites, 75 are blacks, 134 Indians, 96 Orientals, and 94 representing other racial groups.

The following additional five outlying communities in the Mid-Coast area which orient toward the Kennebec Valley region for many social services, report the following (1970) populations:

Unity	-	1280
Palermo	-	645
Somerville Plantation	-	215
Whitefield	-	1131
Richmond	-	2168
TOTAL:		5439

The economic, educational, and social structure of these communities are compatible with the total catchment area. The towns are rural in nature, with the residents looking to Augusta and Waterville for employment, purchasing of major items, and health care. There are no major industries in these communities.

2. Socioeconomic Data

In Kennebec County, 13% of all families have incomes less than $3,000; in Somerset County, 18.4%. In the total catchment area, median family income, however, is $8,185, only slightly less than the state median of $8,205.

Rate of unemployment among the civilian population statewide for February 1972 was 8.8%. The regional breakdown on unemployment was 6.0% for Kennebec County and 14.9% for Somerset.

In Kennebec County the median school years completed is 12.2. In Somerset County the figure falls off to 11.6 years with the State figure put at 12.1.

There are five institutions of higher learning in Kennebec County: the University of Maine at Augusta, Colby and Thomas Colleges in Waterville, Unity College in Unity, and Gates Business School in Augusta. Preparatory schools include those at Kents Hill, Maine Central Institute, and Oak-Grove Classical Institute. The Maine School of Practical Nursing is in Waterville.

In Waterville the three major industrial employers are Scott Paper Co., Keyes Fibre Co., and C.F. Hathaway Shirt Company. Together they employ approximately 3,000 people. In Augusta the major employers are the Federal and State governments with 10,000 employees, and Bates Manufacturing Company, which employs 960 men and women. The area also relies extensively upon pulp and paper, textile and apparel, poultry processing and leather and shoe industries.

The northern half of the region is primarily woodlands and pulp and paper industries are prevalent. This area is considered not only of aesthetic value, but of economic importance to the State. The southern half of Somerset County is devoted to farming, dairy cattle, and light industry. The St. John, Penobscot and Kennebec Rivers flow through Somerset County, assuring ample water supply for industry, recreational facilities, and community needs.

B. EXISTING RESOURCES

1. Services

Kennebec Mental Health Center

Though it has no specially instituted alcoholism program as such, the Center now provides individual and family therapy in this area. Industrial and business referrals made by employers or employer representatives to the center are reported to be on the increase. Especially in the case of one large paper mill in the Waterville area, these referrals of problem drinking employees have become a matter of recognized operating procedure.

The Kennebec Mental Health Center has an excellent working relationship with the Division of Alcoholism Services Counselor for the Kennebec Valley Region whose office is in downtown Waterville. This relationship involves consultations on individual cases between the Alcoholism Counselor and members of the Mental Health Center staff and ajoint effort to deal with the client's problems. At the present time a new facility for the Kennebec Valley Mental Health Center* is under construction on a site adjacent to Thayer Hospital in Waterville. When this facility is operational, the Division of Alcoholism Services Counselor will have an office within the Center.

The Kennebec Mental Health Center has also been approved for an NIMH staffing grant and is now awaiting funding. When this grant is implemented, the Center will initiate and extend services throughout the region. Notable among new services will be community based outreach workers who should be able to play a significant role in identification and referral to the Center of persons troubled by alcoholism or alcohol related problems.

The Diocesan Bureau of Human Relations conducts several programs in the Kennebec Valley Region that bear upon individual and family problems related to Alcoholism and Alcohol Abuse. On-going programs include a homemaker service with a staff of 16 that assist families

*Note that reference is made here to Kennebec Mental Health Center and Kennebec Valley Mental Health Center. When this agency has implemented both building and staffing grants, it will officially be a Community Mental Health Center offering comprehensive services throughout the region. Hence the name change from Kennebec to Kennebec Valley.

where the mother is disabled or family life is seriously disrupted by a crisis situation. This program is an extension of general family counseling services offered through the Waterville office of the Bureau of Human Relations. In addition, this agency is about to extend services through two programs that coordinate closely with other regional agencies.

--A program involving the State Department of Health and Welfare, the State Department of Mental Health and Corrections, and the Kennebec Valley Mental Health Center entitled Comprehensive Aftercare and Preventive Services for Families Undergoing psycho-social Disruption. One target group in the program is 500 discharged patients from Augusta State Hospital living in the Kennebec Valley Region. Among this group of former patients is a sizeable percentage with alcohol abuse problems. This aftercare and follow-up service is projected to be implemented by July 1, 1972.

--The Diocesan Bureau of Human Relations will provide the staff and coordinate the Community Outreach Program of the Kennebec Valley Mental Health Center. This outreach program is a component of the Kennebec Valley Mental Health Center's approved staffing grant proposal to NIMH which is now awaiting funding (see description of Kennebec Valley Mental Health Center, this section).

Regional Health Agency - Upper Kennebec Valley

Until recently, this organization was not a designated Comprehensive Health Planning "B" agency. As a result, initiative in planning for alcoholism services, and some other areas of health care has not been possible. This agency has expressed an interest in including planning for alcoholism services within the scope of its new activities as a "B" agency, and in assisting coordination of alcoholism services in Region III.

Bureau of Rehabilitation

This regional alcoholism counselor functions as one of the Bureau of Rehabilitation's Region III team, under the supervision of a director stationed in Augusta. Closely allied in function therefore, is the general vocational counselor (Division of Vocational Rehabilitation). This worker's active caseload includes a number of individuals whose primary disability has been diagnosed as alcoholism, with its concommitant handicaps to personal and social functioning.

Alcoholics Anonymous meets in the following communities in Region III: Augusta, Gardiner, Fairfield, Skowhegan, Togus V.A., Waterville and Pittsfield. Meetings are held in Augusta and in the Waterville area three or more times a week. AA conducts weekly meetings at Togus V.A. Hospital and provides transportation so that Togus patients can attend meetings in nearby communities. There are Al-Anon family group meetings in Augusta, Waterville, Skowhegan, Pittsfield and Winslow.

The Maine Christian Civic League, with headquarters in Waterville, offers educational and informational material on alcohol and drug abuse to public schools and to organizations having an interest in these problems. For a number of years the League has been in support of legislation to direct a portion of state revenue from the sale of alcoholic

beverages into services that provide for the prevention and treatment of alcohol abuse and alcoholism.

2. Facilities

General Hospitals

Augusta --	Augusta General Hospital (183 beds)
Gardiner --	Gardiner General Hospital (52 beds)
Pittsfield --	Sebasticook Valley Hospital (33 beds)
Waterville --	Thayer Hospital (175 beds) Seton Hospital (150 beds) Waterville Osteopathic Hospital (78 beds)
Skowhegan --	Fairview-Reddington Hospital (85 beds)

The Togus U. S. Veterans Administration Hospital runs a Comprehensive Alcoholism Treatment Program. Elements of the program include:

1. Acute emergency care and inpatient treatment.

2. Individual and group psycho-therapy and counseling, Educational and informational presentations are included in this service element.

3. An array of rehabilitation services offering physical therapy, vocational evaluation and vocational counseling with assistance in job placement and phased adjustment to an independent status in the community.

4. A pilot project to bring in wives of hospitalized alcoholics for bi-weekly discussion groups.

5. A research component involving compilation of statistical data plus a special research project to test and evaluate the effectiveness of lithium carbonate for patients manifesting chronic alcoholism and depression.

All patients admitted to the Neuropsychiatric Section at Togus with a primary diagnosis of alcoholism or an alcohol-related problem are eligible for the program. Admissions to the program are by voluntary consent of the patient. If there are attendant medical problems the patient is first sent to the General Medical Section until his condition is stabilized. The program can accomodate 90 patients

in two special wards, plus a ten bed detoxification section.

The Togus V.A. Hospital is also in the process of developing a counseling program for any of its employees with alcohol problems. This program is being run in conjunction with the Division of Alcoholism Services. The first phase is a familiarization course for supervisors in the hospital, to lay a groundwork of trust and understanding.

Augusta State Hospital

The effect of the policy, adopted recently by the Department of Mental Health and Corrections, of not accepting as patients at the Augusta and Bangor Hospitals persons whose primary diagnosis is acute alcoholism per se, has been particularly felt in Region III, where the Augusta State Hospital is located.

In a larger sense this policy change is an aspect of the prevailing emphasis on community-based mental health services. Community-based services, whether they be inpatient or outpatient, are seen as a much more viable approach to treatment than hospitalization in a statewide institution.

In the past, Augusta State Hospital and its Bangor counterpart have been chronically overcrowded and understaffed, with the result that many patients received little more than custodial care. Consequently, it is hoped that expansion of local mental health resources will permit a more favorable patient-to-staff ratio, and that the quality and scope of treatment for hospitalized patients will markedly improve.

A recent restructuring of both physical facilities and patient services has entailed the "unitization" of the Augusta State Hospital

into geographic units corresponding to a broad configuration of mental health areas in the State. In this way the treatment teams in each unit who work with patients during their hospitalization are able to follow through and coordinate their efforts with those of staff members in the local mental health clinics who handle post-release care.

Through this greater utilization of mental health centers, the advantages of community-based patient services are expected to become much more apparent. Duration of inpatient hospitalization can be shortened, thus reducing the undesirable effects of prolonged institutionalization. The system is expected to result not only in more effective but economical programs. The Commissioner of Mental Health and Corrections has pointed out that whereas it costs about $6,000 annually to keep a patient in the Augusta State Hospital, community-based services through mental health centers can be provided for about 10% of that amount.

Fairfield Institute, Inc.

This 60 bed inpatient facility licensed as a private hospital by the Department of Health and Welfare in January 1972, was established for the express purpose of caring for persons in the acute stages of alcoholism. All admissions are voluntary or by physician referral. Length of stay, depending upon the patient's condition, varies in most cases from five days to two weeks. The Bureau's alcoholism rehabilitation counselor in Waterville is available to interview and counsel patients. In addition, the Institute works closely with local A.A. groups and encourages its patients to attend local meetings. The Institute has a medical staff of three attending and five consulting physicians. In addition to 24-hour medical coverage, there is an

attending physician either on the premises or immediately available each weekend. The Institute supplies 24-hour registered nursing service seven days a week. supplemented by a trained auxiliary staff including orderlies, aides, and volunteers.

Routine laboratory services are provided each patient by a registered technician upon admission, with specialized laboratory procedures available through agreements with local hospitals. Dental services are also available on the premises. Blue Cross/Blue Shield and private insurance companies recognize the Institute's rate structure for reimbursement purposes.

ALCOHOLISM PLANNING REGION IV

Eastern Maine Region

This planning region, comprised of Hancock, Washington, Penobscot, and Piscataquis Counties, is coterminous with the Eastern Maine Mental Health Area II. With the important exception of not including a part of Waldo County, it otherwise corresponds to Comprehensive Health Planning Region IV, and at least demographically, combines the Penobscot and Eastern Maine State Planning and Development Districts.

A. Descriptive Statistics

1. Population Data *

This land area of nearly 12,500 square miles, is the largest single planning region in the State. It is bounded on the north and east by Aroostook County and the Province of New Brunswick, on the south by the Atlantic Ocean, and on th West by Somerset, Kennebec, and Waldo Counties, and Penobscot Bay. The 1970 population was 206,127.**

The primary population concentration is in the Penobscot River Valley where 85,000 live near the Bangor area. There is a seasonal summer influx of nearly 77,000 persons for the entire region, where the normal population density is 16.6 persons per square mile. Over 80 percent of this permanent population lives in rural areas.

*For the most part, descriptive information in this section has been used by permission from two major sources: (1) the original Staffing Grant Application for a Comprehensive Community Alcholism Services Program developed by the Counseling Center in Bangor, June 1970, and (2) State of Maine Community Mental Health Center Survey, Planning and Program Development, Department of Mental Health and Corrections, Fiscal Year 1970, pp. 65-75.

** U.S. Census Bureau, General Population Characteristics of Maine, 1970, Table 34.

Population concentrations occur in the north and northwest around Millinocket and East Millinocket, 10,309; Lincoln, 4,759; Dover-Foxcroft, 4,178; and Milo, 2,572. In the south and southeast these population centers are around Ellsworth, 4,603; Bar Harbor, 3,716; Bucksport, 3,756; Machias, 2,441; Eastport, 1,989; Calais, 4,044; and Lubec, 1,949. In the south and southwest they are Newport, 2,260 and (actually in Waldo County but very close to Bangor) Winterport, 1,963. The region surrounding these pockets of population is a sparsely settled farm area of diminishing productivity, in combination with forest covered wilderness.

The population is predominantly white and Protestant, with these denominations comprising about 74 percent of the total. The remaining 26 percent of Catholic faith are for the most part of either French-Canadian or Irish descent. A significant minority are the 1,232 Maine Indians of the Penobscot and Passamaquoddy tribes. The 1970 census counted only 479 blacks.

2. Social-Economic Data

The economy depends primarily on pulp and paper manufacture, agriculture, and small industrial enterprises. Shoes, textiles, pottery, furniture and wood products are the leading manufactured products. A major though seasonal industry is tourism. Minimum wages tend to prevail in those areas not touched by the large paper manufacturing industries, and the entire region has been designated a 90 percent poverty area for Comprehensive Alcoholism Services planning by the U.S. Department of Health, Education and Welfare.

According to the 1970 census, Washington County had the highest percent of families with incomes below the poverty level than any other county in Maine. This percentage figure, along with those for the other three counties in the region, follows:*

Washington	-	19.0%
Hancock	-	12.0
Piscataquis	-	10.6
Penobscot	-	9.9

The Maine Employment Security Commission reports the annual averages for total unemployment for the same year (1970) as shown here:

Table I - Total Unemployment, Annual Average, 1970

Washington	-	11.8% of labor force, with a high of 16.8 in January and a low of 5.3 in September.
Hancock	-	6.7% with a high of 12.5 in February and a low of 1.6 in September.
Piscataquis	-	6.6% with a high of 12.5 in February and a low of 1.6 in September.
Penobscot	-	4.9% with a high of 5.4 in both March and May, and a low of 4.1 in January.

Along the coast, small boat manufacture is carried on by skilled craftsmen who receive low wages. Fishing for lobster, herring, mackeral and shrimp contributes to the economy. This entails hard work and long hours, often under dangerous conditions and with small financial return for the effort, investment, and risk.

In many ways the area is self-contained, with Bangor-Brewer serving as the commercial hub for distribution of goods and services to eastern and northern Maine. It is also the major center for financial,

*General Social and Economic Characteristics, 1970, U.S. Bureau of the Census, 1972.

medical, social welfare and educational programs and services. As the third largest city in Maine, Bangor with its population of 33,168 has a trading population of 360,000. The twin cities, Bangor and Brewer, have a combined population of 42,468. Within a 25 mile radius live 98,000 people, and within a 50 mile radius, 135,000.

During the 19th century and into the present one, Bangor established its supremacy as a world famous lumbering center. Although 40 miles from the ocean, it is on tidal waters of the Penobscot River, and coastal shipping comes into Bangor from the Atlantic Ocean.

Although 12 institutions of higher learning are situated within the region, only 6 percent of its present adult population over 25 years of age have had one to three years of college or other post-high school education. The area also has a high dropout rate from high school, with many students not entering high school after finishing the eighth grade.

B. Existing Resources

1. Services

The Counseling Center's Alcoholism Services Program*

In the past year and a half the cluster of services available to combat alcoholism and alcohol related problems in Region IV have increased several fold with the introduction of the Comprehensive Community Alcoholism Services Program by the Counseling Center. The Counseling

* The following description of this areawide comprehensive program's major elements has been adapted in part from the Counseling Center's second year continuation grant application.

Center had previously provided general mental health services for all sectors of Region IV, and with the implementation of this program moved into services adapted to the particular needs of clients with alcoholism and alcohol related problems. Although the program size and funding base of the Counseling Center alcoholism program exceeds the present assets and capabilities of all other agencies and services in the area, the prevailing climate has been one of coordination rather than domination, with the Counseling Center working jointly with other agencies.

By means of a NIMH staffing grant approved and funded in January 1971, the Counseling Center has developed and implemented the only Comprehensive Alcoholism Services Program in the State, and the only one in New England to be accredited by NIMH-NIAAA. It employs a staff of over 60 professional and technical personnel, and provides the following services:

Inpatient
Outpatient
24-Hour Emergency
Rehabilitation
Consultation and Education
Intermediate Care
Training
Research and Evaluation
Partial Hospitalization

(a) Inpatient Element

In its original application, the Counseling Center proposed to furnish inpatient services for alcoholics and problem drinkers in a "new specialized treatment program" which was to be established at the Bangor State Hospital. Arrangements for this detoxification and inpatient service element had been worked out with the Hospital's superintendent, and it was believed that the hospital would not only continue to be the major provider of inpatient services for alcoholics

in the acute phase, but would mobilize its resources to handle a larger number of such emergency admissions.

As it turned out, however, at about the same time the application grant was approved and funded, the administration at the hospital underwent a change, a new superintendent was appointed, and a new policy was adopted which denied further admission of non-psychotic, chronic or acutely ill alcoholics. As an alternative solution, arrangements were made to provide this acute inpatient service through the psychiatric inpatient facility at the Eastern Maine Medical Center in Bangor. To facilitate this, The Counseling Center revised its original staffing plan, and through a cooperative arrangement with EMMC, five additional full time physicians were employed during 1971 to staff the emergency room. In so doing, the attitude and treatment of alcoholics at the hospital not only improved, but it made EMMC the only hospital in the catchment area where a physician is on duty 24 hours a day.

From this emergency room a patient may be treated and sent home, admitted as a patient to a medical ward by his own physician, or admitted to the psychiatric unit at EMMC (C-3).

Chiefly through the public relations efforts of the Alcoholism Services specialists, The Counseling Center's Alcoholism Services Advisory Committee, State Alcoholism Services counselors, and a significant number of private citizens concerned about the problem of acute treatment for alcoholics, other general hospitals in the Bangor area, including St. Joseph's and the Bangor Osteopathic, have modified their admission policies accordingly.

In addition to these, the other general hospitals in Region IV provide emergency inpatient services if recommended by a staff physician,

though attitudes toward this particular issue, especially in regard to the uninsured and indigent patient, varies from one institution to another.

Approval of the Counseling Center's staffing grant made possible the hiring of 12 Alcoholism Service Specialists, who serve as a prime source of help to the alcoholic in gaining admission for inpatient care. He accompanies the patient to the hospital, assists in the admitting procedure by furnishing personal information about the patient, and establishes himself with the patient, the hospital staff and accompanying persons as a person to assist in the patient's care.

Once the patient has become stabilized, further treatment and rehabilitation plans are then initiated with him as his individual needs may require. This continuity of care is again provided by the Alcoholism Services Specialist who arranges with the patient for whatever follow up after inpatient treatment may be appropriate in his particular case. This may consist of outpatient counseling, or admittance to an intermediate care facility.

(b) Outpatient Services

The 12 alcoholism services specialists serve another important function, that of outpatient counselor. One of the basic goals of the Counseling Center has been the provision of counseling services within a 50 mile radius of all persons residing within the mental health catchment area. Consequently the satellite branches consist essentially of clinical teams, with an alcoholism specialist serving on each team. These specialists, while serving in their outpatient capacity, provide both group and family counseling, as well as individual counseling, for their clients. They serve also as client advocates, seeking job opportunities, working with police departments and the court system, with

community action agencies, and any others that may be a direct or indirect source of help to the client and his family.

(c) 24-Hour Emergency Service

The Counseling Center, since July 1969, has operated a 24-hour emergency phone service, but it was not until the comprehensive alcoholism program got underway and a much-publicized "Dial HELP" system was put into effect in February 1971 that it became the important entry point into the system that it is today. With phone linkages to the EMMC emergency unit and psychiatric unit, to area hospitals, the ARC, alcoholism services specialists, community representatives and other elements within the network, the worker on duty can receive an incoming call directly, on both a WATS line and local lines, and also on an extension from the Center switchboard. Again the alcohol specialist, on 24-hour duty, seven days a week, plays a key role. It is usually he or she that the volunteer worker summons to provide crisis intervention, and to intercede for the patient in the hospital emergency room.

(c) Intermediate Care and Rehabilitation

Alcohol Rehabilitation Center (ARC)

The ARC facility, located on the grounds of the Bangor State Hospital in a large one-story brick building formerly used for the treatment of tuberculosis patients, incorporated many of the therapy programs which were originally intended for the Counseling Center's inpatient element into an expanded intermediate care and rehabilitation element. These adaptations have been designed to strengthen the alcoholism services program by placing within one facility a continuous program from rehabilitative therapy to vocational rehabilitation.

Now that those who have taken initial responsibility for the treatment of the chronic or acutely ill alcoholic have some place to refer him, the ARC has greatly improved the chances of alcoholic admissions to area hospitals because these hospitals now know they will not be stuck with the patient. The State Hospital's position regarding emergency treatment for alcoholics in the acute phase had been reflected to the smaller hospitals, since each had expected to be inundated with alcoholics unable to pay for their treatment and nowhere to go once this treatment had been supplied.

The ARC has been a jointly sponsored activity of both the Counseling Center and the Bangor State Hospital. It is set off and apart from the main complex, and the building, all utilities, maintenance, supply of services, dietetics, etc., are contributed to the program by the hospital. As part of this cooperative working relationship, all patients admitted to the ARC are informally admitted to the hospital. Under such arrangements patients are free to leave the ARC at their own discretion.

Since the first week of July 1971, the ARC has operated at 90-100 percent of capacity (31 patients), and most of the time has several names on its waiting list. Its staff consists of a full time director, full time assistant director, one registered nurse, three licensed practical nurses, a vocational rehabilitation counselor, a social worker, two part-time alcoholic service specialists, one part-time psychiatrist, a receptionist, a full time Stanford Research Institute (SRI) research assistant, and six full time psychiatric aides. Additional staff include a part-time psychologist two days a week, a part-time pastoral counselor, and a complement of 5 to 15 volunteers and/or students.

An intensive therapeutic regimen is maintained, along with rehabilitation and vocational support, for a period of 90 days.*

(d) Industrial Prevention

Until recently the Counseling Center had been operating a residential facility in East Millinocket providing a three-week course of counseling and treatment for employed alcoholics.

Although results with the few drinkers participating in the program were encouraging, referral response from industry was lacking and the facility was closed for lack of clients. Emphasis has been shifted to establishing industrial consultation programs, and developing communication and understanding of the program in cooperation with union as well as management.

(e) Counseling and Education

The Counseling Center has conducted over two hundred sessions on alcohol abuse in schools, produced five T.V. programs on alcohol and six radio programs.

(f) Research and Education

The Counseling Center carries on a program aimed at the development of information systems for both management and evaluation of problems relating to alcoholism. Its data processing department has integrated the Stanford Research Institute ATC system with the already existing patient record system.

New programs now under way or under development at the Counseling Center:

1. An Industrial Alcohol Program for the Bangor area, aimed at intervening in the destructive alcoholism process. The program will

* See appendix for 1971 admission statistics, Alcohol Rehabilitation Center, reproduced from the Counseling Center's continuation grant application for alcoholism services.

hopefully be funded through the Bangor Youth Center.

2. To locate a day-treatment center within one hour's drive of everyone in the catchment area.

3. Conversion of Industrial Alcohol intermediate care center in East Millinocket to a Halfway House. The house will accommodate eight clients and a resident manager.

4. A funding proposal to assist Indians of Eastern Maine in developing alcoholism services within the tribal community.

5. Enlargement of the Community Representative Program. This program provides community-based outreach workers who can respond on the spot to crises and emergencies.

Bureau of Rehabilitation

As noted earlier, the Bureau of Rehabilitation maintains a regional office at 117 Broadway in Bangor, with each of the three Divisions represented by two workers. One of the two Alcoholism Rehabilitation Counselors, who functions also in the capacity of court representative, covers a geographic area that extends considerably beyond the two counties. The alcoholism counselor who is in charge of the Alcoholism Division's regional Counseling Center in the building also carries a caseload that includes persons in Penobscot and Piscataquis counties. However, he finds it necessary to devote the major portion of his time to work activities in the urban Bangor-Brewer area and its neighboring communities. Both these counselors coordinate many of their work activities with those of the area mental health center's Alcoholism Services staff. This Alcoholism Services component of the regional mental health center includes not only the personnel who work out of the Counseling Center in Bangor, but also those in the Center's branch offices at Ellsworth, Millinocket, Machias, Bar Harbor, Dover-Foxcroft, and Calais.

In regard to their affiliation with the Counseling Center's Alcohol Services Program, for example, the State Division's alcoholism counselors, perform these functions, among others:*

1. Conduct group and individual counseling at ARC,
2. Assist in the cooperative development of specific alcoholism programs for schools,
3. Provide the Center's Alcoholism Program with a movie projector to be used in the presentation of information about alcoholism to various groups,
4. Provide liaison between ARC and the Bangor Halfway House,
5. One counselor provides conjointive therapy with the Counseling Center's alcoholism therapists for individuals leaving the State correctional system and entering either the ARC or the Halfway House.
6. One counselor serves as a member of the Center's Alcoholism Services Committee.

The two State alcoholism counselors attached to the Bureau's Division of Alcoholism Services also contribute substantially to the program at the Bangor Halfway House, a private non-profit corporation with its own Board of Directors that has ties of affiliation with the Counseling Center. They also cooperate with a number of other community-based programs that are either directly involved or otherwise concerned with alcohol related problems.

At the present time one of the Vocational Rehabilitation Counselors in the Bangor Office has clients in his active caseload who are receiving intermediate care at both the ARC and the Bangor Halfway House. In

* Cf. "Alcohol Staffing Grant (Continuation)," The Counseling Center, submitted March 27, 1972, by Executive Director Richard T. Lamping to the National Institute of Mental Health.

addition to these, he has a number of other clients with alcohol related problems who do not require this domiciliary type of care, but who are receiving some other combination of diagnostic, restorative, vocational, and supportive services through the Division.

Alcholics Anonymous

Alcoholics Anonymous has chapters in a number of communities in Region IV and holds meetings several times weekly in the Bangor-Brewer Area, including a Sunday morning group at the Halfway House and Tuesday evening group at the Alcohol Rehabilitation Center. Other communities with active A.A. groups are Dexter, Mattawankeag, Machias, Dover-Foxcroft, Ellsworth, Millinocket, and Indian Island. There are Al-Anon groups in Bangor, Ellsworth and Millinocket.

Diocesan Bureau of Human Relations Services

This agency maintains a regional office in Bangor located within the Counseling Center's facility. The Bangor office runs an information and referral service for social problems which links up with the Counseling Center's I & R network. In Washington County the Bureau of Human Relations conducts a crisis intervention family homemaker service with a staff of 16.

2. Facilities

General Hospitals

Bar Harbor	-	Mt. Desert Island Hospital (93 beds)
Blue Hill	-	Blue Hill Memorial Hospital (23 beds)
Calais	-	Calais Regional Hospital (71 beds)
Castine	-	Castine Community Hospital (16 beds)
Dexter	-	Plummer Memorial Hospital (35 beds)
Dover-Foxcroft	-	Mayo Memorial Hospital (36 beds)
Eastport	-	Eastport Memorial Hospital (29 beds)
Ellsworth	-	Maine Coast Memorial Hospital (60 beds)
Lincoln	-	Workman Hospital (25 beds)
Machias	-	Down East Community Hospital (38 beds)
Millinocket	-	Millinocket Community Hospital (36 beds)
Milo	-	Milo Community Hospital (19 beds)

The above listed hospitals provide emergency alcoholism treatment in their respective localities. Admissions policies may vary from one to the other.

In addition four hospitals in the Bangor area provide detoxification. These are:

1. J. A. Taylor Osteopathic Hospital (98 beds)
2. St. Joseph's Hospital (130 beds)
3. Eastern Maine Medical Center (322 beds) runs a unit (C-3) that is an affiliate of the Counseling Center's Comprehensive Alcoholism Services Program.
4. Utterback Private Hospital is a 26 bed facility.

The Bangor Halfway House, a residential intermediate care facility, is described under Facilities in the State Survey section of this report.

Alcoholism Planning Region V (Aroostook County)

This land area is in all important respects coterminous with Comprehensive Health Planning Region V, Mental Health Area 1, and the Northern Maine State Planning District. It comprises approximately one half of the Bureau of Rehabilitation's Region IV, which also includes Penobscot and Piscataquis counties.

A. DESCRIPTIVE STATISTICS

1. Population Data

Northernmost of Maine counties, Aroostook's 6,453 square miles represents a land mass larger than the States of Connecticut and Rhode Island combined. Although on its $4\frac{1}{4}$ million acres of cleared land the inhabitants grow potatoes at the rate of a packed carload every ten minutes, day and night, from May to October, it is 80% forests, mountains, rivers and streams, and remains one of America's great wilderness areas. It is bounded on the north and northwest by the Canadian Province of Quebec, on the northwest and east by the Province of New Brunswick and on the south and southwest by the Maine counties of Washington, Penobscot, Piscataquis and Somerset.

Its population of 94,078, of which 7,881 are servicemen stationed at Loring Air Force Base in Limestone, is concentrated in the eastern section of the area along a line from south to north near the New Brunswick border. This is the great agricultural region in which there are about 1,400 square miles of cultivated fields. The remaining area of about 5,400 square miles is largely wilderness, dotted with lakes and streams, through which runs the newly-created Allagash Wilderness Waterway, flowing north to join the St. John River that forms the

United States-Canadian border. Within this tract are the limits of the Appalachian Mountain Range.

The area is 640 miles from New York City, 425 miles from Boston, 325 miles from Portland, and 160 miles from Bangor, Maine, the nearest metropolitan trading and banking center.

The principal communities in the area are Houlton, the county seat which is situated in the southern section, with a population of 8,111; in the east central area, Presque Isle, 11,452; Caribou, 10,419; Fort Fairfield, 4,859; and Limestone, the location of Loring Air Force Base, with a civilian and military population of 10,300. To the northeast lie the towns of Van Buren, 3,971; Madawaska, 5,585; and Fort Kent, 4,575.* There is no Standard Metropolitan Statistical Area within the region or within 150 miles of it.

The population density in the area is about half that of the State: 11.8 per square mile, as against 32.1 inhabitants per square mile for Maine. Of the people in the area, 49.4 percent live in urban areas (towns and places of 2,500 or more) and 50.6 percent in rural areas.**

* General Population Characteristics: Maine; U.S. Department of Commerce, Bureau of the Census, August 1971.

** Ibid, U. S. Census Bureau

During and after World War II, when several military installations were functioning there, Aroostook County's population showed a decided increase. This was then followed by an even larger decrease in the 1960's when all but one of these bases were closed. This 12,000 decrease in population is shown below:

TABLE I

Population of Aroostook County by Census Year.

1940	1950	1960	1970
94,436	96,090	106,064	94,078

Despite having the highest outmigration, Aroostook also has the highest birth rate in the state: 23.2 births per thousand population compared with the State's 19.9 (The large proportion of French-Canadian settlers have tended to have larger families than the other ethnic groups. Also, the young servicemen and their wives have contributed to the higher rate.)*

In 1970, the non-white population of Aroostook was 1,415, or 1.5 percent of the population. Many of these (760) were servicemen and their dependents stationed at Loring. The remainder is accounted for by the estimated 436 Maine Indians living throughout the County and 219 persons of other non-white races. There are no Indian reservations.**

* Fertility ratio for Loring Air Force Base and its environs is given in the Census report as 539 children under 5 years of age per 1,000 women 15 to 49 years, compared with the County's ratio of 414 and the overall State ratio of 376.

**U.S. Census Printout, 1970, Maine State Library, and General Population Characteristics: Maine, p. 86

Maine has one of the highest percentages of population over 65 in the nation, with 11.6 percent in this group: Aroostook has only 8.5 percent, the State's lowest.

The median age of 24.3 years (in 1970) is below state and national averages, a statistic accounted for in part by the Loring population.

2. Socioeconomic Data

(a) Unemployment

According to statistics of the Maine Employment Security Commission, unemployment is higher in Aroostook County than in any other county in the State. In July of 1971 Aroostook County, with a work force of 38,100, had 7,200 unemployed and an unemployment rate of 18.9 percent. For the same period the State of Maine, with a work force of 429,000 had 38,700 unemployed and an unemployment rate of 9.0 percent. Thus, Aroostook County's unemployment is more than twice that of the State as a whole.*

(b) Family Income

A study of Maine families in 1968 shows that of the 26,000 Aroostook County families in 1967, 5,642 (21.7 percent) had annual incomes of less than $3,000. Another 5,200 families (20 percent) had annual incomes of between $3,000 and $5,000. In other words, 41.7 percent of Aroostook County families in 1967 had annual incomes of $5,000 or less. Considering the median size of Aroostook families

*Demographic descriptions and the rationale for proposed services in this section have been adapted by permission from a staffing grant application for a comprehensive community alcoholism services program submitted in September, 1971, under the auspices of the Aroostook Mental Health Services, Inc., Fort Fairfield. This application for $345,056 in staffing funds has since been approved by NIMH but not yet funded.

(4.27 persons per household and the highest in the State) this puts an extremely high proportion of families in the poverty bracket. The usual definition of poverty is a family income of less than $3,000 per year. However, an income between $3,000 and $5,000 may be grossly inadequate for a family that is large or facing problems of health. This then is another reason why Aroostook families must make their income go further than most other families in Maine and the U.S. Maine had 3.34 persons per household and the United States 3.29.* When applied to median family income, this means that Aroostook County families had only $1,039 per household member while Maine had $1,459 and the United States $1,720 in 1960. In using the Poverty Area Primary Designation method for Mental Health Catchment Areas, the State Mental Health Authority concluded that Mental Health Area I, Aroostook County with 26.4 percent of its families having incomes less than $3,000, ranks number 1 on its Poverty List by regions. Poverty in Aroostook is exceeded only by that in Washington County, where 28 percent of all families are so designated.

As already noted, the economic base of Aroostook is largely centered in potato growing. This agricultural industry fluctuates widely from year to year, depending on the overall national economy and a complex of other factors, not least of which is the weather. Thus, it is never stable and it would appear that undue reliance has been placed on potatoes as the one staple crop. As prices fluctuate with supply and demand, the economic well-being of

* Ibid, (from Poverty in Maine, researched and prepared for the Maine Office of Economic Opportunity by ARCO, Inc., Augusta, Third Edition, 1968, pp. 21-132.)

the whole area fluctuates accordingly, with depressed conditions often occurring even when the rest of the country is experiencing prosperity. Attempts to alleviate these wrenching shifts in economic well-being have been made by introducing some diversification of commercial crops. Along with this, the development of larger, corporate-owned and/or supported farms selling produce at stable prices is attempting to steady the economy. As it stands at present, a good year for the farmer puts a fair amount of money into the region's economy, while a bad year has far-reaching and depressing economic effects. Thus banks often have to carry Aroostook farmers through a second and third season and make additional loans which cuts sharply into the supply of available money.

The economic problems of rural farm-based families, particularly in this potato growing area are further influenced by the fluctuations in personal income from farming. Despite greatly increased costs of living, costs of production, and other inflationary factors that have drastically reduced dollar value, Maine total cash farm income in millions of dollars was actually less in 1970 than it was ten years previously. Whereas crop income for the state was $92.8 million in 1960, it had declined to $92.3 million in 1970.

Despite these vagaries of "the potato game," this staple commodity is still the backbone of the economy and is also industrially vital to the county. The growth of potato processing plants has done much to stabilize the marketing of certain grades and increase domestic consumption.

Other attempts are also being made to strengthen the industrial aspects of the economy. Some Aroostook communities have had success

in attracting industries to industrial park developments. Presque Isle has converted a former Air Force Base to a "Skyway Industrial Park" now housing several important industries including Aroostook Shoe Company, Converse Rubber, International Paper, and Indian Head Plywood. Allied Houlton Footware Corporation has come to Houlton, and other emerging industries have provided employment to more than 3,000 men and women in the area.

Loring Air Force Base in Limestone, Maine, with a population of 10,300 servicemen and their dependents, contrubutes substantially to the regional economy.

The country is also beginning to take advantage of its unparalled opportunities for developing a major recreation industry. Aroostook claims one of the most beautiful parks in the nation, and its natural terrain and climate offers all the advantages of a Vacationland throughout the four seasons of the year. Ski slopes are being developed, and snowmobiling has become especially popular. Not only because of its unlimited potential for attracting outdoor recreation and sporting enthusiasts in search of unspoiled country, but also for the benefit of its own residents, this recreational development has both economic and social importance. Although some sports such as skiing and snowmobiling are comparatively expensive and therefore beyond the reach of many wage-earners in the county, in an area with as long and confining a winter as Aroostook, this aspect of expanding its wintertime recreation resources is of considerable importance.

B. Existing Resources

1. Services.

In its staffing grant application cited at the beginning of this section, the Aroostook Mental Health Center commented on its research findings that revealed great discrepancies between the survey it conducted of existing resources and its survey of need, in the following statement:

> 'Recognizing that poverty, economic fluctuations, and uncertainties, and the pressure of large families and lack of education place unusual demands upon individuals, it is apparent that high quality mental health services are needed in the area. Low income is usually accompanied by dropping out of school, and therefore, inadequate education, vocational skills not commensurate with abilities, unemployment and under-employment, substandard housing, food, clothing, medical and dental care, a low level of social and civic participation, lack of mobility and loss of motivation, hope, and incentive for oneself and one's family. When these things occur, all the emotional and mental health problems associated with feelings of worthlessness and inadequacy arise.'

As part of its survey, the Aroostook Mental Health Center reviewed both its inpatient and outpatient admissions to determine the percentage of services being provided to alcoholics. In the three month period April through June of 1971, 18 of 165 individuals admitted as outpatients were given a primary diagnosis of alcoholism. This represents 10.9 percent of the total admissions. The Center was therefore providing 345 hours per week of outpatient services. This 10.9% represents 37.6 hours per week of outpatient services related to alcoholics.

During a five month period from January through May of 1971, the inpatient service admitted 53 patients with a primary diagnosis of alcoholism out of a total of 195. This represents 27 percent of the admissions to that unit. Of the 360 hours per week of inpatient service, 27 percent represents 97.2 hours of service provided. The Center was

thus providing at the time of its grant application a total of approximately 134.8 hours of inpatient and outpatient services to alcoholics per week.

In preparing its application, the Center reflected its current volume of man-hours for maintaining this level of effort by showing that 7 of the 14 part-time positions requested in its staffing grant proposal, and 1 of the 28 full time positions, were "old services" now being performed. The one full time position (40 hours per week) is that of Psychiatric Aide. The Executive Director, Program Director, Budget Counselor, and two psychologists have been devoting at least half of their time to this work, and the Inpatient Social Worker devotes 8 hours per week for a combined total of 156 hours.

In addition, this Center, as well as the outpatient clinics in Houlton and Fort Kent are supplying numerous other direct and supportive health services to their clients.

Association of Aroostook Indians

The Association of Aroostook Indians has received an Alcoholism Grant of $25,000 from the Office of Economic Opportunity for the period of September 1, 1971 through August 31, 1972. The program was designed for the purpose of bringing Indian people in contact with quality services related to the problem of alcoholism. It represents an outreach program into the Indian community, staffed by Indians in the service of Indians.

Central Aroostook Action Program Alcoholism Services

Central Aroostook Action Program submitted a proposal for alcoholism services to provide counseling to alcoholics and to encourage

them to participate in AA efforts. The grant was funded for two years at $25,000 a year. When the grant was returned from O.E.O. it stipulated that counseling services should not be the main focus of the program. As a result of this grant, however, both the program director and assistant director have been enabled to attend and complete the six-weeks training course at the Rutgers School of Alcohol Studies, in New Jersey.

Under their direction, the CAAP Center functions primarily as an information and referral service. As such it has established highly effective working relationships with all of the human services agencies, not only in the Central Aroostook area, but in Northern and Southern Aroostook as well. Consequently, the staff has been making progress in coordinating services.

2. Facilities

The following general hospitals have entered into Agreements of Affiliation with Aroostook Mental Health Service to work together in providing services for the alcoholic, contingent upon funding of the NIMH-approved proposal for a Comprehensive Community Alcoholism Services Program in Aroostook County:

Community General Hospital, Fort Fairfield (a 65 bed facility)

Arthur R. Gould Memorial Hospital, Presque Isle (81 beds)

Van Buren Community Hospital, Van Buren (30 beds)

Peoples Benevolent Hospital, Fort Kent (70 beds)

Each of these area hospitals have agreed "to admit alcoholic patients for emergency medical care consistent with accepted medical

standards." Each has further agreed "to refer the patient to the Aroostook Mental Health Center at or near the time of admission." The Center on its part has agreed "to accept such referrals and respond by seeing the patient and assisting in the development and implementation of an appropriate post hospital plan." Exchange of information and records as needed is further agreed" between member-parties.

3. Special Needs of Specific Groups

A. Indians

Maine's Indian population is a distinct minority group with particular needs in service design. Maine Indians are the last group of native Americans in the northeastern part of this country who have retained a good measure of cultural distinctiveness and been able to resist homogenizing assimilation into the pervasive life style of predominantly European descendants. As with Indians in other parts of the country, this straddling of two cultures points up various social problems, particularly poverty and alcoholism. Alcoholism and alcohol abuse have a high incidence among Maine Indians, and form a reciprocal relationship with other problems besetting this group.

Indian life style is based on a different world view than that of European descended whites. An Indian's relation to his environment is one of integration, with a pronounced respect for natural order. In contrast, the prevailing world view in western civilization and among white Americans has been to dominate and "conquer" the environment. In this view man and nature are seen as distinct, unreconcilable entities. In many ways the "conquest" of nature has been carried ad absurdum, hence the current attention to ecology - a distinctly Indian trait. The transplanted American cultural tradition as a corollary to its concept of man and nature, stresses individualism, competitiveness and the attainment of success in a chosen field. The Indian sees no great merit in financial and material attainment for its own sake, and has often been characterized as "lazy" because of this. Possibly, if ecology becomes a functional part of this nation's cultural and economic life

rather than a public relations catchword, the Indian's problem of adjustment to the dominant culture will be lessened. Until such time, a goal in planning services for alcoholism and any other societal problems among the Indian population should be the delivery of social services through the Indian cultural structure.

Maine's statewide Indian population is approximately 2600. Of this population 75% live in Penobscot, Washington and Aroostook Counties which comprise the eastern and northern quadrants of the state. Within the sector are three reservations and three urban areas with a significant Indian population.

Washington County:

Pleasant Point Reservation and vicinity - 400

Indian Township Reservation and vicinity- 300

Penobscot County:

Indian Island Reservation and Old Town - 350

Bangor and vicinity - 150

Aroostook County:

Houlton and vicinity - 250

Caribou and vicinity - 250

The State Department of Indian Affairs has submitted a grant proposal for planning funds to NIMH to help create "an alcoholism program for Indians in Maine designed to fit the unique cultural and social parameters of Indian life." Both the Counseling Center in Bangor and Aroostook Mental Health Center have agreed to coordinate with this study and work with its research investigator.

On a regional basis The Counseling Center has sent a grant proposal to NIMH for development of an Indian Alcoholism Program within the eastern Maine region. This program calls for services that will be structured primarily within the tribal communities. Included is a provision for "mini halfway houses" run by Indian families and a treatment staff of four Indian Alcoholism Liaison personnel functioning under a Program Coordinator. Linkages with other general service components of the Counseling Center's Community Alcoholism Services Program will be utilized whenever they appear to be beneficial for the individual Indian client.

Development of effective indigenous Indian alcoholism services will require a large amount of input from and attention to local tribal councils as well as coordination between the agencies delivering services.

B. Troubled Employee Programs

Employed alcoholics and problem drinkers on the job constitute a group that offers a special challenge to various treatment resources in the state. Here, we can deal with persons manifesting alcohol problems who are not yet debilitated to the extent where a total rehabilitative effort is necessary. Also, among employed problem drinkers are those who may never develop chronic alcoholism symptoms, but will continue on in a difficult state of marginal adjustment. In this context, employee alcoholism programs are preventative as well as treatment oriented. The principal effort is to intervene in the destructive alcoholic process before such assets as job, family, friends and social standing are lost.

Alcoholism is, of course, a segment of an interrelated array of individual and social problems that may beset the work force in a given industry. As such, a comprehensive approach to employee alcoholism is achieved by treating this problem within the larger scope of a troubled employee's occupational health program. Within such a program however, specific services for alcoholics and alcohol abusers should be available.

Development of a troubled employee's program may proceed from several agencies offering coordinated services to the employer, or from a single agency that is capable of delivering a number of services. Following are some important elements of a troubled employee program that includes services for alcoholism and alcohol abuse:

1. Groundwork; where representatives from the service agency(ies), management and unions meet to define objectives.

2. Establishment of trust; workers must be sure that they are not being subjected to a "shake down".

3. Internal capacity for identification and referral of troubled employees; the cooperation and understanding of a foremen and supervisors is essential to insure the referral of employees for the program to operate. Particularly in the case of alcohol problems where an employee's job may be at stake, foremen are often loath to identify someone with such a problem.

4. Within the factory, business or organization group discussions on alcoholism and other employee problems can be encouraged to complement counseling services extended by the assisting outside agencies.

5. Recognition by insurance companies as third party payers of alcoholism as a treatable illness.

C. Educational and Preventative Programs for Youth

Educational and informational programs concerning alcohol use and abuse vary greatly from one school system to another throughout Maine. Many schools limit mention of the subject to a yearly assembly presentation on "Temperance Day", while others incorporate information and discussion of alcoholism as a part of the curriculum in health classes. Educational approaches vary not only in the method of presentation, but also in regard to the content and thrust of the information presented. Too often total abstinence is stressed as the only way of adjusting to the question of alcohol usage, while in fact our society "sells" alcohol consumption as an important social function. The disparity between what society actually accepts and encourages and the content of many school alcohol education presentations is so great as to render them virtually ineffective. The first step in developing educational programs is to insure that they reflect the prevailing attitudes in society at large.

There is a need for flexible curriculum guidelines in alcohol education that all schools in the state can utilize. Assembly presentations have some value, but emphasis needs to be laid on continuous exposure to the material in the classroom where opportunity for discussion and feedback from the students is possible. Following are some particular areas of attention in the development of such a curriculum.

1. Moral stigma against alcohol use should be avoided, and particularly the alcoholic should not be characterized as one who has "fallen into evil ways".

2. Recognizing that alcohol usage is condoned by the majority of society, preventative education should show how alcohol abuse

is a convenient but dangerous reaction to various problems that may confront a person during his lifetime. It should be stressed that susceptability to alcohol addiction and resultant alcohol dependence and addiction can be presented and pupils told where they can turn for help should they perceive such a pattern developing.

3. Alcohol abuse and alcoholism needs to be compared and related to other forms of drug abuse. Abuse of addictive drugs is currently a high visibility issue and offers a natural approach to the subject of alcoholism and alcohol abuse which is our number one drug abuse problem.

4. Attention should be paid to the child who is being adversly effected by a family situation involving an alcoholic parent. Outside agencies such as Alateen and the Community Mental Health Centers work in this area but involvement of the schools has been incidental. An alcoholism education curriculum can be designed to provide help for a student in such a situation by describing and promoting discussion on the effects of alcoholism on the family as a whole and telling the student where he can turn for further assistance.

The University of Maine should develop training programs on alcoholism for teachers who are responsible for health instruction in the schools. Most teachers prepared in the State have never been exposed to a unit on alcohol use and abuse. This is true at both elementary and secondary preparation levels. Instructional resources need to be pulled

together and made available to both teachers in preparation and those in the field. Summer workshops on alcoholism and alcohol abuse for teachers, administrators and public service workers would equip out school systems with educated personnel able to approach the subject on a more objective basis.

III. ACTION PLAN

A. PLAN

1. Recommendations Based Upon Survey of Need

Earlier in this study it was reported that the Division of Alcoholism Services, basing its estimate on the Efram and Keller figure which in turn is derived from the Jellinek formula, generally considers that 25,000 persons of drinking age in Maine are "alcoholics". The Division uses this term in reference to persons in the early, incipient stage of alcoholism and on through to the late, chronic-acute stage. Another estimate, suggested by the State Bureau of Mental Health, and derived from the formula: 993,663 total population times 5%, yields an estimate nearly twice that, or 50,000. Somewhere in the middle is the suggestion by the National Highway Traffic Safety Administration, that some 7% of any state's driving population are alcoholics. Applied to Maine, this would be approximately 28,000 men and women.

(1) Uniform Data Collection and Reporting System

One of the most evident needs to emerge from the survey was for some uniform system of reporting and recordkeeping that would permit the State and the regions to become much better informed concerning the numbers of persons they are currently providing services to; how many persons in each of the specific target groups - for example, problem drinking drivers; underage and hence "illegal" problem drinking youth; "closet drinkers", etc., they should be planning for; and also to be able to project these estimates for purposes of planning and financing needed programs. It is recommended, therefore, that:

The designated State agency should take the initiative in adopting and encouraging statewide use of a uniform system for keeping statistical information by public and private agencies, organizations, and institutions that already maintain records in some form as part of their standard operating procedure.

More specifically, it is recommended that the designated agency develop or adopt such a system which will utilize a common data base, in cooperation with other bureaus and divisions within the Department of Health and Welfare; with the Department of Mental Health and Corrections, and particularly that Department's Community Mental Health Services component; with the Secretary of State's Motor Vehicles Division which administers the Alcohol Safety Action Program; the Maine Hospital Association and all others as appropriate.

Law enforcement and medical psychological treatment data will be especially important information sources. In the case of the latter, such information should include numbers of persons treated, frequency of admission and readmission, and duration of treatment. Court records and hospital patient discharge summaries obviously contain this information. In their present form, however, neither of these sources provide a reliable index of alcohol related cases.

At the local and regional level, responsibility for such data collection and utilization should be assumed as a major function of each regional alcoholism planning and implementation unit.

2. Utilizing Existing Resources Through Comprehensive Community Programming

A prerequisite for a comprehensive community alcoholism services program is the mobilization of all existing resources, defined in the

broadest sense to include current services, facilities, professional and nonprofessional personnel, community support, and both actual and potential sources of funding. This is of particular importance in those regions of the State characterized by scarce, fragmented services, and undocumented community attitudes.

The major recommendation of this plan, therefore, and the one given the highest priority, is that:

The Division of Alcoholism Services shall administer the State plan through a system of regional planning organizations.

The primary charge of each of the regional planning bodies will be directed toward the examination and discovery of local needs as a basis for determining how resources can best be mobilized and allocated to meet those needs. Implicit in this charge will be the objectives of establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism.

It is evident that the extent of the problems must first be measured to determine the kinds and extent of resources available to meet them. There already exists in each of the regions--but in a widely varying distribution-- a number of institutions and agencies that are already providing or that have the potential to provide some aspect of a broad range of programs to these target populations. It then becomes essential to assess the capabilities of these existing resources in terms of the numerical incidence and special needs of the various groups which have been identified. It is expected that the regional planning organizations, once established, will address themselves to: (1) collecting and analyzing

data and research results, (2) evaluating current programs in light of this data, (3) implementing a regionwide education and information program, and (4) assuring adequate involvement of organized professional and lay groups in the development of a comprehensive program.

3. Planning and Implementing a Broad Range of Services

The components of a comprehensive service delivery program have already been cited; a major recommendation of this State plan, and also of top priority, is that:

> An areawide comprehensive alcoholism service system should be established and/or expanded in each of the alcoholism planning regions.

A model for the comprehensive service system recommended here is the one developed under the auspices of the Counseling Center in Bangor, which is the Comprehensive Mental Health Center for the Eastern Maine Mental Health Area (Area II). Its several components are geared to meeting needs by means of Prevention; Outreach and Referral; Treatment and Rehabilitation; and Aftercare.

It should be noted in this context that the proposed regional planning organizations will not ordinarily engage in the direct provision of services, although they will be incorporated bodies. They will pursue their objectives of promoting the development of comprehensive services through influencing other organized groups and agencies that do have operating responsibilities to adapt or modify their activities for the purpose of implementing this overall objective.

The goals toward which the regional alcoholism planning organizations will direct their activities, therefore, will be:

(1) Comprehensiveness (services having the capability to meet the differential problems of alcohol abuse and alcoholism)

(2) Community centeredness (services operating in and designed for local areas) and

(3) Coordination (so as to assure a sufficient array or continuum of services to meet various needs).

4. Meeting Local Needs

It is believed that the most effective method of meeting local needs is through the direct involvement of services providers and local citizens in the formation of these regional alcoholism planning organizations. It is recommended that:

Regional alcoholism planning organizations should develop their own area plans on an ongoing basis, with the full cooperation of those governmental or private agencies, organizations or institutions whose assistance they may wish to engage.

5. Meeting Needs of Specific Groups

Most problem drinkers and alcoholics, though they may not acknowledge their problem, are already in contact with one or more major helping agencies such as welfare agencies, general hospitals, mental hospitals, community mental health centers, or family service agencies. Provision of comprehensive services, therefore, involves much more than responding to the needs of self-identified alcoholics and obvious alcohol abusers. To be sure, this aspect of service is of prime importance. It is also these groups which, in the past have constituted almost the entire clientele of alcoholism service agencies. But at least of equal importance is the

intercepting and identifying of alcoholism problems among those individuals already known to community agencies for other problems. It is in this context that an operational system of uniform reporting will be most meaningful to helping agencies, and will provide the opportunities for offering therapeutic intervention to persons whose alcohol connected problems heretofore have gone unrecognized and untreated.

B. ACTIVITIES IDENTIFIED

1. Activities of the Designated Agency

(a) Maintain, as an ongoing activity, a continuing survey of need for the prevention and treatment of alcohol abuse and alcoholism, including a survey of the facilities needed to provide services for alcohol abuse and alcoholism and an ongoing plan for the development and distribution of such facilities and programs throughout the State,

(b) Provide for the administration of the plan through the system of regional planning organizations proposed in the foregoing recommendation,

(c) Provide such reports as may be required or requested by the Secretary of Health, Education, and Welfare through his designated authority, the National Institute of Alcohol Abuse and Alcoholism in the National Institute of Mental Health,

(d) Submit modifications and amplifications of this present State plan at any time upon request of the Institute, and at least annually,

(e) Provide assurances, as specified in Part VIII (Assurances) of this State plan,

(f) Make contracts and/or agreements necessary or incidental to the performance of its duties and the execution of its authority, in-

cluding contracts and/or agreements with public and private agencies, organizations, and individuals,

(g) Coordinate its Statewide administrative functions with the activities of the regional alcoholism planning organizations, and with all other State, local, or private agencies, organizations, or institutions concerned with alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs, and assist in the advancement of such programs,

(h) Act as the State clearinghouse for alcoholism education and training. As such, the agency will be responsible for designing innovative training materials for lay and professional workers in the field of alcoholism on a statewide basis. It will also be responsible for preparing and disseminating educational materials for the general public and potential service beneficiaries on the subject of alcohol abuse and alcoholism, describing what service resources are available in the State, and how these services may be obtained,

(i) Organize and sponsor training programs for all persons concerned with these problems, including both professionals and laymen,

(j) Design an overall evaluation system which can be used by the regional planning organizations in evaluating local programs. This effort should allow objective decision-making both with respect to existing programs and those programs which may be proposed,

(k) Sponsor and encourage research studies both for statewide program planning and implementation, in cooperation with other interested parties, and also design specific research studies in consent with regional planning organizations. The latter will ordinarily be

focused on specific issues indigenous to the local areas, and will be conducted essentially by the regional organizations, their consultants, aides, community representatives, and volunteers,

(l) Assist in the development of and cooperate with alcohol education and treatment programs for employees of Federal, State, and local governments, and with businesses and industries in the State,

(m) Exert leadership in promoting State legislation for the funding and development of alcoholism program in Maine.

2. Activities of the State Advisory Council

Functions and responsibilities of this official advisory body, including such duties as advising the official agency, reviewing certain grant applications as these relate to the State plan and particularly as they relate to the provisions of the Hughes Act, recommending priorities, and encouraging public understanding and support of the alcoholism program, have been described in Part I (C) of this State plan in the words of Governor Curtis.

3. Activities of the Regional Alcoholism Planning Organizations

Regional planning organizations will include both service providers, public and private, and other representatives of organizations, agencies, institutions and interested groups, and at least equal numerical representation of consumer interest groups and individuals. It is recommended that each planning organization be composed of at least 51% consumers, including recovered alcoholics.

Each regional planning organization will be staffed by a full-time planning coordinator whose salary will be paid from the State's formula grant allocation.

The regional coordinator's function will be to assist in the development and coordination of an areawide comprehensive alcoholism system. It will be his responsibility to assure that areawide participation in the planning organization is representative of the broad spectrum of present and contemplated alcoholism and alcohol related services.

Specific responsibilities of the regional planning organizations will include:

(a) Developing, encouraging and fostering regional and local plans and programs for the prevention of alcohol abuse and alcoholism.

Each region will develop a plan of services based upon a study of need. Priorities emerging from these plans will provide the basis for encouraging service development. The process of developing plans and priorities will be emphasized in order to assure the dynamic, ongoing nature of regional program assessment and development.

(b) Coordinating programs within a service system designed to meet the criteria of comprehensiveness and insure continuity of care.

Coordination will be fostered through (a) representation in the regional planning organization, and (b) through a regional review and comment procedure relating to grant proposals originating in the region and proposed by groups and individuals for funding under provisions of P. L. 91-616.

(c) Reviewing and commenting on alcohol related grant applications.

The review and comment function at the regional level will be consistent with the State plan process for setting priorities and upon

other criteria developed by the regional planning organization. Applications will then be referred to the State Advisory Council for review and comment.

(d) Evaluating programs for alcohol abuse and alcoholism prevention, treatment, and rehabilitation.

Preliminary criteria, subject to further review and refinement, are set forth in Part IV, B (2) of this plan. These evaluation criteria will add another dimension to decision making at the local level. It is expected that these may be modified to fit the specific goals and objectives of particular programs at the local level.

(e) Functioning as an initiator and clearinghouse for alcohol related information.

This function will include referral to and development of community, State and Federal resources for alcohol abuse and alcoholism programs. Information and education programs of various kinds, designed for a variety of target groups, may be expected to include media campaigns, utilizing printed resources, radio, television, audio-visual materials, etc.; speakers bureau, conceived of as a coordinated effort in cooperation with individuals such as A.A., Al-Anon, and Al-Ateen members, alcoholism counselors and specialists, vocational rehabilitation counselors, etc.; youth campaigns, with local school systems, colleges and university, vocational-technical institutes, etc., as primary targets; programs for business, labor, and industry, and professional education, with a coordinated effort to educate and enlist the help of employers, union officials, and the entire spectrum of professionals including medical personnel, mental health, educators, clergy, social service, legal, law enforcement, and others.

(f) Engaging in resource development.

A prime function of these regional organizations will be to endeavor to generate local financial and other resource contributions to support a system of "community services" in the most literal sense. Legislative action is also an important element of resource development which is best addressed at the "grass roots" local levels.

The structure of the regional planning organizations will be consistent with the requirements for incorporation. Beyond this necessary structure, by-laws, committees, work groups, etc., will be determined by the organization members.

4. Activities of the State Alcoholism Planning Coordinator

In addition to the five regional planning coordinators, it is proposed that:

A State-level alcoholism planning coordinator be engaged whose salary will be paid from the State's formula grant allocation.

This State alcoholism planning coordinator will serve as assistant to the Division Director of Alcoholism Services. He will function as a secretary to the State Advisory Council, as well as in a liaison capacity with the Department of Mental Health and Corrections and other major appointments at the State level. In addition he will serve as the overall coordinator for the regional and State alcoholism planning effort. Among his duties will be the establishment and maintenance of uniform reporting, research, evaluation, education, and training designs.

5. Activities of the Regional Alcoholism Planning Coordinators

The regional planning coordinators, functioning as staff agents for the regional planning organizations, will assist them in their efforts to carry out responsibilities.

Specifically, the regional coordinators will:

(a) Provide technical assistance to the planning organization and other agencies and groups.

(b) Oversee and monitor research and evaluation efforts generated by the planning organization and aid in the analysis of the results of such efforts.

(c) Exert leadership in organizing activities at the community and local level.

(d) Stimulate coordination of existing services and the development of services for which a need has been seen to exist.

(e) Coordinate, in conjunction with the planning organization, all planning efforts in the region concerned with alcoholism and alcohol abuse.

C. PRIORITIES

1. As noted, the overriding objective of this State plan, and the one given highest priority, is the establishment of a statewide network of comprehensive alcohol abuse and alcoholism programs available to every recognized or potential user of these services throughout the State. These encompass the broad areas of prevention, treatment, and rehabilitation, and are to be made available not only to those persons who themselves have an alcohol problem, but also to their significant associates including family members, employers, and others.

Each region, therefore, will be encouraged to proceed with plans for implementing an areawide system that meets the criteria for comprehensiveness and continuity of care. Each regional system will be designed to:

(a) Offer alternative levels of care for both males and females of all ages.

(b) Be accessible and responsive to the needs of client and family regardless of ability to pay.

(c) Be free of unnecessary duplications and/or gaps in service, manpower, and facilities.

(d) Be integrated into the total spectrum of health, education, and welfare services.

(e) Coordinate planning, implementation, and evaluation with existing regional, State-Federal, and private non-profit agencies, organizations, and institutions.

Clearly, to achieve these goals it will be necessary to draw upon all available resources at the community, State, and Federal levels. A concerted effort will be required to obtain adequate funding from every available source, particularly at State and local levels.

Effective leadership and planning, development of resources, and coordination of present and proposed programs are seen as the prime means of attaining this objective.

2. Equal priority is given in this plan to the proposed statewide and regional mechanism for designing and implementing this statewide, comprehensive pattern of care. All of the components described in the preceding section--establishment of regional planning organizations, each having a full-time coordinator, and the full-time employment of a planning coordinator at the State level to provide assistance to the regional planning efforts--are seen as essential in carrying out this State plan.

3. Also essential to the implementation of this comprehensive plan will be the funding of specific grant applications, some of which have already been submitted to NIMH-NIAAA and approved but not yet funded; some have been submitted and are awaiting approval, and others are still at the stage of being drafted.

Among these priorities are:

(a) Funding of the Counseling Center's Alcoholism Services Program continuation application.

(b) Funding of the Counseling Center's expansion grant application for an Alcoholism Services Program for Indians of Eastern

Maine, which will be part of the Center's Comprehensive Alcoholism Services Program.

(c) Approval and funding of a grant application for a Maine Indian Alcoholism Field Survey submitted by the State Department of Indian Affairs.

(d) Approval and funding of an Initiation and Development grant application, awaiting (at the time of this writing) endorsement under Circular A-95 provisions, which will launch a Tri-County program, under the joint auspices of the Tri-County Alcoholism Council and Tri-County Health Planning Agency, leading to the planning and implementation of a regional program as recommended in this plan.

(e) Funding of an already NIMH-approved staffing grant application to launch a Comprehensive Alcoholism Services Program in Aroostook County.

(f) Funding of two grant applications in connection with ongoing ASAP programs in York and Cumberland Counties, for Comprehensive Services for Problem Drinking Drivers.

(g) Other grant applications, now being prepared and subject to revision in connection with programs at Milestone Foundation, Inc., Serenity House and 24-Hour Club in the Southern Maine Region, which will contribute to the development of a comprehensive service delivery system.

Criteria for Priorities

Stated in their simplest terms, the general criteria for establishing priorities for the above recommendations, and those to follow, have been:

(1) In what way does the service component contribute to meeting the total needs of the individual and his family?

(2) In what way does it contribute to meeting the total needs of the community?

Individual needs are seen as including:*

--Better physical and mental health,

--Better functioning as a person, as a family member, and as a contributing member of society.

Community needs include:*

--Reduction of economic loss due to alcohol abuse and alcoholism,

--More healthful social climate for the whole community,

-- Reduction of "revolving door" demands on scarce and costly community resources (health, social, legal, penal, etc.)

--Effective use, through joint planning, coordination, and mutual cooperation, of scarce community resources, facilities, and personnel.

Axiomatic to these are the criteria:

(3) It is, or does it promise to be, a productive, well-integrated element within the total community context of local health, education, and welfare resources? In other words, has it shed any notion of being a "specialized" service, and fullfilled its role within the total community service network?

As noted above, the designated agency, with assistance from the State Advisory Council and the regional planning organizations, will be designing a formalized evaluation system with specific criteria for determining priorities for existing and proposed programs. Grant applications will be reviewed at the local level by the regional planning

*Developing Community Services for Alcoholics: Some Beginning Principles, National Institute of Mental Health, p. 32

organizations, and at the State level by the Advisory Council and the State Planning Office, before their final endorsement by the designated agency for approval and funding by the Federal agency.

D. PROJECTION OF AMOUNTS FOR ACTIVITIES

1. Formula Grant Funds

The budget for administering the State plan is as follows:

Personal Services:		
Central planning coordinator		11,492.00
Five (5) Regional planning coordinators @ 10,941.00		54,705.00
Six (6) clerical positions @ 4,795.00		28,770.00
	Total	$ 94,967.00
Capital Equipment:		
Professional		8,160.00
Clerical		5,910.00
	Total	$ 14,070.00
Miscellaneous:		
Travel - all personnel		15,000.00
Clerical and Professional supplies		1,260.00
Duplication, computer time, postage, etc.		5,000.00
Rent		5,520.00
	Total	$ 26,780.00
Council and Planning Organization Expenses:		
State Council		3,000.00
Five Regional Planning Organizations @ 1,500.00		7,500.00
	Total	$10,500.00
Consultation:		
Research Education and Training	Total	$38,683.00
	GRAND TOTAL	$185,000.00

2. Other Funds

As shown on the attached "State Health Plan Budget or Expenditure Report", State public funds appropriated to the Division of Alcoholism Services for current operating expenditures totalled $81,220 for the fiscal year ending June 30, 1972.

No statistical breakdown of financing is currently available from the State Department of Mental Health and Corrections for services to alcohol abusers and alcoholics through its community mental health centers, state hospitals, probation-parole activities, and other current services. Neither are similar fiscal data available from the other State Department of Health and Welfare divisions which provide such services, such as the services to the children of alcoholics served by the Division of Child and Family Service through its Aid to Families with Dependent Children Program; for example, the Division of Adult and Financial Services, for example, this division's programs of Aid to the Aged, Blind and Disabled, as well as programs of General Assistance; Division of Community Services, which administers Services for the Aging, with its homemaker and volunteer services; or the Bureau of Medical Care, through its Medical Assistance Unit (Medicaid).

(a) Federal

Alcohol abuse and alcoholism prevention, treatment and rehabilitation programs currently receiving Federal funding include the following:

NIMH

Comprehensive Alcoholism Program,
The Counseling Center, Bangor $360,515

OEO

Central Aroostook Alcoholism Action Program . .	$25,000
Association of Aroostook Indians	25,000
Waldo County Social Action Committee.	25,000
CURRENT TOTAL	$435,515

Projection of Federal Funds Currently Being Requested from NIMH-NIAAA, and/or Alcoholism Grant Applications Now Being Drafted for Submission to Federal Agency

Comprehensive Alcoholism Services Program The Counseling Center, Bangor	$445,366
Alcoholism Services for Indians of Eastern Maine, The Counseling Center, Bangor	91,767
Department of Indian Affairs Research Grant . .	36,157
Comprehensive Alcoholism Services Program Aroostook Mental Health Center . .	402,895
Tri-County I&D Alcoholism Grant Application . .	48,164
Comprehensive Services for Problem Drinking Drivers, Bureau of Human Relations Services, Portland	191,043
Comprehensive Services for Problem Drinking Drivers, York County Counseling Services, Biddeford	160,133
Troubled Employee Program, "Behavioral Program Control: Business-Industry-Labor," Milestone Foundation, Inc., Old Orchard Beach	240,460
Special Occupational Alcoholism Programs Department of Health and Welfare, Bureau of Rehabilitation, Division of Alcoholism Services, Augusta	46,620
TOTAL PROJECTED NIMH	$1,709,198

E. USE OF FUNDS CONSISTENT WITH STATED PRIORITIES

It is believed that all of these funding requests are essential to the development of a statewide comprehensive alcoholism services program in the State of Maine. They do, in fact, represent only a beginning of what must be done if this broad objective is to be achieved.

At the present time Federal assistance is an obvious necessity for initiating alcoholism programs in regions where few if any now exist, and for continuing those in regions, and for significant target groups, which have already demonstrated their effectiveness. This is particularly true in those regions of the State, such as the northern region, and the coastal area, where local resources for development and support of such services, at the present time at least, are virtually non-existent.

One of the imperatives in regional and statewide planning over the next ten years is to generate State and local funding to provide back-up for these initial Federal investments in alcohol abuse and alcoholism programming. This has already been defined as a major recommendation with top priority in this present State plan, and the mechanism by which this will be done has been described. This activity will take the form not only of urging more adequate State and local government expenditures through a coordinated and comprehensive educational effort to engage the support of the general public and its legislators and other change agents in the community, but it will also explore all possible sources of revenue from the private sector through a similar education and promotion effort.

To cite an example, Maine is a monopoly state and realizes an annual revenue in excess of $20,000,000 from the State sale of alcoholic beverages and from license fees paid to the State by private retailers of wines and malt beverages. At present this $20 million net profit goes into the State's General Fund. Over the past several years an attempt has been made at each legislative session to have a portion of this revenue earmarked for alcoholism treatment and rehabilitation programs and each time it has failed. Aside from its sponsorship by the "militant drys" it has created little if any public support. In fact, it is now regarded by many, including legislators who have heard the arguments for it several times, as a "sin tax" which legislators are reluctant to support, and who point out that this would represent a form of "dedicated revenue" which is contrary to the State's fiscal policies. (The only dedicated revenue now permitted by the legislature is a gasoline tax to support the State's share of the State-Federal highway program, and the revenue from hunting and fishing licenses, which is received directly by the Department of Inland Fisheries and Game to support that department's operations and to promote the conservation of the State's natural resources.)

It is envisioned, however, that the stigma which has accompanied this heretofore unsuccessful proposal can be removed through an intelligently conceived and executed educational campaign. Once the information and education function, as described in this State plan, becomes operational, the bill can and should be appropriately modified and reintroduced at one of the next legislative sessions.

PROGRESS REPORT

During the past year the Division of Alcoholism Services (DAS) has begun its process of taking the initiative in organizing, coordinating, and planning alcoholism services in the state. Positive action has been taken in almost all of the areas outlined in the initial state plan, despite problems with the state's personnel system. Considerable progress has been made in

- developing uniform data and evaluation systems
- outstationing regional planning coordinators
- coordinating state level alcoholism planning activities
- furthering interorganizational relationships
- sponsoring training programs
- developing an active State Alcoholism Advisory Council
- participating in site visit teams
- dealing with problems of Indian Alcoholism
- dealing with problems of industrial alcoholism
- supporting alcoholism legislation

1. Uniform Data

One of the first needs pointed up in the initial plan was for a uniform data collection and reporting system that would permit the State and the regions to become better informed concerning the numbers of persons being served and how many persons are in specific target groups; and, to be able to project these estimates for purposes of planning and financing programs. In looking at this issue the recognized uniform data collection and record keeping as part of a larger issue. The State Plan calls for the development and implementation of a comprehensive system for the prevention,

treatment and rehabilitation of alcohol abuse and alcoholism. Each of the five planning regions will develop its own program based on locally determined need, but all will be committed to the four elements of comprehensiveness, viz:

1. Prevention
2. Outreach/Referral
3. Treatment/Rehabilitation
4. Aftercare

This scheme implies the existence of three target groups, i.e., alcoholics, alcohol abusers, and potential members of these two groups. There is the task, therefore, of 1) estimating the extent of the regional problem not only in terms of the target groups, but also in terms of the correlative social factors, problems and resources germane to the problem, 2) of estimating the necessary comprehensive effort to adequately meet the needs of these groups and 3) to assess the effectiveness of the effort.

With respect to the first point it is worth pointing out specifically that the extent of the problem is partly determined by attitudes towards alcoholism and alcohol abuse and public support of the comprehensive plan is virtually mandatory if success is to be achieved. It would therefore be wise to conduct a base line survey of attitudes of the community-at-large and of sub groups such as doctors, lawyers, judges, service clubs, etc. towards the problem drinker as such and the social problems associated with his pathological drinking.

The latter two points need elaboration to clarify the distinction between effort and effectiveness. It is theoretically (but not practically) possible to bring appropriate comprehensive treatment to every potential or actual target individual. It this were to be the case, the program would be 100%

effective in terms of response to the need situation. But just to apply preventive, treatment, or rehabilitation measures says nothing about the impact of the measures on the problem behavior, i.e., the success or failure of the measures in reducing or eliminating the problem. With this distinction made it may be said that three interdependent data systems must be developed:

1. Community Monitoring System
2. Program Monitoring System
3. Assessment of Effectiveness

This tripartite system must be compatible with existing federal and state systems and be standardized for state wide use in the five regions.

In sum, then, we will have a design that will continuously monitor significant variables in each region. Such information will enable the regional organizations to develop and apply the elements of the comprehensive models on the basis of local need. The actual application of the elements of the program in quantitative terms, e.g., number of persons contacted by outreach, number of persons in treatment, etc., will be the measure of the program effort in response to the empirically determined need. The impact of the program elements will be measured in terms of changes in the extent of the problem in the region-at-large and changes attributable to treatment procedures on the variously defined target populations. Lastly, impact effectiveness will also be subjected to cost benefit analysis.

Social Systems Research Corporation was awarded a contract to design and implement the systems outlined above. We are fortunate that circumstances are such that the development of monitoring and evaluation systems can run conjointly with the development of comprehensive planning and coordination functions. Maximum compatibility between objective information and sound decision making is thereby assured.

Since the Department of Mental Health and Corrections is developing a statewide information system, a liaison has been developed between the DAS and the Department to insure compatibility and non duplication of effort. Compatibility with the SRI information system being used by mental health centers will also be assured.

2. Regional Planning Coordinators

Prior toreceiving approval of the initial State Plan the mechanics of creating a classification for Regional Planning Coordinator was begun. The characteristics of planning, community organization, managerial, and evaluation expertise were unique in the Department of Health and Welfare. Creating a suitable classification and finding suitable people to qualify were difficult and time consuming tasks. It was, therefore, late in January 1973 before a full complement of planning coordinators was hired.

Since that time the four planning coordinators have been trained and are effectively outstationed in the four northern regions of the State (Regions II - V). Since the Comprehensive Health Planning Agency in the southern region (Region I) made excellent progress in organizing a representative group of people during the first half of the year, the Division of Alcoholism Services gave a grant for the support of that group. The group incorporated as the Southern Regional Alcoholism Council (SRAC) and with the grant has hired a planning coordinator and an assistant. SRAC in its justification of planning, structure, personnel, etc., also committed itself to adhering to the mission set forth for all regional planning bodies and to full cooperation with the activities of state agencies.

Although the regional planning coordinators in the other regions are state employees, they and their regional councils will be affiliated with agencies in the regions which have the proven capacity to aid planning and coordination efforts. This type of affiliation should afford maximum

potential for unified efforts between state and local community in dealing with problems of alcoholism.

The regional planning coordinators have been trained, have introduced themselves into the regions, and have begun to assess the existing planning and service resources and to organize regional planning councils. We expect that councils will be operational by the end of this fiscal year and that regional plans will begin to emerge during the next year of funding. Out of this process will emerge the activities of coordination, review and comment, resource development, monitoring and evaluation and public information.

3. Coordinating State Level Alcoholism Planning Activities

The State Alcoholism Planning Coordinator has assumed her responsibilities. She is effectively managing the activities of the regional planning coordinators, acting as liaison with State agencies, functioning as assistant to the Division Director, formulating policy guidelines, and planning for the implementation of alcoholism legislation. She helped design and participated in the training curriculum for the regional staff, and is coordinating their continuing training. She is also monitoring the development of the alcoholism data systems.

As the data systems and regional plans develop, and as the Division assumes its leadership role in alcoholism, the State Coordinator's activities will expand accordingly. In conjunction with the Division Director, the State Coordinator will effect the administration of the system which will provide for the development of area wide alcoholism treatment.

4. Interorganizational Relationships

The most encouraging area in which positive relations between organizations have been established is with the Bureau of Mental Health (BMH). Based upon the initiative of BMH, the Division of Alcoholism Services has over the past

year maintained a close working relationship with that Bureau. Mutually agreeable goals and objectives have been negotiated into an operational plan which assures close coordination at the state level and also at the regional level through the Mental Health Centers. The State Coordinator also sits on the Steering Committee of a group established through the Bureau of Mental Health which provides close cooperation with the Federal establishment around mental health related problems. A list of goals and objectives for alcoholism and the agreement between the Department of Health and Welfare and the Department of Mental Health and Corrections is included in the agreements section.

Close cooperation with the Maine Commission on Drug Abuse is also being maintained. With increasing acceptance of the notion that alcohol is the most misused drug in our society, the Division of Alcoholism Services is becoming involved in the planning process around drug abuse. As the State Plan for Drug Abuse emerges from the regions, the Alcoholism Regional Planning Coordinators will play a role in its development.

The opportunity for input is made easier because the Drug Abuse State Plan development is coming through mental health centers in the northern part of the State and through the comprehensive health planning agency in the southern part. The Division of Alcoholism Services, having good working relationships with these agencies, will be able to build upon and strengthen those relationships in the drug abuse planning effort.

With the controversy and apprehension over future funding of alcoholism services in mind, stronger liaison with the Bureau of Social Welfare has been developed. Since alcoholism and drug abuse remain allowable categories of services under revenue sharing and welfare guidelines, we are exploring the possibility of using Title IV-A funds for alcoholism services. Despite the fact that Social Welfare's funding regulations are in a state of flux at

this time, we are hopeful that they will be able to take up some of the shifting gaps in alcoholism service funding. Our relationship will be strengthened here for both purposes of increased funding and improved provision of social services already available through Social Welfare's own offices.

In addition to Mental Health and Social Welfare at the state level, we are expanding coordination with Comprehensive Mental Health Centers. In the two regions where CMHC's have alcoholism staffing grants, either ongoing or in application, our regional coordinators are being housed in those facilities. It is hoped that this joint housing will assure cooperation and mutual support of common objectives.

In two other regions with strong Comprehensive Health Planning "B" Agencies we also have good working relationships. In southern Maine, for example, the regional alcoholism council is affiliated with the "B" Agency and derived much of its impetus for developing from that agency. A strong and close affiliation, therefore, exists. In other regions where "B" Agencies have done work in alcoholism planning and programming, we hope to build upon a solid base that already exists.

5. Training Programs

The Division has purchased from the American Hospital Association a packaged, two-day conference on alcoholism and the responsibilities of the general hospital and the community in the care, treatment, and follow-up of alcoholic patients. This training program will be used on a regional basis with hospital personnel in preparation for their participation in projected acute emergency care units. Negotiations are currently under way with hospitals in the mid-central region of the State for this program and an encouraging number of other hospitals are asking for training.

Scholarships to the New England School of Alcoholism Studies have been provided to a number of different kinds of people involved in the field of alcoholism. Many members of the Governor's Alcoholism Advisory Council will be attending. In familiarizing themselves with issues of alcholism training, they will expand their present commitment to the field and be better able to pursue the objective of the Council. Some half-way house personnel will be sent and a smaller number of other direct services people will attend. All of the Division's new staff are also going. The overview and orientation these new people receive will better focus their perspective on both alcoholism treatment and planning.

Due to time constraints, lack of personnel, and activities at the federal level, the Division has not gone beyond these training efforts. As communities become better organized and as training resources become available, we can increase our training and public education efforts. We will also be looking toward the National Clearinghouse, as it becomes better developed, for technical assistance in training and public educatin.

6. State Alcoholism Advisory Council

Problems exist with the quality of commitment members have on any governmentally appointed advisory body. The commitment and interest of most members of the Alcoholism Advisory Council, however, have been outstanding. Attendance at meetings has been encouraging and the energy of the members has been excellent. The Council is fully organized and has its committees set up. It is currently supporting alcoholism legislation for appropriations for treatment and the Uniform Alcoholism and Intoxication Treatment Act. Although the Council's activities have been largely organizational, its members are currently working on development of next year's objectives. With a full year of operation ahead and with its strong beginning, the council will be an active and dynamic force in the field of alcoholism.

7. Site Visits

The Division of Alcoholism Services anticipates operating a grant-in-aid program using state appropriated funds. We will link grant-in-aid to needs assessment and outcome evaluation and have to develop on site techniques for reviewing programs based upon objective data we will have. Our experience with federal site visit teams over the past year has given us valuable insight into developing on-site techniques.

We have participated in both the OEO review and the NIAAA review of the ATC in Bangor. The latter was most comprehensive and pointed up several general principles we will incorporate into our site visit procedures. For example, we will have teams composed of several different disciplines and review in depth specifically designated areas of concern.

Given our experience with site visit reviews, we also feel that visits can be expended to form at least a partial basis for review and comment functions of both state and regional level advisory councils. By having involvement at the planning stages, objective data from our information systems and site-visits, we feel that our staff and the councils can make well founded, rational decisions about alcoholism service programming.

This type of system is necessary particularly in view of the fact that review and comment has been largely a proforma exercise. Although we have no reason to say that present programming is inadequate, we feel that everyone would benefit by increased involvement and accountability. We expect that limited resources could be spent more wisely and alcoholic people could benefit to a greater degree.

8. Indian Alcoholism

One of the priorities listed in Maine's original State Alcoholism Plan was that of the approval and funding of a grant for a Maine Indian Alcoholism Field Survey submitted by the State Department of Indian Affair. Through a

special project grant this proposal has come to fruition. Although complete findings and specific projections will not be submitted until October 1973, a number of ongoing activities can be related to show the scope of the survey.

Investigative measurement is being applied toward definition of the extent of the alcoholism problem in Maine Indian Communities. (These being the two on-reservation tribes known as the Penobscots and the Passamaquoddies, and an off-reservation group in Aroostook County consisting of the Micmac and Maliseet Tribes) Determination of numbers and categorical correlation is geared to the following problematic areas: foster home placements due to alcohol related problems, school behavior and learning problems resulting from alcoholic background, job problems, community attitudes toward alcohol consumption, hospital admittance rates, acts of violence, arrests, automobile accidents, mortality rates, church affiliations, activities of reservation AA groups, and alcohol related separations and divorces.

A second phase of the survey is the identification of resources and programs presently available which do, or could, assist in dealing with alcoholism in Indian Communities. Further exploration of this identification has led to the discovery of cultural biases of existing facilities and/or personnel.

Although, as stated before, culmination of the survey is not expected for another six months some possible solutions are evolving with regard to both prevention and treatment. An ongoing community education program, closer cooperation and coordination among existing agencies, enlistment of assistance from churches, AA, Al-Anon and Al-teen groups, and further medical assessment of potential alcoholics are some of the suggested preventative measures. In the area of treatment very little in the way of constructive rehabilitation has been provided to the Maine Indian thus far. More and more the Indian comes to feel that the most successful method of treatment probably lies within his own cultural environment guided by people of his particular understanding and beliefs. For this reason indepth consideration

is being given to alcohol counselor and other professional training programs that may be geared especially for indians, mini half-way houses on reservations, utilization of varied types of trained indian liason personnel, assessment of treatment centers in the state to determine those most potentially effective and cooperative with indian programs while working more closely with them in planning treatment.

9. Industrial Alcoholis - Troubled Employee

Considerable effort has been made in dealing with troubled employees in both the industrial and private sectors. The state employee specialist has structured treatment services through existing facilities in the Central Maine area. Central Maine was chosen as the beginning of the program because the State Capitol complex in Augusta has the largest concentration of public employees.

In addition the Augusta General Hospital is initiating an "in house" program for its own staffing complement. Excellent cooperation has yielded a positive policy regarding roubled employees and a training program will begin in the near future. When a training team becomes involved in training supervisors, the training will be oriented toward the identification of troubled employees because of poor work performance and erratic job behavior. Employees can then be linked to the treatment system.

The training team, being made up of employees from a number of different organizations having concerns over alcoholism, will have an eclectic approach. This team will be available to work with organizations wishing to set up troubled employee programs for their employees.

Concurrently with the development of treatment resources and a training component, we have been engaged in establishing a pilot State employee program. Our first contact was with the Director of the State Personnel Department, and after several exploratory conferences, we assigned his assistant to work

directly with us to help program the employees of the State Department of Health and Welfare, which number about 1250.

In the industrial sector much interest in troubled employee programs has been generated. Because of past relationships with the Great Northern Paper Company, we selected this company with its 3000 employees in plants at Millinocket and East Millinocket as the logical industry in which to establish a "pilot" program. Aside from Management, it has been necessary to involve 14 different unions in joint agreements -- and all except one are cooperating. A policy statement has been developed for labor-management consideration, a network of community helping referral resources have pledged their cooperation, so within 2 or 3 months policy acceptance should become translated into an action progra at Great Northern.

The second industry contacted was the Bates Manufacturing Company of Augusta with 840 employees, and after a series of conferences with the Personnel Manager, the climate has been created to negotiate policy. Management is receptive and the one union in the plan is analyzing the proposal for future action.

A third company to which policy has been introduced is the Diamond International corporation in Old Town, with 640 employees. At a time when progress was being made with both management and labor representatives, a union election was held which produced a new slate of officers. It will now be necessary to re-introduce the policy to the new union officials, but there is reason to believe that they will be as receptive as their predecessors, and that a program can eventually be implemented.

It is our philosophy to get one or two established program models in place -- a large and a small company -- to be used as shining examples to attract the interest of other industries. For this reason he has been giving special attention to Great Northern Paper Company and Diamond International Corporation.

This is apparently good strategy, because several industries are requesting information about the "troubled-employee" program -- companies such as St. Regis Paper in Bucksport, Oxford Paper in Rumford, Scott Paper in Waterville, Georgia-pacific of Woodland, S. D. Warren of Westbrook and the Bath Iron Works.

10. Alcoholism Legislation

The Uniform Alcoholism and Intoxication Treatment Act is being debated in our current legislative session. With the resounding support exemplified at the legislative hearing, we anticipate successful action. The Uniform Act is widely supported as an enlightened piece of legislation affording the opportunity to deal with alcohol related problems in a unified and humane manner. The Division of Alcoholism Services and its Advisory Council will continue to fight for passage of the Act in conjunction with other organized community groups.

Although the Uniform Act has no appropriation attached to it, the Division is requesting from this legislature $600,000 for a grant-in-aid program related to the provisions of both the Hughes Act and the Uniform Act. This money will go a long way toward having direct services available in the communities of Maine. Alcoholism services in Maine have for too long been a low priroity for public spending, and the Division is doing everything in its power to see that that situation is remedied. The combination of state, federal and local resources being brought to bear in a planned and coordinated manner is one of the most heartening developments the field of alcoholism has seen.

The Division believes that all of the programming of services should be done by local community based agencies, which are in the best position to know, understand, and solve problems of alcohol abuse and alcoholism. Local agencies such as hospitals, half-way houses, alcoholism treatment facilities, and Mental Health Centers, however, cannot develop programs of a comprehensive

nature alone. Recognizing the fiscal limitations of local agencies, the Division of Alcoholism Services requested $600,000 in additional appropriations. These funds are to be used as grants-in-aid to help local agencies either match available funds or supplement funds otherwise obtained. This grant-in-aid process will help the Division encourage the development and implementation of programs which meet identificable gaps in services and which produce results. The partnership of money, evaluation, and coordination from the State level; money, programs, and support from the local level; and, money and assistance from the federal level, is the most constructive for dealing with the problems of alcohol abuse and alcoholism.

PROJECTIONS -- Second Year

The largest problem faced by the Division of Alcoholism Services during this initial year has been time. Since it took six months to get a full complement of staff, progress has been slow. Much effort, however, has been given to what can broadly be termed organizational activities. We have initiated the development of information systems to be used for planning; we are setting up the alcoholism planning structure; we are generating and consolidating resources for direct services in communities; we have attended to interorganizational relationships at the State and local levels; and, we have made progress in the design and initiation of treatment programs, especially for troubled employees. In short, we have laid a firm groundwork for an active and productive year ahead.

It is beginning to appear as though the primary problem in the coming year will be money. Our grant-in-aid program for the biennium is contingent upon favorable action by our legislature. Alcoholism grants under the Hughes Act are contingent upon favorable action by Congress and the President on amendments to that Act. The Fy '74 federal budget cuts have forced state legislatures to struggle with the necessity of picking up the decreased federal share of money of human service programs with state appropriations. We are all waiting to see what happens with special revenue sharing and with national health care proposals. And the nation is waiting to see the results of the battle between the Executive and Legislative branches of government. Much of what Maine does in alcoholism, therefore, depends upon systems and struggles beyond its control.

Despite the turmoil growing up around fiscal issues the mission of the Division of Alcoholism Services remains the establishment of a statewide network of comprehensive alcohol abuse and alcoholism programs available to every recognized and potential user of these services throughout the State. These encompass the broad

areas of prevention, treatment, and rehabilitation, and are to be made available not only to those persons who themselves have an alcohol problem, but also to their significant associates including family members, employees, and others. Our most pressing concern will, therefore, be to get as much direct service money into communities as is possible and feasible.

In establishing the objectives on the following pages we recognized that much needs to be done prior to reaching any degree of success in alcoholism programming. For example, information systems must be operational and compatible with the regionalized planning process before rational program planning, evaluation and funding decisions can be made. Regional planning bodies should be fairly well developed in order to rationally operate a grant-in-aid program. Alternative sources of funding should be explored and developed in conjunction with grant-in-aid and collaboration between significant agencies. Many of the objectives must be pursued simultaneously. It is, therefore, difficult to order objectives in the form of meaningful priorities.

For the coming year our projected activities are briefly outlined under the three dominant aspects of the alcoholism program -- The State Agency, the Regional Planning Bodies, and the State Alcoholism Advisory Council.

We, consequently, adopted two overriding general priorities in establishing projected activities. These are first to finish establishing the state and regional planning structure concurrently with completion of the development of information tools necessary for the planning structure to operate and manage regional activities. The second priority is to maximize the resources in terms of money, support, coordination, etc. necessary for programs to be developed.

The criterion we used in projecting our activities was simply the logical sequence of events. We have to complete structuring and implementing the planning process and providing the tools necessary to manage it. Under current contingencies resources must be developed. From an existing process and with sufficient resources sound programming emerges. We, thereby, move toward our ultimate goal of statewide alcoholism and alcohol abuse programs. The criteria for those programs will remain as outlined in last year's action plan.

State Agency

-- Complete the development of three interlocking data systems: community monitoring, program monitoring, and assessment of effectiveness.

-- Integrate the data systems into an ongoing statewide planning structure, including regional planning bodies, other regional state and private agencies, and state level organizations bearing upon the field of alcoholism.

-- Use the data generated by the systems in the activities of ongoing assessment of the problem and of planning, maintaining, coordinating, and evaluating projects for more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism.

-- Train necessary people and groups in the use of the data systems to assure their cooperation and the usefulness of the systems.

-- Establish and maintain a site-visit system to be used in planning and the allocation of resources.

-- Establish written guidelines and implement the system for the review and comment function at both state and regional levels.

-- Assure the wisest possible allocation of resources and program development.

-- Aid development of comprehensive alcoholism services in all planning regions.

-- Have five regional planning bodies incorporated and functioning.

-- Have five area alcoholism plans completed and operational.

-- Coordinate and provide technical assistance to the five regional planning bodies and their related activities.

-- Support existing alcoholism legislation.

-- Develop and implement a community grant-in-aid program for funding alcoholism services provided by local agencies, including guidelines and criteria for the grants.

-- Pursue alternative sources of funding for alcoholism services at the state level. For example: Revenue sharing; Title IV-A; state appropriations, various federal sources, etc.

-- Stimulate further development of joint collaboration among state agencies regarding alcoholism services. These agencies will include but not be limited to:

Bureau of Mental Health

Bureau of Health

Comprehensive Health Planning - (both A & B agencies)

Department of Indian Affairs

Maine Commission on Drug Abuse

Law Enforcement

Bureau of Social Welfare

-- Coordinate state level alcoholism program planning and related alcoholism activities.

-- Deal more effectively with problems of Indian alcoholism by working more closely with Indians and by cooperating with them to implement the results of their study of the problem.

-- Continue and expand activities in occupational alcoholism.

-- Implement provisions of the Uniform Alcoholism and Intoxication Treatment Act.

-- Continue and expand efforts in acute emergency care and occupational alcoholism programming.

-- Establish and implement guidelines for certification standards for alcoholism treatment facilities.

-- Initiate and encourage research studies for both regional and statewide program planning and implementation activities.

-- Strengthen and continue the activities of the State Alcoholism Advisory Council.

Regional Planning Bodies

1. -- have the regional planning body incorporated and functioning.

2. -- use objective data from developing information systems in decision making for planning, review and comment, evaluation, research, etc.

3. -- have the area alcoholism plan completed and operational.

4. -- plan and develop comprehensive, community based, coordinated alcoholism programs in each region.

5. -- coordinate existing and developing alcoholism programs, agencies, and activities.

6. -- find and develop alternative sources of funding for alcoholism programs at the local level.

7. -- engage in public relations activities.

8. -- initiate and support training activities.

9. -- work in cooperation with the State Alcoholism Advisory Council in all areas seen appropriate by that Council.

10. -- function as an initiator and clearinghouse for alcohol related information.

State Alcoholism Advisory Council

-- Review overall plans and priorities of the State Alcoholism Authority.

-- ,Act as advocates for generating funds and developing funding sources for alcoholism programs.

-- Cooperate with regional planning bodies in the review and comment function.

-- Maintain public relations activities in support of alcoholism prevention, treatment, and rehabilitation activities.

-- Design and implement statewide education and information program in conjunction with regional planning bodies.

-- Foster public understanding of problems related to alcoholism and alcohol abuse.

-- Stimulate statewide interest in alcoholism prevention, treatment, and rehabilitation.

-- Support existing and propose new alcoholism legislation.

Budget

In order to affect these objectives we propose the following budget:

Administration	$20,000
Personal Services (5 professional, 5 clerical)	80,350
Fringe Benefits	8,839
Travel	10,000
Council and Planning Organization Expenses	
State Advisory Council	5,000
Regional Planning Organizations (4)	10,000
Continuation of Contractual Commitments	53,000
Miscellaneous	
Rent and Communications - (e.g., supplies, duplication, computer time, postage, phone, printing, etc.)	12,811
Total	$200,000

IV. PARTICIPATION BY OTHER PUBLIC AND PRIVATE NONPROFIT AGENCIES

As noted under Section I (B), "Administrative Organization", of this State plan, there are no agencies which are supervised by the single designated State agency. There are, however, contractual arrangements and cooperative agreements between this agency and others, both governmental and nongovermental.

A. Policies and Procedures

1. Cooperative Agreements

A formal agreement will be negotiated to ensure cooperation between the designated agency and the Department of Mental Health and Corrections, which is the other most important public agency in delivering alcoholism services in the State.

In correspondence addressed to the Department of Mental Health and Corrections from the designated agency on May 10, 1972, the director, C. Owen Pollard, expressed his "intent to develop in collaboration with Mental Health and Corrections a written agreement that will spell out the role of Mental Health and Corrections with the designated State agency in the area of planning, implementation and evaluation". He attached to this memo the proposed draft of an "Agreement of Cooperation" which is reproduced on the following pages.

The Department of Health and Welfare, as represented by its Bureau of Rehabilitation and within it, the Division of Alcholism Services, hereby enters into agreement with the Department of Mental Health and Corrections, as represented primarily by its Bureau of Mental Health. For the purpose of establishing and maintaining an effective working relationship resulting in a coordinated planning, service delivery, and evaluation system of alcholism services.

This agreement specifically addresses itself to these broad objectives:

1. The necessity to achieve and maintain a level of cooperation and coordination between member-parties of this agreement that will serve to expedite the development and implementation of a truly comprehensive State Plan for alcohol abuse and alcholism prevention, treatment and rehabilitation in the State of Maine.

2. Establish more effective communication and intra-agency liaison between and among these service elements for which Mental Health and Corrections and Department of Health & Welfare have legally assigned responsibility at state, regional and local levels and thus insure maximum coordination of all service components in a comprehensive alcoholism service delivery system.

3. Promote the most effective utilization of current and projected client services administered separately by each of the member-parties by:

    (a) Developing uniform standards for client care and treatment in all instances where such uniformity is considered possible or desirable,

    (b) Encouraging and facilitating the free passage of clients from one service element to another as seen proper and desirable by caretakers of whatever agency has direct responsibility for the particular client's welfare, and

    (c) Expediting this client's movement between and among service elements through mutually agreed upon procedures for referral and acceptance, including but not limited to:

(1) Sharing of client information, such as case records, certain other written reports, as well as continuing dialogue among caregivers, and

(2) Implementing this by developing an efficient system of record keeping and reporting by means of a mutually agreed upon common data base.

(d) Drawing at least in part upon this standardized system of data gathering and recording to promote efforts between member-parties to establish a cooperative information system for ongoing program planning, research, and evaluation.

4. Determine what steps may be taken to ensure that this mutual agreement of cooperation is reflected at the community level through regional intra-agency partnership and its most important concommitant; a more integrated and productive pattern of continuing care and treatment for problem drinkers and alcoholics in the State of Maine.

2. Regional Alcoholism Planning Contracts and Agreements

It has also been noted that the designated agency will administer the State plan through a system of regional planning organizations, and that while these will not ordinarily engage in the provision of direct services, they will each be incorporated. It is expected that they, too, will be entering into formal agreements with direct service providers in their respective areas and enter into contracts for consultative services, and subject to review by the State Advisory Council and staff of the designated agency.

3. Determination of Funds

The proposed budget for administering the State plan has been shown under Action Plan, Section III (D) (1).

4. Notification of Availability of Funds

Regional planning organizations are already in existence or underway in most of the five regions. Examples are the Tri-County Alcoholism Planning effort, initiated under the auspices of the State Comprehensive Health Planning 314 (b) Agency for that region, Tri-County Health Planning Agency. Similarly, the 314 (b) agency for the Southern Maine region, Southern Maine Comprehensive Health Association, Inc., has exerted leadership in the recent formation of the Southern Maine Regional Alcoholism Council, comprised (as described earlier in this State plan under State Survey, II (D) (2)) of the Mid-Coastal, Cumberland, and Southern Maine (York County) State Planning and Development Districts.

The Kennebec Alcoholism Planning Region III, which is coterminous with the Kennebec State Planning and Development District, which so far has no organized mechanism for ongoing alcoholism planning, although its planning capability, as noted in its regional profile, is in the process of being greatly accelerated.

Alcoholism Planning Region IV, comprised of the Penobscot and Eastern Maine State Planning and Development District, and Alcoholism Planning Region V, representing the Northern Maine State Planning and Development District, have both demonstrated their planning capability through their respective Community Mental Health Centers--The Counseling Center in Bangor, and Aroostook Mental Health Services, Inc., in Fort Fairfield.

B. METHODS FOR REQUESTING FUNDS

1. Funding Requests

The procedure for developing Federal grant applications, submitting these to the regional alcoholism planning organization for review and comment, after which they will be referred to the State Advisory Council for further review and comment before application is made to the Federal agency, has been described.

2. Evaluation and Approval of Requests

NIMH-NIAAA "Guidlines for Evaluation of Projects and Proposals" are currently being followed. These guidelines are reproduced here for the instruction of individuals here in the State who are, or will be, charged with the responsibility of preparing grant proposals for either Federal or State funding:

GUIDELINES FOR EVALUATION OF PROJECTS AND PROPOSALS

1. All reasonable proposals or applications must be clear in their definition, stated accurately with regard to problems and needs, and be understandable in terms of goals, objectives and expected results.

   A. Have regional committees and appropriate local units of government, Comprehensive Health Planning and Regional Mental Health agencies, institutions, or groups reviewed the proposals, made commitment of funds or approved the statements contained in this proposal?

   B. Problems must be clearly defined and correspondingly documented by supportive data. Describe nature and scope of the problem. This description explains the

justification for submitting the grant application. Define the problem in workload or quantitative terms and indicate data sources. Use meaningful facts and data to support need; for example, arrest rates and number of alcohol abuse and alcoholism-related occurences over a one-year period.

C. Needs must be clearly defined and documented by supportive data. The condition that will be improved by this anticipated grant must be outlined as specifically as possible. Need and accomplishment by objectives will serve as a basis for project evaluation and must be detailed in behavioral terms whenever possible.

D. The specific area effected by this project (either in a direct or indirect fashion) must be identified and the anticipated result or goal described. Give a concise statement of each of the objectives of the proposed project. These are precise statements of kinds of improvements sought and outcomes expected. A measurement of these conditions as they exist before and after the impact of the action proposal will form the basis for evaluating the worth of the program.

E. Is the proposing agency capable of carrying out this project? What evidence of the capability can be shown? Describe the tasks to be undertaken for the achievement of the project objectives and the costs involved. Provide a detailed time schedule showing how long the various tasks will take to complete. Describe the

staffing required and the program role of each.

Indicate how project progress will be reported.

F. What are the strengths and weaknesses of the proposal? Describe the general method, procedure, or strategy for attaining the objectives. State reasons why the proposed approach is offered. For example, what evidence is there that this approach will work? What are the alternative approaches and why is this method preferable? If there are other projects which relate to this proposal, summarize those projects and describe the relationship.

SUMMARY

G. Special considerations that must be specifically detailed:

1. Cost
2. Urgency or need of this project.
3. Duration
4. Certainty of results
5. Uniqueness of problem and level of technicality
6. Innovative qualities
7. Effectiveness of coordination with other agencies or efforts with similar missions.

H. What is the likelihood of this project continuing under local or state auspices if successful? Note the specific considerations or items that insure future support.

I. The proposal must conform to State Alcohol Abuse and Alcoholism Plans and be consistent with priorities and goals of those efforts. It must be consistent with and be identified as a priority of the State Alcoholism and Alcoholism Council in the approved State Plan.

II. Monitoring of Projects by Division of Alcoholism Services and Regional Planning Committees where feasible.

Itemization: (1) each service to be purchased
(2) each major article purchased
(3) all salaries or expenses other than above

III. Evaluation of Projects by State Division of Alcoholism Services. Relate each of these criteria once they have been monitored and found to have occurred or not occurred according to the grantee agreement, to the original needs this project addressed, and the projected results expected.

A. Was the program carried out as it was stated?

B. What impact did it have on the goal (s) and objectives of the project - describe by emphasizing degrees of accomplishment. Was it undetermined in its effectiveness? What major developments led to its success? Did this project reflect elements of both success and failure - In what ways?

V. COORDINATION

A. Responsible State Agency

1. Procedures for Review

The single State agency responsible for administering the State plan is the Department of Health and Welfare, Bureau of Rehabilitation, Division of Alcoholism Services.

Section 247, Part C (2) of the amended Community Mental Health Centers Act, reads as follows:

> "Each applicant from within a state, upon filing its application with the Secretary for a grant or contract under this section, shall submit a copy of its application for review by the State agency designated under section 303 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act..."

Since the above State agency was so designated by Governor Kenneth M. Curtis in October, 1971, this procedure has been, and will continue to be followed.

Project grant applications are submitted to the State agency, which is then required to submit to the Federal agency "within 30 days from the receipt of the application, a written evaluation of the project set forth in the application..."

With the implementation of the proposed mechanism for administering the State plan which has here been described, it is expected that the review and evaluation of grant applications submitted by public and private nonprofit agencies, organizations, and institutions, and requests for contracts on the part of these groups or individuals,will be greatly facilitated.

2. Criteria for Evaluation

The criteria for evaluation are those detailed in the NIMH-NIAAA "Guidelines". In addition, it is understood that the criteria established under Section 247, (3) of Part C, Community Mental Health Centers Act as amended by P.L. 91-616, are to be met. These require that (A) the activities and services will be substantially administered by or under the supervision of the applicant; (B) programs or projects will be administered by such methods as will ensure proper and efficient operation; (C) provision is made for such fiscal control and accounting procedures as may be necessary and (D) assurance is given that "Federal funds will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available... and will in no event supplant such State, local, and other non-Federal funds."

B. Provisions for Review of Grants Submitted Under Other Acts As Requested

Applications for construction grants, including those to be approved for funding under the Hill-Burton Act, are reviewed by the Health Facilities and Construction Service Director of the Department of Health and Welfare, which is the designated State agency for the administration of the Community Mental Health Centers Construction Plan. While the administration of the CMHC Construction Plan rests with the Department of Health and Welfare, the Department of Mental Health and Corrections is designated as the Mental Health Authority in

the State of Maine, and as such is responsible for Community Mental Health Center program promotion and planning, and the development of a comprehensive plan for community mental health services, including centers construction.

The arrangement providing for program and plan development in the Department of Mental Health and Corrections is by agreement between the two departments as follows:

> The Department of Mental Health and Corrections has entered into an agreement with the Department of Health and Welfare for the express purpose of utilizing the experience and knowledge of the Hill-Burton officials in constructing community mental health facilities approved under Maine's Community Mental Health Center Survey and Construction Plan.*

With the implementation of the regionalized administrative structuring of alcohol abuse and alcoholism programs as described in the present State plan, it is anticipated that funding requests from other sources such as Model Cities, Department of Transportation, etc., will also be cleared through the regional alcoholism planning organization, when these proposals have an alcohol related component.

Similarly, as set forth in Part C of P.L. 91-616, private and public general hospitals wishing to receive Federal funds for alcoholism treatment programs will be expected to submit their applications through the regional and State Advisory Council mechanism for preliminary review and comment, in order to ensure that their proposed programs are consistent with the intent and purposes of this State plan.

*Community Mental Health Center Survey, Planning and Program Development, Department of Mental Health and Corrections, FY 1970, p. 1.

C. Provisions for Review by Other State Authorities

As noted earlier, all grant applications under P.L. 91-616 are subject to State Clearinghouse Review by the State Planning Office, which has been officially designated by the Governor to review all federally assisted programs and projects under "Circular A-95" of the U.S. Office of Management and Budget. This State plan is currently under such review, as is the Tri-County I & D grant application for alcoholism services.

Applications pertaining to provision of services through community mental health centers or other Mental Health and Corrections administrative components are subject to review by that agency.

Programs that receive funding from other Federal or State sources are subject to review by the funding agency. Examples are Serenity House and the 24-Hour Club in Portland, both of which receive their major financial support from Model Cities.

VI. ADMINISTRATION OF PLAN

A. State Plan Administration Costs

Section 302 (c) of Title III, P.L. 91-616, permits the expenditure, not to exceed 10% of the State allotment, (or $20,000 in Maine per year), for allowable administrative costs. These are defined by the Federal agency to include the following:

(a) Costs of compensation of personnel and other administrative expenses directly related to developing and administering or supervising the administration of the State Plan.

(b) Expenses of the designated State alcoholism advisory council, including per diem and travel expenses incurred by council members at rates not exceeding those established under applicable State law.

(c) Expenses of regional and local alcoholism and alcohol abuse advisory groups to the extent that such groups provide advice or contractural services related to administering, or supervising the administration of the State Plan.

As reported in the introduction of this plan, the designated State agency in November, 1971, contracted with the Health Council, Inc. of Maine, a nonprofit private organization representing 60 public and private health agencies in the State, to assist in its development. Subsequently, a loan in the amount of $15,000 was obtained through an interdepartmental arrangement with the Bureau of Administration of the State Department of Health and Welfare to enable the drafting of a plan. These funds, however, did not become available until several months (March 15, 1972) after the contract with the Health Council had been negotiated, and the regional workshops originally scheduled for February, consequently, had to be postponed until late in March.

This $15,000 for technical assistance in planning, which includes an amount budgeted for printing and statewide distribution of the State plan, represents the difference between the $185,000 earmarked for State and regional planning, coordination, and program development, and Maine's State Formula allotment of $200,000.

B. Merit System

The designated State agency, along with all other bureaus and divisions of the Department of Health and Welfare, conforms to Civil Service policies adopted and enforced by the Maine State Department of Personnel. These "Standards for a Merit System of Personnel Administration" which comprise Part 70 of Subtitle A, Department of Health, Education, and Welfare, and also as 28 F.R. 7931, as well as several U.S.C. statutes, apply in Maine not only to personnel of those agencies that are engaged in the administration of Federal grant-in-aid programs or in the development and implementation of approved State plans required as a condition of Federal grants, but to all State employees, including those of the Department of Mental Health and Corrections, Employment Security Commission, and all others equally.

This merit system of personnel selection and administration adheres to Federal requirements in: (1) establishing clear definitions of function, (2) employment of the most competent available personnel, and (3) development of staff morale and individual efficiency.

The statewide civil service system in Maine conforms to the Federal merit system in all respects including these:

(1) Impartial administration of the merit system,

(2) Operation on the basis of published rules and regulations,

(3) Classifications of all positions on the basis of duties and responsibilities, and establishment of qualifications necessary for the satisfactory performance of such duties and responsibilities,

(4) Establishment of compensation schedules adjusted to the responsibility and difficulty of the work, and qualifications of the employee,

(5) Selection of permanent appointees on the basis of examinations so constructed as to afford all qualified applicants opportunity to compete,

(6) Advancement on the basis of capacity and meritorious service, and

(7) Tenure of permanent employees.

In addition, the provisions of the Federal Hatch Political Activities Act, as amended, are enforced, and participation in political activity, especially by employees engaged in carrying out duties in connection with State-Federal programs, is prohibited.

A classification plan for all State positions is maintained, with job descriptions; classification titles; and requirements of minimum training, experience and other qualifications published and enforced for each State position. Salary schedules, adjusted to the responsibility and difficulty of the work, and ranging from minimum, to intervening, and maximum rates of pay, provide for salary advancements based upon quality and length of service.

Regulations governing the State administration of the civil service merit system include:

(1) Examinations constructed to reveal the capacity of the applicant for the particular position for which he is applying,

(2) Registers of eligibility, recording final scores and standing in relation to other applicants,

(3) Six-months probationary period for all employees before certification for permanent status,

(4) Periodic evaluations of work performance, and maintenance of such personnel records as necessary for the proper maintenance of a merit system and effective personnel administration.

VII. ACCOUNTING PROCEDURES

All accounting and auditing of expenditures and commitments made by the designated agency, along with other Health and Welfare administrative components, are under the continuing review of the Department's Division of Accounts and Audit in the Bureau of Administration. Further State review on an ongoing basis is provided by the State Bureau of Accounts and Control, under the administration of a State controller. A data processing and programming system is used by both agencies.

All financial records and proposed expenditures are available at all times to the U.S. Office of the Budget, the U.S. Comptroller General and his authorized representatives, and to the Federal and regional representatives of the National Institute on Alcohol Abuse and Alcoholism.

Financial reports are to be prepared and submitted to any of these State and Federal agencies upon their request. Similarly, expenditures by private agencies, organizations, and groups providing services under this plan and made from funds provided by the designated State agency for that purpose are also required to conform to standard fiscal control and fund accounting procedures. Records of expenditures made by these public and private agencies in carrying out the provisions of the State plan are maintained and available for inspection and audit at any time upon request.

In this State plan, a clear differentiation has been made between proposed expenditures from the State formula grant allotment of $200,000 under P.L. 91-616 and all other Federal formula and project grant programs.

Fiscal records in connection with alcohol abuse and alcoholism programs conducted under the provisions of this State plan are to be retained for 3 years after the close of the period for which the funds involved are available for expenditure, in accordance with Section XII, page 26, of the "Guidelines for Preparation of State Plans", received from the Chief, State Assistance Branch, NIMH-NIAAA.

VIII ASSURANCES

A. FACILITIES

1. Admission to Hospitals

It is understood that no formula grant funds will be awarded any public or private general hospitals which have received Federal funds for alcoholic treatment programs and which refuse admission and treatment to alcoholic persons solely on the basis of their alcoholism.

2. Maintenance and Operation

a. Inpatient services.

All facilities housing patients will conform to the requirements for hospitals and related facilities established by the Department of Health and Welfare and shall be licensed in accordance with legal requirements.

b. Other services.

Facilities other than inpatient facilities shall be inspected and licensed or approved by appropriate state or local authority (ies) as being safe and sanitary.

3. Conflict of Interest

No full-time officer or employee of the designated State agency, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs shall receive funds from a grant applicant directly or indirectly for payment for services provided in connection with the planning, design, construction or equipping of a treatment or rehabilitation facility currently operating or proposed under this State plan.

B. NONDISCRIMINATION

1. All services provided under this State plan shall be made available without discrimination on account of race, creed, color, sex, age, marital status, or duration of residence.

2. The State agency or any other agency, organization, or institution administering and/or carrying out any activity under the State plan shall not discriminate in any way against any employee with respect to compensation, terms, conditions, or privileges of employment solely because of race, color, creed, sex, or national origin.

3. The State agency or any other agency, organization, or institution administering and/or carrying out any activity under the State plan shall not refuse employment to any qualified applicant for a position solely on the basis of the fact that he or she has had or has not had a problem of alcoholism.

C. MAINTENANCE OF EFFORT

1. State funds

Federal funds will not be used to supplant non-Federal funds appropriated by the State Legislature or those currently being received or requested from other sources for purposes of providing the services and carrying out the activities under the State plan. Rather, such Federal funds will, to a large extent, be used to increase the level of State and local funding for the activities described in this report. Consequently, assurance can be given that:

a. The level of State funds available to and spent by the State agency for alcohol abuse and alcoholism prevention, treatment, and rehabilitation services and activities under the proposed State plan (including State funds allocated to other public and private non-profit agencies,

institutions and organizations) will be at least no lower in the fiscal year for which this State formula grant application is being made than it was for the immediately preceding fiscal year.

b. Assurance is also given that the aggregate level of non-Federal funds (other than Federal funds allocated under the Act by the State agency) available to and spent by the State and each other public or private non-profit agency, institution, and organization to which Federal funds are to be made available under the State plan from the State's formula grant of $200,000 is no lower for the fiscal year than it was for the immediately preceding fiscal year.

D. ACCESSIBILITY CRITERIA

A. Geographic

Barriers of geography and demography present unique and often exceedingly difficult problems in the State of Maine. In the absence of any adequate public transportation system in the state, except for persons living in the most urban areas, the problem of getting from place to place is most acute for the severely disadvantaged and especially those who live in the more isolated and remote parts of the State. Quite often such persons are prevented access to the services they need because they are unable to get to them. Not only distances, but routes of travel, climatic conditions, and the local characteristics of the population are factors which must be considered in the development of an efficient service delivery system.

While recognizing that these and related factors add to the complexity and difficulty of meeting optimum standards of accessibility,

it is the objective of this plan to make appropriate and needed alcohol abuse and alcoholism service programs available to any person in the State within one hour's travel time from his place of residence.

B. Financial

Comprehensive alcohol abuse and alcoholism program components including emergency care, inpatient hospitalization, outpatient service, care and treatment at an intermediate facility, follow-up services, and any others which may be indicated on the basis of individual need will be available without exclusion of any person solely by reason of his ability or inability to pay.

IX. OTHER REQUIREMENTS

A. PUBLICIZING PLAN

1. A publicity campaign was launched prior to the scheduling of the five regional workshops, and coverage by press, radio and television while the workshops were being held reached virtually every part of the State. Examples of press coverage are included in the Appendix. In addition, some 10 radio interviews were broadcast, and television coverage of the workshop sessions was extensive. Each session was covered by at least one TV channel. The Portland workshop was a telenews subject on two TV channels which cover the southern half of the state. The Bangor workshop was featured by two channels on their evening news telecasts that cover the northeastern half of Maine, and the Waterville workshop in Central Maine was covered by three radio-television news directors and their cameramen.

2. A general description of the plan was published as a legal advertisement in central Maine's most widely read newspaper and ran for three days. A photocopy of this public notice is attached.

3. A copy of the interim State plan, as reported in the final paragraph of the legal notice, has been available for examination at the Maine State Library in Augusta since the end of March.

B. GOVERNOR'S REVIEW

1. The procedure for State Clearinghouse Review by the State of Maine Executive Department, in accordance with Part III of the revised

LEGAL NOTICES

Legal Notices 1

LEGAL ADVERTISEMENT

PUBLIC NOTICE

The 1972 State Plan for comprehensive services relating to alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs in Maine as provided for under terms of the federal Hughes Act, Public Law 91-616, has been prepared. Upon approval of this plan, fiscal year 1972 funds in the amount of $200,000 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 as well as development of new prevention, treatment, and rehabilitation modalities.

Recommendations and priorities include:

1. Services pertaining to education, prevention, and early identification alcoholism-related problems.
2. Treatment functions including medical, psychological, and general counseling and social services offered on either an inpatient or outpatient basis.
3. Rehabilitation functions of numerous public and private service elements proposed or already existing which are either now or can become capable of serving individuals and families with alcohol-related problems.
4. Administration and planning of an orderly, integrated service network, available to all without discrimination, and in all areas of the State.
5. Achievement of objectives through ongoing regional and statewide mechanism that will promote the integration of alcohol-related programs with all other appropriate community services, public and private. This coordination of planning, implementation, and evaluation is to be regarded as a positive and continuously evolving process, rather than a static, program-oriented structure.
6. Involvement of those for whom these processes and services are developed: These participants representing client interests include the general public, i.e., the taxpayer and concerned citizen, as well as the client, his family, employer, and significant others.
7. Development, implemented with the strong backing of concerned individuals and groups, of appropriate legislation in such areas as nondiscrimination of recovered alcoholics in employment; enactment of a statute abolishing the crime of public intoxication per se, and substituting alcoholism treatment and rehabilitation provision in the place of incarceration and fines; and more adequate financial backing for alcoholism and alcohol-related service programs.

A copy of the State Plan is available for examination at the Maine State Library in Augusta.

LEGAL ADVERTISEMENT

LEGAL NOTICES

1—Legal Notices

LEGAL ADVERTISEMENT

The 1972 State Plan for comprehensive services relating to alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs in Maine has been updated as provided for under terms of the federal Hughes Act, Public Law 91-616. Upon approval of this plan, fiscal year 1973 funds in the amount of $200,000 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 as well as development of new prevention, treatment, and rehabilitation modalities.

The updated sections include:

1. A progress report of FY'72 activities
2. Minor revisions such as address changes, A-95 review changes, and addition of Advisory Council by-laws and cooperative agreements.
3. Summary of overall objectives for FY'73.

A copy of the State Plan and its revisions will be available for examination at the Maine State Library in Augusta for 30 days.

U.S. Office of Management and Budget Circular A-95, was initiated on April 21. As noted on the attached interdepartmental memo from the State Planning Office, the 22 agencies to which it was sent, including each of the State's Regional Planning Commissions, were requested to review the State plan materials within 40 days and return their responses to the State's A-95 Coordinator. Copies of the plan had already been sent by the Health Council to several of the persons to whom this memo was addressed, since they, along with all others of the more than 200 participants in the regional planning workshops, as well as invitees who were unable to attend these sessions, were mailed a copy of the interim State plan early in April.

To date, no official response has been received from the State planning office, though this memo has generated numerous letters and phone calls from persons interested in learning more about the current status of the plan.

MAINE FEDERAL GRANT APPLICATION / AWARD NOTIFICATION FORM 189

1 APPLICATION DATE (yr,mo,day): 19 73 3 19

ITEMS 1-29 TO BE COMPLETED BY APPLICANT OR CLEARINGHOUSE DEPENDING UPON STATE PROCEDURES.

3 APPLICANT-Organizational Unit	4 ADDRESS-Street or P. O. Box	2 APPLICATION NUMBER (Optional)
Division of Alcoholism Services	32 Winthrop Street	

5 CITY	6 COUNTY	7 STATE	8 ZIP CODE	9 PROG NO. (Catalog of Fed Domestic Assistance)
Augusta	Kennebec	Maine	04330	13.257

10 TYPE OF GRANT ACTION: a [ ] New b [X] Continuation c [ ] Modification

TYPE OF CHANGE (Complete if 10 b or 10 c was checked)
11 a [ ] Increased Dollars b [ ] Decreased Dollars
12a [X] Increased Duration b [ ] Decreased Duration
13a [ ] Other Scope Change b [ ] Cancellation

14 EXISTING FED GRANT NUMBER: MH X 23 9500 72 0

15 REQUESTED FUND START (yr,mo): 19 73 7
16 FUNDS DURATION: 12 (Months)
17 EST. PROJECT START (yr, mo): 19 73 7
18 EST. PROJECT DURATION: 12 (Months)

19 APPLICANT TYPE (Enter Letter) [a]
a. State e. School District
b. Interstate f. Community Action Agency
c. County g. Sponsored Organization
d. City h. Other (Specify in Remarks)

FUNDS REQUESTED [For Changes Show Only Amount of Increase (+) or Decrease (-).]

20 FEDERAL	( ) $	200,000 .00
21 STATE	( ) $	.00
22 LOCAL	( ) $	.00
23 OTHER (Specify in Remarks)	( ) $	.00
24 TOTAL (20,21,22,23)	( ) $	200,000 .00

25 DESCRIPTIVE NAME OF PROJECT (Purpose)
State Plan for Prevention, Treatment and Rehabilitation of Alcohol Abuse and Alcoholism in Maine.

26 AREA OF PROJECT IMPACT (For Facility Projects Indicate City, County and State)
Statewide

27 CONGRESSIONAL DISTRICTS Of Applicant: [1] Districts Impacted By Project: [1 and 2]

28 HAS AN ENVIRONMENTAL IMPACT STATEMENT BEEN PREPARED? Yes a [ ] No b [X]

29 CLEARINGHOUSE(s) TO WHICH SUBMITTED: State a [X] Metro b [ ] Reg Dist c [ ] None d [ ]

ITEMS 30-35 TO BE COMPLETED BY CLEARINGHOUSE.

30 CLEARINGHOUSE ID	31 FINAL CLEARINGHOUSE ACTION DATE (yr,mo,day)	32 ACTION BASED ON REVIEW OF	33 ACTION TAKEN	34 STATE PLAN REQUIRED	35 STATE APPLICATION IDENTIFIER
ME01	19___ ___ ___	a [ ] Notification b [ ] Application	a [ ] With Comment b [ ] Without Comment c [ ] No Interest	[ ] Yes [ ] No	

ITEMS 36-37 TO BE COMPLETED BY APPLICANT BEFORE SENDING FORM TO FEDERAL AGENCY.

36 CERTIFICATION - The applicant certifies that to the best of his knowledge and belief the above data are true and correct and filing of this form has been duly authorized by the governing body of the applicant. (Check box if no clearinghouse response was received in 30 days) [ ]

37a NAME (Print or Type)	b TITLE	c SIGNATURE OF AUTHORIZED REPRESENTATIVE	d TELEPHONE NUMBER

ITEMS 38-42 TO BE COMPLETED BY THE FEDERAL OFFICE RECEIVING THE GRANT APPLICATION.

38 NAME OF FEDERAL OFFICE RECEIVING APPLICATION	39 CITY	40 STATE	41 ZIP CODE	42 DATE RECEIVED (yr,mo,day)
				19___ ___ ___

ITEMS 43-54 TO BE COMPLETED BY FEDERAL OFFICE EVALUATING AND RECOMMENDING ACTION ON THE APPLICATION.

43 GRANT APPLICATION IDENTIFIER (Assigned by Federal Agency)	52 APPLICATION REC'D. yr mo day	53 RETURN FOR AMENDMENT yr mo day	54 EXPECTED ACTION DATE yr mo day	EST. ACTION REVISED AS OF yr mo day
	___ ___ ___	___ ___ ___	___ ___ ___	___ ___ ___

	REVISIONS	Amended Applic. Rec'd.	Subsequent Returns to Applic.	Revised Est. Action Date
44 GRANTOR AGENCY		___ ___ ___	___ ___ ___	___ ___ ___
45 ORGANIZATIONAL UNIT		___ ___ ___	___ ___ ___	___ ___ ___
46 ADMINISTERING OFFICE		___ ___ ___	___ ___ ___	___ ___ ___

47 ADDRESS-Street or P. O. Box	48 CITY	49 STATE	50 ZIP CODE	51 TELEPHONE NUMBER

ITEMS 55-64 TO BE COMPLETED BY THE FEDERAL OFFICE APPROVING THE GRANT APPLICATION.

FINAL ACTION	Final Dates	FUNDS REQUESTED [For Changes Show Only Amount of Increase (+) or Decrease (-).]	
55 [ ] Awarded [ ] Rejected (yr,mo,day)	19___ ___ ___	60 FEDERAL AMOUNT (FY_____ funds)	( ) $ .00
56 FUNDS AVAILABLE (yr,mo,day)	19___ ___ ___	61 STATE SHARE	( ) $ .00
57 ENDING DATE (yr,mo,day)	19___ ___ ___	62 LOCAL SHARE	( ) $ .00
58 FEDERAL GRANT NUMBER		63 OTHER	( ) $ .00
59 FEDERAL FUND ACCOUNT NUMBER		64 TOTAL (60,61,62,63)	( ) $ .00

REMARKS

APPENDIX

STATE LEVEL COOPERATIVE AND CONTRACTUAL AGREEMENTS

EXHIBIT I

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

On October 30, 1972 the Department of Mental Health and Corrections and the Department of Health and Welfare signed a cooperative agreement which is reproduced on the following pages. This agreement is a formalization of the outline presented above.

A COOPERATIVE AGREEMENT BETWEEN THE BUREAU OF REHABILIATION, DEPARTMENT OF HEALTH AND WELFARE AND THE BUREAU OF MENTAL HEALTH, DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS REGARDING COLLABORATION IN THE PLANNING AND DELIVERY OF ALCOHOLISM SERVICES

The goal:

To establish a mechanism for collaboration in the planning, development and delivery of comprehensive alcoholism services which are responsive to the needs expressed by the community and which reflect the integral relationship between alcoholism and mental health.

Assumptions:

1) The development of such joint agreements at the state level will assure a more highly integrated and coordinated mental health-alcoholism services program at the community level.
2) There are areas in which each agency has uniquely different roles which can be identified (statutes, federal and state policies, regulations, etc.) and should be mutually respected.
3) As components of a single human services system there are many activities which overlap and require considerable communication to carry on effectively.
4) There are ways in which the problem of duplication of services can be resolved, if the purposes and specific component tasks of such services are clear to the community and to the providers of services.
5) The community would more appropriately request and better utilize services from the Bureau of Rehabilitation and the Bureau of Mental Health if respective roles were also clear to them.
6) A particular relationship between the Bureau of Rehabilitation and the Bureau of Mental Health will vary from region to region in terms of collaboration and service delivery by respective agencies.

7) Both the Bureau of Mental Health and the Bureau of Rehabilitation serve essentially the same target population in terms of geographical, socio-economic and high risk populations.

Role and function of each agency:

The Bureau of Mental Health has responsibility for providing comprehensive mental health services which may include alcoholism treatment and rehabilitation through its institutions and community mental health centers. The Bureau of Mental Health will provide funds within certain policy guidelines and standards to community mental health centers for the provision of comprehensive mental health services which may include alcoholism services.

The Bureau of Rehabilitation has responsibility for the development of a State Plan for Alcoholism Services to be implemented through five regional alcoholism planning bodies. The Bureau of Rehabilitation will provide matching funds to local agencies developing and deliverying alcoholism services within its funding capabilities. Funds for regional alcoholism planning bodies come from the federal formula grant and will be administered according to policies developed in consultation with the Governor's Advisory Council on Alcohol Abuse and Alcoholism.

Statewide coordination of alcoholism services rests with staff designated by the Bureau of Rehabilitation. This staff, advised by the Governor's Alcoholism Advisory Council, establishes guidelines for regional alcoholism planning bodies, maintains the federal grant mechanism, provides technical assistance, and assures the development of statewide planning activities for the various aspects of alcoholism prevention, treatment, and rehabilitation. The staff designated by the Bureau of Mental Health for mental health related aspects of alcoholism will function as a staff person within the structure stated above.

In areas of difference or conflict in policy or preference, the liaisons of each Bureau will be responsible for negotiating a mutually agreeable and

workable solution.

Guidelines for regional collaboration in the planning, development and delivery of mental health related alcoholism services:

1) The Bureau of Rehabilitation regional office will negotiate its own agreements with the respective affiliate of the Bureau of Mental Health; such agreements will be based on these guidelines.

2) Services to be funded must conform to federal and state regulations related to scope of services, target population and generally to the state policies of both bureaus.

3) Planning for such services should include input from the counterpart agency as appropriate.

   a) in program areas where there is minimal interdependence in the functions involved or where a program is mandated by statute, it would be appropriate to merely inform the other agencies;

   b) in program areas which involve functions that could be carried on by either agency, it would be appropriate to actively involve the other agency in both the planning and implementation process.

4) It is assumed that in any joint planning activity, sound planning procedures would be adhered to:

   a) documentation of need;

   b) determination of priorities;

   c) documentation of community input;

   d) insurance of accountability--both financial and service evaluation.

5) The delivery of agreed upon services to the alcoholic and his family may be accomplished by one or the other of the two agencies, or by purchase from a third agency, or combination of these, e.g.

   a) effective case finding; community mental health services must be outreach-oriented in serving the alcoholic;

screening and referral services for the nonintoxicated alcoholic;

emergency services for the acute alcoholic;

psycho-social evaluation of alcoholics coming to centers directly or referral by other caregivers;

the development of a plan of action for alcoholics requiring mental health services;

provision of a wide range of treatment services, individual, group, outpatient, inpatient, partial hospital, etc.

aftercare for alcoholics returning from inpatient service;

development of therapeutic residential care, etc.

education and consultation to other alcoholism service agencies.

6) The final decision as to what services are to be funded will be subject to the recommendations of the regional planning organizations. Such decisions must consider both mental health and specific needs as related to alcoholism and provide for planning on an ongoing basis to assure effective use of expert knowledge and resources in comprehensive human service delivery.

7) Suggested mutually agreeable priorities for services will be set by the respective Central Office staffs but recognition is given to the fact that regional needs may indicate a different order of priorities. This is possible if there is a rationale given which is acceptable to the respective central office agency.

8) There must be a method of evaluating the quantity and quality of these jointly developed services which are acceptable to both the Bureau of Rehabiliation and the Bureau of Mental Health.

Shared Responsibilities:

Within the context of the respective roles of the Bureau of Rehabilitation and the Bureau of Mental Health, certain areas of shared responsibility are evident.

Each Bureau will appoint a liaison through whom shared activities will be carried out.

1. Funding: The Bureau of Mental Health will, to the extent possible, retain and expand its funding of comprehensive mental health services, including alcoholism activities within the community mental health centers through its regular grant-in-aid program and Mental Health Improvement Fund.

   The Bureau of Rehabilitation will assume responsibility for providing community mental health centers and other agencies which are developing and delivering alcoholism services with financial support through federal formula and project grant funds and will attempt to establish a grant-in-aid program.

2. Decision making: Through designated liaisons each Bureau will involve the other in decision making regarding alcoholism programs a) in mental health centers and institutions, and b) in alcoholism agencies developing mental health related services whether these decisions be concerned with policy, programs or funding.

3. Legislative activities: Given mutual interests in the funding, planning and delivery of high quality comprehensive alcoholism services, the Bureau of Rehabilitation and Bureau of Mental Health will collaborate in legislative activities. Such areas as appropriations and legal regulations, standards, certification are appropriate for collaboration.

William F. Kearns, Jr., Commissioner
Department of Mental Health and Corrections

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

William E. Schumacher, M.D., Director
Bureau of Mental Health
Department of Mental Health and Corrections

Owen Pollard, Director
Bureau of Rehabilitation
Department of Health and Welfare

Date: October 30, 1972

EXHIBIT II

STATE PROGRAM DEVELOPMENT

The Department of Mental Health and Corrections has an agreement with the National Institute of Mental Health which places Maine as a priority state for technical assistance and special consideration in funding in mental health programming. This agreement is termed State Program Development (SPD). Under the SPD arrangement alcoholism services are a statewide priority for mental health. It is through the liaison activities of the state level Alcoholism Planning Coordinator that reciprocal input is made between the Bureau of Mental Health and the Division of Alcoholism Services. This liaison has generated a mutually acceptable set of goals and objectives constituting a day-to-day commitment to work cooperatively toward achievable ends in comprehensive community and state level alcoholism planning and service.

The following SPD alcoholism goals and objectives reflect the spirit of cooperation presented in the agreement between the Department of Mental Health and Corrections and the Department of Health and Welfare as well as the state/federal partnership of State Program Development.

SPD ALCOHOLISM GOALS AND OBJECTIVES

mpletion Date		
	1.	Stimulate further development of joint collaborative relationship between BR and BMH regarding Alcoholism Services.
		a) Implementation of cooperative agreement.
October 1, 1972		1) Sign agreement
January 1, 1973		b) Presentation and discussion of BR/MH agreement at SPD workshops.
Ongoing		c) Participation of BR on SPD Steering Committee.
Ongoing		d) Periodic participation of BR staff in appropriate SPD Team meetings.
Ongoing		e) Participation of MH staff in State Alcoholism Advisory Committee meetings.
November 1, 1972		f) Advisory Council review and comment on MH/Alcoholism SPD goals and objectives.
November 1, 1972		g) Advisory Council participation in SPD input for Alcoholism Services.
October 2, 1972		h) Joint review of Uniform Intoxication Act.
November 1972		i) Joint testimony on Uniform Intoxication Act.
	2.	Development of comprehensive Alcoholism Services in all alcoholism planning regions.
July 1, 1973		a) Develop and implement regional alcoholism planning structure.
		1) The utilization of existing appropriate regional planning mechanisms for the coordination of alcoholism in mental health planning.
		2) The utilization of mental health centers as a major resource in regional alcoholism planning.
July 1, 1973		b) Develop and implement conceptual operational models for delivering comprehensive alcoholism services in selected regions.
		1) The utilization of the "Think Tank" as a means of further developing conceptual models.
		2) The provision of technical assistance to regions in the development and implementation of such models.

3) The implementation of models in selected areas in relationship to the SPD objectives emerging from regional meetings.

July 1, 1973 c) Development and implementation of I & D grants in those regions not ready for implementing comprehensive services.

1) Provide technical assistance to regions pursuing the development of I & D grants.

2) Utilize the regional SPD reports as input in the selection of regions for the development of I & D grants.

April 1974 d) Submission of comprehensive alcoholism grants in all regions.

1) Utilization of the Regional Alcoholism Council for review and comment on all grants submitted.

2) Utilization of the State Alcoholism Council for review and comment of alcoholism proposals approved by the Regional Councils.

July 1975 e) The implementation of comprehensive alcoholism grants, either separately or in conjunction with other programs within available resources.

3. Develop a compatible inter-bureau data system for alcoholism services.

July 1974 a) Insure maximum capatibility between SRI and State data systems and insure maximum utilization of the systems by mental health centers.

1) Collaboration between the statistics and evaluation system being developed by the Bureau of Mental Health and the system currently being developed by the Division of Alcoholism Services.

January 1, 1973 4. Development of BR central office staff capability for insuring the implementation of these objectives through--

a) assignment of central office coordinator (funded under the formula grant) to this task as a priority responsibility.

July 1, 1973 5. Development of a community grant-in-aid program for funding alcoholism services provided by local agencies.

a) Active support of BMH and Community Mental Health Centers toward securing legislative support and enactment of a community grant-in-aid program to be administered by BR for community alcoholism services.

1) Submission to the 107th Legislature of a community

grant-in-aid budget proposal of $400,000

2) Mobilization of the Bureau of Mental Health and community mental health centers in support of legislation and budget at the legislative hearings.

April 1974 6. Joint planning in the development of certification standards for alcoholism activities within mental health centers.

a) Establishment of an inter-bureau committee to develop criteria for a certification system.

b) Joint review of the standards proposed in the Uniform Act.

April 1974 7. Joint development of mechanisms for the recruitment, training, and ongoing development of staff members who provide alcoholism services in MH agencies.

a) Development of workshops, seminars, and other educational experiences through NIMH technical assistance and/or funding.

EXHIBIT III

INFORMATION SYSTEM

In addition to the cooperative agreements the Division of Alcoholism Services let a contract with Social Systems Research Corporation (Bangor, Maine) to develop an information system. The system, described in the following pages, will provide for the development of three interdependent data systems:

1. Community Monitoring System
2. Program Monitoring System
3. Assessment of Effectiveness

This information system, when it becomes operational, will provide the Division of Alcoholism Services and its regional structure a data base upon which to make objective planning decisions with respect to alcoholism services.

RIDER A

Specifications of Work to be Performed

The Contractor shall fulfill Priorities I, II, and III as set forth in Rider B. The evaluation and planning activities subsumed under Priorities I, II, and III, which the Contractor shall provide are specifically:

Priority I

A. Development of three interdependent data systems:

1. Community Monitoring System
2. Program Monitoring System
3. Assessment of Effectiveness

The development of each system includes the following:

1. Identification of the relevant variables.
2. Location and/or creation of data sources for identified variables.
3. Collection of baseline data including preparation of collection forms and development of a system for data collection.
4. Development of data storage and retrieval system.
5. Procedure to generate reports derived from data collected via Community and Program Monitoring.
6. Statistical analysis of data and provision of procedures for continuing such analysis.

Priority II

A. Provide information to illustrate the gap between need and response capability and provide a model for the effective use of such information in grant applications.

B. Provide a model illustrating how the Community Monitoring data may be used to facilitate rational empirically based decisions.

C. Provide a short course describing the various alcoholism models and their implications for the conceptualization of the alcoholic and consequent therapeutic response.

D. Provide a comprehensive model to the planning groups which permits the greatest possible latitude in local planning but will insure it is in keeping with the State Plan commitment.

Priority III

A. Provide consultation service to render program specific the information and models provided under Priorities I and II.

B. Offer assistance in establishing and funding an ongoing research and evaluation capability by specifying the form of local grant applications which would provide the funding for a state research office as well as a systematic record keeping system for each local agency.

C. Training and meeting with Regional groups.

D. Advisement and development of State evaluation.

Any product of this contract (report, map, chart, movie, etc.) shall bear the following legend upon the title page or block: The preparation of this report, chart, map, etc., was financially assisted by the State of Maine, Department of Health and Welfare, Appropriation Account Number 4413-9.

III. PROJECT DESIGN

III. PROJECT DESIGN

The State Plan calls for the development and implementation of a comprehensive system for the prevention, treatment and rehabilitation of alcohol abuse and alcoholism. Each of the five planning regions will develop its own program based on locally determined need, but all will be committed to the four elements of comprehensiveness, viz:

1. Prevention
2. Outreach/Referral
3. Treatment/Rehabilitation
4. Aftercare

This scheme implies the existance of three target groups, i.e., alcoholics, alcohol abusers, and potential members of these two groups. There is the task, therefore, of 1) estimating the extent of the regional problem not only in terms of the target groups, but also in terms of the correlative social factors, problems, and resources germane to the problem, 2) of estimating the necessary comprehensive effort to adequately meet the needs of these groups and 3) to assess the effectiveness of the effort.

With respect to the first point it is worth pointing out specifically that the extent of the problem is partly determined by attitudes towards alcoholism and alcohol abuse and public support of the comprehensive plan is virtually mandatory if success is to be achieved. It would therefore be wise, if financially feasible, to conduct a mail out or telephone baseline survey of attitudes of the community-at-large and of influential sub groups such as doctors, lawyers, judges, service clubs, etc.

towards the problem drinker as such and the social problems associated with his pathological drinking.

The latter two points need elaboration to clarify the distinction between effort and effectiveness. It is theoretically (but not practically) possible to bring appropriate comprehensive treatment to every potential or actual target individual. If this were to be the case, the program would be 100% effective in terms of response to the need situation. But just to apply preventive, treatment, or rehabilitation measures says nothing about the impact of the measures on the problem behavior, i.e., the success or failure of the measures in reducing or eliminating the problem. With this distinction made it may be said that three interdependent data systems must be developed:

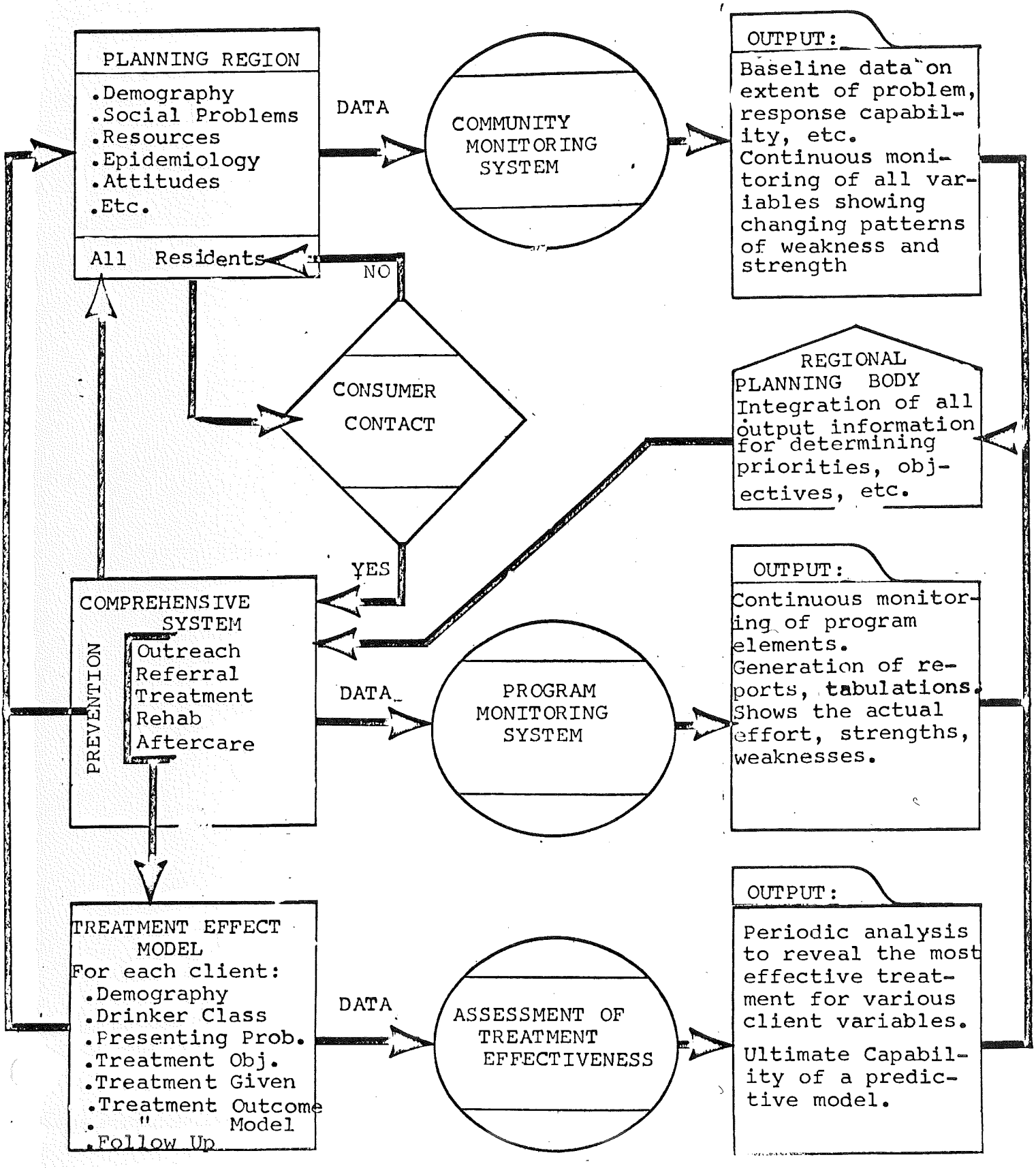
1. Community Monitoring System
2. Program Monitoring System
3. Assessment of Effectiveness

This tripartite system must be compatible with existing federal and state systems and be standardized for state-wide use in the five regions.

In sum, then, this proposal suggests a design that will continuously monitor significant variables in each region. Such information will enable the regional organizations to develop and apply the elements of the comprehensive models on the basis of local need. The actual application of the elements of the program in quantitative terms, e.g., number of persons contacted by outreach, number of persons in treatment, etc., will be the measure of the program effort in response to the empirically determined need. The impact of the program elements will be

measured in terms of changes in the extent of the problem in the region-at-large and changes attributable to treatment procedures on the variously defined target populations. Lastly, impact effectiveness will also be subjected to cost benefit analysis.

FUNCTIONAL RELATIONSHIPS OF THE TRIPARTITE DATA SYSTEM



Flow Chart Narative

The flow chart shows a typical planning region with some of the variables that describe the region that are also correlated with alcoholism and alcohol abuse. The epidemiology item refers to the alcohol problem. People live in the region who fall into two major groups determined by whether or not they have consumer contact with any of the elements of the comprehensive system except that of the prevention effort.

An arrow links the comprehensive system to the planning region to illustrate that it is integral with the community. Likewise an arrow links the comprehensive treatment elements except prevention to the treatment effect model. This is to illustrate that the treatment effect model is a data collection procedure employed with comsumers of the various services. An arrow from treatment effect merges with the prevention effort and leads back to the community with its resident population and characteristics. The implication here is that the prevention and treatment/rehabilitation effort is taking place in the community in which the ultimate success or failure of the comprehensive system must show itself.

Data input arrows indicate that variables are measured in each of the three blocks and constitute the input of the three systems prepared for storage, processing and retrieval of the relevant information. Each system has its specific output. The community monitoring output is actually multifaceted. Although not indicated by the chart the first output of that system will provide the baseline information necessary to establish the initial configuration of the comprehensive system.

Subsequent output provides information on the state of the community that includes changes produced by the program effort itself. In this sense, then, this output system also functions in impact assessment. Data input for the program monitoring system is, as previously described, the activity of the various program elements. The output of this system is that of continuous monitoring of the effort. Its functions are to process performance measures to satisfy reporting requirements, and to provide information to program personnel on the degree to which various elements are being utilized and performance emphasis met. Data input for assessment of treatment effectiveness is processed to measure the direct impact of the various program elements on identifiable consumers of services. The processing of client, treatment and outcome data is that of sophisticated multivariate analysis that will indicate what treatment or combination of treatments yields the most favorable outcome for what constellation of client characteristics. Continued application of this model can ultimately lead to the isolation of certain client characteristics that predict the outcome of the application of given treatment procedures.

The output of all these systems furnishes the continuously updated information on the state of the program in its environment. As such it constitutes the input to the human element on the basis of which decisions for effective and needed allocation of priorities, objectives, etc. are fed back into the comprehensive system.

IV. METHODOLOGY

IV. METHODOLOGY

A. Priority I

The development of the tripartite system will proceed sequentially according to the following outline:

1. Identification of the relevant variables.
2. Location and/or creation of data sources for identified variables.
3. Collection capability.
4. Storage and retrieval procedures.
5. Generation of reports.
6. Statistical analysis.

1. Identification of the Relevant Variables

In the present context, the identification of relevant variables is a two-fold problem. Heretofore the words "problem", "target group", "alcohol abuse", "alcoholic", "prevention", "treatment", "rehabilitation", etc. have been employed without definition. For evaluation purposes, the identification of a variable is not complete until or unless it is specified in measurable terms. The State Plan proposes to do something about the "alcohol problem". This problem manifests itself in observable ways depending on varying subjective and environmental contexts. The procedure here will be that of working with state and regional coordinators, who represent the various lay and professional attitudes, to identify in measurable terms the variables of significance to all three of the data system components. This procedure will be very time consuming and frustrating for both data system designers and program developers. Variables of incomparable relevance to alcoholism specialists are sometimes impossible to objectively quantify.

Variables of incomparable relevance to data system specialists are often seen as completely irrelevant to program developers.

Intrinsic to this identification procedure will be the specification of objectives. Example: Suppose we are discussing a particular treatment procedure and the matter of outcome measures is the specific focus. Let us say that treatment personnel decide to measure outcome in terms of "improved", "no change", or "worse". The evaluation expert will want to know what is "improved", etc. and on what basis the treatment person makes his judgment. Such questions bring treatment objectives and the method of measuring them into sharp focus. Evaluation would also want to know who is improved, i.e., who is being treated. Such questions bring subject variables into sharp focus and the clarification of the criteria for classifying drinkers.

2. Location and/or Creation of Data Sources

Once variables have been identified and measures specified, a source of the measure must be sought. This may appear an either - or situation, i.e., either a source exists or it doesn't. Experience informs, however, that data, as other phenomena, often exists in shades of gray. Other data may exist in potentially measurable form but there may be no way to create a source, e.g., the number of "closet drinkers." Still other data may exist already in collected form, but unavailable to evaluation because it is privileged or because an administrative decision forbids it or because it would be too expensive to collect.

At this point in the development of the data system,

Social Systems Research Corporation would rely heavily on the Director of Alcoholism Services to secure the cooperation of various state and participating agencies in making available and/or creating sources of required data.

Examples of variables felt to be relevant to the Community Monitoring System are presented in Table 1. The applicability and source of each of these variables, plus others not included on this list must be debated and decided upon. Data on such variables would help indicate the impact of the regional rehabilitation programs on the target population.

Table I

Examples of Variables Which Could be Included in the Community Monitoring System*

Socio-economic Characteristics	Community & Topographic Data by County
Mail out or telephone survey of baseline attitudes towards alcoholism and alcohol abuse manifested by the region-at-large, doctors, judges, lawers, teachers, etc.	Total population
Overcrowding	Birth & Death Rates
Migration	Number of high school, graduate or post-high school education
Urban-Rural	High School dropouts
Education	Index in change of # of workers
Total Income	# of paid employees & payrole of retail establishments
Source of Income	Number and % of poor families
Expenditures	Type and # of health services
Living Standards	Type and # of community organizations
Labor Force Standards	Type and # of mental health facilities
Death Rate & Cause	Hospitals - Hospital beds
Diseases	Nursing homes
Medical Expenses	Medical personnel
Housing	Alcohol related traffic accidents & arrests
* We will also utilize past census and other data sources to present other relevant characteristics of target population	# of arrests for intox. on a public way
	# of divorces

TABLE II

Examples of Variables Which Could be Included in the Program Monitoring System

1. # of individuals contacted through outreach.
2. # and % of outreach contacts in various target groups.
3. # and % of outreach contacts with each target group referred to treatment/rehab.
4. # and % of treatment/rehab referrals actually entering treatment/rehab.
5. # and% of those entering who complete the treatment/rehab requirements.
6. # and % of those completing treatment/rehab followed with aftercare.
7. All of the above classified according to presenting problem, objective and outcome.
8. Prevention effort in terms of public information and education through mass media, speaker bureaus, etc. Estimate of quality and quantity of population reached.
9. Any and all other program variables found to measurable and collectible.

Assessment of impact effectiveness on the region-at-large will be designed to show any changes in the incidence of alcohol related social problems, such as arrest, divorce, job loss attributable to the various elements of the comprehensive program including prevention effort. This will be accomplished through proper analysis of Community Monitoring data. A further measure of impact could be assessed via periodic phone or mail out surveys of a random sample of region residents and specific populations, for example, judges, police teachers, doctors, measuring attitude change with respect to the community in general and alcohol related attitudes in particular.

The impact on specific target groups actually contacting

the program elements will be assessed by relating client classification data (i.e., "type" of drinker) to treatment type, objective and outcome in terms of the objective of the treatment and the socially destructive behaviors correlated with alcoholism and alcohol abuse.

3. Collection Capability

Once sources have been located or created, the data must be collected. This means not only the assignment of collection responsibility but a system that triggers the timely collection along with a system of checks to insure that collection has occurred. It also means the preparation of collection forms designed with storage and retrieval in mind.

4. Storage and Retrieval Procedures

Storage and retrieval procedures are contingent upon the uses to which the data will be put. There are obvious national, state, and regional reporting requirements that must be considered. The data should be stored in a form that lends itself to machine print-out of routine reporting requirements. Beyond this special analyses must be anticipated in order that the data be stored in a form that enables retrieval of desired or potentially desirable information. Social Systems Research Corporation will furnish the computer techniques to accomplish these purposes.

5. Generation of Reports

The generation of reports follows logically from the previous section. Reports in this sense are primarily national, state and local reporting requirements derived from data collected via Community and Program Monitoring as described

previously. The computer programs to this end will be supplied by Social Systems Research Corporation.

6. Statistical Analyses

These procedures refer to special computer manipulations of data that relate various elements of the State Plan to one another on the basis of which to assess effort and impact effectiveness within and among the five regions and the state as a whole. Social Systems Research Corporation will assist the Director in determining the kinds of analyses that are desirable, models for gathering the required data, and the personnel or consultation services required for actual performance of the analyses.

The accomplishment of all these steps for the Problem Monitoring component, the Program Effort Monitoring component, and the Assessment of Effectiveness component for all elements of the comprehensive model will satisfy all requirements of Priority I.

B. Priority II

2a.) The Problem Monitoring and Program Monitoring systems are designed to measure the extent of the problem and the response capability of each region to the need. Regions will differ in terms of the problem configuration, response capability, and varying emphasis on the comprehensive elements depending on community need and planning organization philosophy. Funds will be required to match program effort to the perceived need. Social Systems Research Corporation will have built into the data collection the kind of empirical imformation required

to illustrate the gap between need and response capability and a model for effectively using that information in grant applications.

2b.) Planning groups will be faced with the problem of interpreting the Community Monitoring data as a basis for making decisions on mounting an appropriate response. Social Systems Research Corporation will provide a model illustrating how the data may be used to facilitate rational empirically based decisions.

2c.) There are a number of different theories on alcoholism and alcohol abuse but the major trichotomy is among the disease theory, psycho-social theories and learning theories. All personnel working in alcohol programs will knowingly or unknowingly espouse a particular theory or element, sometimes conflicting, of two or more theories. The theory held is of more than academic interest since it largely dictates the content of preventive, treatment, and rehabilitation procedures. Social Systems Research Corporation will provide a mini-course that describes the various alcoholism models and their implications for the conceptualization of the alcoholic and consequent therapeutic response. This training model will not eulogize or denigrate any particular model but will, hopefully, stimulate a careful thinking through of the various approaches to reduce inconsistency in whatever response is made to the client and his problem.

2d.) State and regional planning groups will be multi-disciplinary with both professional and lay people including consumers of the services. Different individuals in the group

will have widely divergent attitudes towards the causes, manifestations and response to alcoholism. The State Plan, however, is committed to the comprehensive model with its several elements and continuity of care within the elements. A model must be provided to the planning groups that will insure that a comprehensive plan evolves despite the likely parochialism of some of the individual members. Such a model will permit the greatest possible latitude in evolving a locally determined configuration of comprehensiveness, but will insure that it is in keeping with the State Plan commitment.

All Priority II elements are necessarily contingent upon the prior completion of the data systems subsumed under Priority I.

C. Priority III

3a.) The groundwork for defining goals and objectives and establishing local priorities will have been laid as a result of working with the state and regional coordinators and planning bodies in meeting Priorities I and II.

Priority III a. calls for assisting regional planning groups towards those same ends not only during the collection of baseline data when the regional groups are being developed, but also when the development of the comprehensive plan is established and the groups are functioning. Social Systems Research Corporation is prepared to provide consultation service to render program specific the information and models provided under Priority I and II. In this sense Priority III is completed during the completion of Priority I and II.

3b.) Under Methodology: Priority I, 6, Social Systems Research Corporation has proposed to provide the state level agency with models for performing statistical analyses of impact effectiveness and the staffing and/or consultation services required for actual accomplishment of the analyses. As with Priority 3a., the present priority item calls for going beyond mere information giving to actual assistance in establishing and funding an ongoing research and evaluation capability. Social Systems Research Corporation is prepared to offer such assistance mainly in the sense of specifying the form of local grant applications which would provide the funding for a state research office as well as a systematic record keeping system for each local agency. This system would automatically feed into the state system and become a prerequisite for funding. Also, assistance will be given for future funding efforts.

EXHIBIT IV

REGIONAL ALCOHOLISM PLANNING CONTRACTS AND AGREEMENTS

Since the Southern Regional Alcoholism Council (SRAC, Region I) was well organized during the initial planning phase of the first year State Plan, they were able to continue in that capacity during the 1972 phase of planning. Subsequent to the approval of the State Plan SRAC incorporated as a viable planning body for southern Maine. The Division of Alcoholism Services was, therefore, able to build upon the spontaneous development of grass roots community interest in alcoholism services. SRAC in meeting the Division's requirements for structure, planning intent, representation, and relationship to the state agency was granted $46,000 dollars to hire necessary staff to begin comprehensive alcoholism planning and coordination in the southern region of the state.

The following justification was given by SRAC for having a grant for planning services given to them. Within this justification the Division of Alcoholism Services has assurances that SRAC activities will be in conformity to the guidelines for the Division's own regional councils.

BACKGROUND:

As prescribed in P.L. 91-616 (Hughes Act), the State Alcoholism Authority conducted a public workshop in Region I on March 28, 1972. During the first six months leading to the incorporation of the Southern Regional Alcoholism Council (Region I) more than twenty grassroot meetings were held with a broad cross-section of residents, both consumer and provider. These meetings were held to prepare a regional plan, to organize the Council and to establish by-laws and a Board of Directors. With administrative and financial assistance from the Southern Maine Comprehensive Health Association, the Council was incorporated and held its Organizational Meeting on September 21st. The Board of Directors have been meeting monthly with numerous committee meetings occurring in the interim.

On July 21, 1972, Rev. Gerard Bolduc, acting on behalf of the Council, sent a letter to Max Good, Director, State Alcoholism Authority, informing him of the Council's concern for the hiring and assignment of Regional Coordinators. Although the State Plan called for the assignment of a State employed Coordinator to Region I, Mr. Good's letter of August 4th stated his willingness to consider an alternative arrangement via grant request from the Council to select, employ, supervise, and administrate its own Coordinator, Secretary and budget.

On December 8th, a budget of $57,428 and job description for a Coordinator, Assistant Coordinator and Administrative Secretary were mailed to Max Good.

The Assistant Coordinator's position was "new" to previous discussions with the State Authority, but felt by the Council to be justifiable in light of existing population, alcoholism incidences, and other Federal grant factors.

Mr. Good met with Rev. Bolduc, President; Jack Archibald, Treasurer; and Paul Adams, Board Member; on December 28th to negotiate the total budget and the new position. The Council's reasoning is as follows:

JUSTIFICATION:

The enclosed map of Maine portrays the State as divided into the eight mental health catchment areas with the lower four (5-6-7-8) being identical to Region I (SRAC) and its three subareas of York, Cumberland, and Mid-Coastal. The State's

1970 population was 992,048 and Region I comprises 389,818 (39.2%).

Presently, the Penobscot Region (IV) is entering its third operational year of an eight year community alcoholism staffing grant which has the potential and responsibility of providing comprehensive alcoholism services. This grant involves more than fifty staff positions with the Federal participation beginning at approximately $380,000 and a substantial "annual" local support being provided by the State Bureau of Mental Health (via Bangor State Hospital).

The adjoining Aroostook Region (V) has an O.E.O. funded alcoholism grant and the Aroostook Mental Health Services has submitted a comprehensive alcoholism staffing grant. The latter has been approved but unfunded to date. This eight year grant would include more than thirty staff positions funded through a request of approximately $400,000 from NIAAA.

Together, Regions IV and V will be able to provide comprehensive services to a total 1970 population of 298,660 (Region IV - 206,127 and V - 92,533) or 30.1% of the State.

In the Tri-County Region (II) a one year Initiation and Development (I & D) planning grant has been submitted which will provide full-time and supportive staff to identify and prepare a comprehensive plan for the development of alcohol services for its total population of 157,180.

Therefore, the Aroostook, Penobscot, and Tri-County Regions have or will be in a positive position to employ staff during the next fiscal year for planning and coordination. Together, their populations total 455,840 or 45.9% of the State.

The remaining two Regions - Southern Maine and Kennebec Valley - comprise the balance (54.1%) of the State's population. Because neither region has submitted nor written any Federal staffing grant applications, it is concluded that both regions deserve highest priority in use of State formula funds. In addition, the Southern Region, due to its size of population, its estimated incidence of alcoholism (38.9%) and cirrhosis death (11.7%/100m) (38.4%)*, must receive the highest consideration and commitment of State resources.

The Southern Regional Council has been formed in total conformity to the Hughes Bill in that the approximately 145 member Council representing six counties has a balance of consumers and providers; direct and related services agencies, and private and public organizations concerned with the problems resulting from alcoholism.

Geographically, it is unreasonable to assume that one Coordinator can be all things to all people from Kittery to Belfast to Fryeburg - especially when the State Divison of Alcoholism no longer employs an alcoholism counselor as in Areas II, III and IV. The exception would be the small O.E.O.

grant to the Waldo C.A.P. Agency for counseling services in that area.

Those who have been working with alcoholism services in the "greater Portland area" are aware of the difficulties inherent in the historical development of local services and changing administrations, as well as the competition for funds. Cumberland County is the only non-poverty area in Maine. This dense urban area alone demands the full attention of an experienced staff member. In addition, the Council realizes its commitment to the "whole" region and must be prepared to deal with it effectively if the Council is expected to remain cohesive and constructive in its collective efforts to attain regional goals.

Based on these comparisons of existing State and local staff in other regions and to avoid costly duplication of manpower in those regions, it is common sense to add an Assistant Coordinator to Region I, which is allowed for in our requested budget of $46,000.