STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
AUGUSTA

ADDRESS REPLY TO:

DEAN FISHER, M. D.
COMMISSIONER

32 Winthrop Street
Augusta, Maine 04330
(207) 289-2141

February 14, 1974

Mrs. Anne L. Twomey
Associate Regional Health Director
for Mental Health
Department of Health, Education and Welfare
Region I - JFK Federal Building
Boston, Massachusetts 02230

Dear Mrs. Twomey:

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

Since our information system is now functional, the data base for the Plan is the best available in the State and a marked improvement over the original plan.

This Plan reflects the State's reorganization of alcoholism and drug abuse programs into a single Office of Alcoholism and Drug Abuse Prevention. It also reflects the implementation efforts given to the Uniform Intoxication Act.

Because Maine has passed the Uniform Act, the budget in the Plan reflects an additional $124,000 over the $241,624 formula funds.

We hope you find our new Plan acceptable, and that we will be notified to that effect when final review has been completed.

Sincerely,

Marilyn L. McInnis

(Mrs.) Marilyn L. McInnis, Director
Office of Alcoholism and Drug
Abuse Prevention
Bureau of Rehabilitation

MLM/llk

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PURPOSE OF THE PLAN

The State Plan described herein presents a coordinated, comprehensive program for the continued orderly development and provision of needed alcoholism prevention, treatment, and rehabilitation processes in the State of Maine. It has been developed on the foundation of existing and growing resources, and in response to the unique needs of the State.

The plan describes the specific activities which have been initiated, and those which are planned for implementation within the State. It also provides a rational basis for the utilization of Federal, State, and other available resources in dealing with the problem of alcoholism in Maine.

In presenting the State Plan for 1973 we expressed the hope that it would point the way for the setting of realistic goals and priorities, that it would become a useful tool for evaluation, generate other forms of support, both public and voluntary, and aid in the furtherance of direct and purposive action. As will be seen in other sections of this, the 1974 State Plan, programs based on these aims are now an ongoing reality. Passage of new State legislation, and the allocation of $200,000 in State funds have aided progress, and new and more accurate baseline data are now available as a result of activity in the past year. Our basic concerns, modified by the foregoing, remain as follows:

1. Continued efforts aimed at decentralization of authority and responsibility for program planning, development and implementation through the five alcoholism planning regions, now established and functioning.

2. Further development of the ongoing priority system based on the increased availability of comprehensive alcohol abuse and alcoholism prevention, treatment and rehabilitation programs in each region.

3. The continued requirement that comprehensive services for alcoholics and problem drinkers be provided without discrimination; that no person shall be excluded solely by reason of his inability to pay, and that service processes be so implemented as to assure continuity of care.

BACKGROUND OF THE STUDY

The Action Plan of the 1973 Maine State Plan for the Prevention, Treatment, and Rehabilitation of Alcoholism and Alcohol Abuse in Maine proposed the following actions:

(1) Development of a Uniform Data Collection and Reporting System

(2) Utilizing Existing Resources Through Comprehensive Community Planning

(3) Planning and Implementing a Broad Range of Services

(4) Meeting Local Needs

(5) Meeting Needs of Specific Groups

(1) The first priority was met. Social Systems Research Corporation of Bangor, under contract to the Division of Alcoholism Services did develop a uniform data collection and reporting system, a copy of which is provided in the Appendix to this report. Implementation of the system begins this year and will provide the Office of Alcoholismand Drug Abuse Prevention and its regional structure with a data base upon which to make its planning decisions with respect to alcoholism services.

(2) The utilization of existing resources through comprehensive community planning required that the highest priority be given to the development of a system of regional planning organizations. This goal was also met. Regional Coordinators were appointed, Regional Counsils were established and goals and priorities set. Grant-in-aid programs were implemented, and the regional groups are now addressing themselves to collecting and analyzing data and research results, evaluating current programs in light of this data, emplementing a region-wide education and information program, and assuring adequate involvement of organized professional and lay groups in the development of a comprehensive program.

(3) It will be remembered that a model for the comprehensive service system recommended in the 1973 Action Plan was that developed under the auspices of the Counseling Center in Bangor, which is the Comprehensive Mental Health Center for the Eastern Maine Mental Health Area. Its several components are geared to meeting needs by means of Prevention, Outreach and Referral,

Treatment and Rehabilitation, and Aftercare. It was also stated that the regional planning bodies would not ordinarily engage in the direct provision of services, rather, their activities would be directed toward these goals:

(1) Comprehensiveness - (Services having the capability to meet the differential problem 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).

It can be said now that progress has been made in all these areas.

(4) Regional planning organizations are developing their own area plans on an ongoing basis with the cooperation of such governmental agencies, private agencies, organizations and institutions whose assistance is required. Where cooperation has been reluctantly given, it is expected that implementation of the new legislation creating the Office of Alcoholism and Drug Abuse Prevention with its broad powers will overcome the obstacles in future cases. Local needs, however, are closer to being metthan at any time in the past.

(5) 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.

I. ADMINISTRATION

A. SINGLE STATE AGENCY

The Maine Legislature in 1973 made into law the Uniform Alcoholism and Intoxication Treatment Act, which was later followed by and became part of the 1973 Alcoholism and Drug Abuse Act, creating a single State agency with sole authority for administering the State Plan. Sections of the Act are reproduced below.

1. Identifying Information:

   Office of Alcoholism and Drug Abuse Prevention
   Bureau of Rehabilitation
   32 Winthrop Street
   Augusta, Maine 04330

   Marilyn L. McInnis, Director

2. Organizational Structure:

   See charts at the end of this Section.

3. Evidence of Authority:

§ 7104. Office of Alcoholism and Drug Abuse Prevention

There is created within the Bureau of Rehabilitation of the Department of Health and Welfare the Office of Alcoholism and Drug Abuse Prevention. The office shall be under the immediate and full supervision of the Director, Bureau of Rehabilitation. The office shall be the sole agency of state government responsible for administration of this chapter. It shall be a separate, distinct administrative unit, which shall not be in any way integrated as a part of function of any other administrative unit of the department.

The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the Division of Alcoholism Services heretofore established in the Department shall, by this Act and implementation of it, be reconstituted and unified into a single administrative unit, functioning as an integrated agency of State Government.

§ 7105. Director

The Office of Alcoholism and Drug Abuse Prevention shall be administered by a director, who shall be appointed, subject to the Personnel Law, under the classified service by the commissioner after consultation with the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. The director shall be a person qualified by training and experience with drug abuse, or alcoholism and intoxication, or who has had satisfactory experience of a comparable nature in the direction, organization and administration of prevention or treatment programs for persons affected by drug abuse or drug dependency. He shall be immediately and fully responsible to the Director, Bureau of Rehabilitation and shall not be indirectly responsible to any other official of the department.

The director shall serve full time in a position that is separate from and not in any way integrated with another position in the department. He shall not concurrently hold another title and shall perform duties solely germane to the powers and duties of the office as provided for in this chapter.

The director shall possess full authority and responsibility for administering all the powers and duties of the office provided in section 7106, except as otherwise provided by statute. He shall, with the advice of the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, assume and discharge all responsibilities vested in the office. He shall not in any case assign to another unit of the department which is not responsible to him any powers and duties granted to the office by statute, or by rules, regulations or procedures adopted pursuant to this chapter. He shall make full use of existing support services available in State Government to assist with carrying out the responsibilities set by this chapter.

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

4. Functions:

§ 7106. Powers and duties

The office shall establish in accord with the purposes and intent of this chapter, and with the advice of the council and the cooperation of the coordinating committee, the overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic, which are conducted or supported in the State of Maine. In order to carry out the above, the office shall have the power and duty to:

1. Encourage and assist development of more effective, more coordinated, more efficient administration of resources and services available for drug abuse prevention;

2. Develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention. The information shall be available for use by the people of Maine, the political subdivisions, public and private nonprofit agencies and the State. Educational materials shall be prepared, published and disseminated. Objective devices and research methodologies shall be continuously developed. Uniform methods of keeping statistical information shall be specified for use by public and private agencies, organizations and individuals. Existing sources of information shall be used to the fullest extent possible, while maintaining confidentiality safeguards of state and federal law. Information may be requested and shall be received from any state government or public or private agency. To the extent feasible, information shall maintain compatibility with federal information sharing standards.

Functions of the drug information system shall include, but not be limited to:

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

B. Collecting, maintaining and disseminating such knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention as will enable the office to fulfill its responsibilities;

C. Determining through a detailed survey the extent of the drug abuse problem, and the needs and priorities for the prevention of drug abuse and drug dependence in the state and political subdivisions. Included shall be a survey of health facilities needed to provide services for drug abuse and drug dependence, especially alcoholics and intoxicated persons;

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

E. Conducting a continuous evaluation of the impact, quality and value of drug abuse prevention facilities, programs and services; including their administrative adequacy and capacity. Activities operated by or with the assistance of the State and Federal Governments shall be evaluated. Included shall be alcohol and drug abuse prevention and treatment services as authorized by this and so much of the several Acts and amendments to them enacted by the People of the State of Maine, and those authorized by the United States Acts and amendments to them as relate to drug abuse prevention:

(1) The Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255);

(2) The Community Mental Health Centers Act (42 USC 2688);

(3) The Public Health Service Act (42 USC);

(4) The Vocational Rehabilitation Act;

(5) The Social Security Act;

(6) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616) and similiar Acts.

3. Assist, with the advice of the council and cooperation of the coordinating committee, the Legislature and executive branches and Judicial Council of State Government, especially the Governor, commissioner, and Bureau of the Budget, to coordinate all state government efforts dealing with drug abuse prevention and control, including alcoholism, by:

A. Submitting to each branch of State Government no later than September 1st of each year an annual report covering its activities for the immediate past fiscal year and future plans, including recommendations for changes in state and federal laws, and including reports of the council and coordinating committee;

B. Reviewing all proposed legislation, fiscal activities, plans, policies and other administrative functions relating to drug abuse prevention activities made by or requested of all state agencies. The office shall have the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and commissioner shall be advisory; and which in the case of other state agencies shall be binding. Such findings, comments and recommendations shall specify what modification in proposals or actions shall be taken to make proposed legislation, fiscal activities and administrative activities consistent with such policies and priorities;

C. Making recommendations to the respective branches of State Government concerning prevention of drug traffic and shall consult with and be consulted by all responsible state agencies regarding the policies, priorities and objectives of functions to prevent drug traffic.

4. Prepare and administer a comprehensive state plan mutually developed by the office, council and coordinating committee, relating to all drug abuse prevention and treatment of alcoholics and intoxicated persons and control of drug abuse. The comprehensive state plan shall be implemented for the purpose of coordinating all drug abuse prevention activities and of assuring compliance with applicable state and federal laws and regulation and with the state plan relating to drug abuse prevention. Implementation of this duty shall mean that the office shall have the authority to supervise through a review process the preparation and administration of any portion of any state plan relating to drug abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government to obtain federal funding under federal legislation. Such state plans, or portions thereof, shall include, but not be limited to, all state plans dealing with criminal justice, education, employment and vocationsl services, law enforcement, medical, rehabilitation, social services, welfare, drug abuse prevention and treatment of alcoholism and intoxicated persons.

The office shall advise the commissioner and Governor on preparation of and provisions to be included relating to drug abuse prevention and relating to alcoholism and intoxicated persons. Such state plans shall provide for methods of administration which will supplement, compliment and broaden related state plans, including, but not limited to, those developed under the U.S. Public Health Service Act, section 314(2);

5. Plan, establish and maintain necessary or desirable prevention or treatment programs for individuals or groups of individuals, except that the office and its staff, whether assigned to the office or to operating units, may provide direct service only to a drug dependent individual or groups of such individuals, whose drug dependency is related to alcohol. The office may use the full range of its powers and duties to serve any drug dependent person through indirect services provided for by agreements;

6. Function as the organizational unit of Maine State Government with sole responsibility for conducting and coordinating, with the advice of the council and the cooperation of the coordinating committee, state programs and activities authorized by this chapter, and by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended; and other programs or Acts of the State of Maine or United States related to drug abuse prevention which are not the specific responsibility of another state agency under federal or state law.

The Office is designated as the single agency of Maine State government solely responsible for administering the state plans required by those Acts;

7. Help communities mobilize their resources to deal with drug abuse. The office shall provide, or coordinate the provision of information, technical assistance and consultation to state, regional and local governments; and to public and private nonprofit agencies, institutions, organizations and individuals. The help shall be for the purpose of encouraging, developing and assisting with the initiation, establishment and administration of any plans, programs or services to prevent drug abuse.

Included in this duty is authroity to coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in drug abuse prevention, especially alcoholism and treatment of alcoholics and intoxicated persons. The support and assistance of interested persons in the community, particularly recovered alcoholics and abusers of drugs, shall be utilized to encourage alcoholics and drug abusers voluntarily to undergo treatment;

8. Seek and receive funds from Federal Government and private sources to further its activities. Included in this function is authority to solicit, accept, administer, disburse and coordinate for the State in accordance with the intent, objectives and purposes of this chapter; and within any limitation which may apply from the sources of such funds, the efforts to obtain and the use of any funds from any source to treat alcoholism or prevent drug abuse. Any gift of money or property made by will or otherwise, and any grant or other funds appropriated, services or property available from the Federal Government, the State or any political subdivision thereof and from all other sources, public or private, may be accepted and administered. The office may do all things necessary to cooperate with the Federal Government or any of its agencies in making application for any funds. Included in this duty is authority to coordinate the disbursement of all state funds, or funds administered through agencies of State Government, appropriated or made available for drug abuse prevention. No fiscal transaction, including encumbrance or disbursement, shall be made for drug abuse prevention without approval of the office;

9. Enter into agreements necessary or incidental to the performance of its duties. Included is the power to make agreements with qualified community, regional and state level, private nonprofit and public agencies, organizations and individuals in this and other states to develop or provide drug abuse prevention and treatment facilities, programs and services. Such agreements may include provisions to pay for such prevention or treatment rendered or furnished to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or person in need of assistance due to use of a dependency related drug. Such contracts shall be executed only with agencies that meet the standards for treatment promulgated by the office under section 7115, subsection I, and approved under section 7115, subsection 3, and licensed pursuant to section 5-A or other applicable provisions of law. The office may engage expert advisors and assistants who may serve without compensation, or to the extent funds may be available by appropriation, grant, gift or allocation from a state department, the office may pay for such expert advisors or assistants;

10. Prepare, adopt, amend, rescind and administer policies, priorities, procedures, rules and regulations to govern its affairs and the development and operation of facilities, programs and services. The office may adopt rules to carry out the powers and duties conducted under the authority in

accordance with the purpose and objectives of this Act. It shall especially adopt such rules and regulations as may be necessary to define contractual terms, conditions of agreements and all other rules as are necessary for the proper administration of this chapter. Such adoption, amendment and rescission shall be made as provided under Title 5, chapters 301 to 307, Administrative Code;

11. Establish operating and treatment standards, inspect and issue a certificate of approval for any drug abuse treatment facility or program, including residential treatment centers, which meet the standards promulgated under section 7115, subsection I, and licensed pursuant to section 5-A and other applicable provisions of law. The office shall periodically enter, inspect and examine the treatment facility or program, and examine their books and accounts. It shall fix and collect the fees for such inspection and certificate, Insofar as licensing and certification of drug abuse prevention facilities and programs may also be the responsibility of another administrative unit of the department, the office may assign performance of this responsibility to such a unit or make other mutually agreeable arrangements with such a unit for assisting with performance of this responsibility;

12. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons and persons who abuse or are dependent on drugs. Assist in the development of, and cooperation with, alcoholic education and treatment programs for employees of state and local governments and businesses and industries in the State. Convene and conduct conferences of public and private nonprofit organizations concerned with the development and operation of drug abuse prevention programs. Included shall be the power to encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons who abuse or are dependent on drugs and to provide them with adequate and appropriate treatment. Also included is the power to encourage all health and disability insurance programs to include alcoholism as a covered illness;

13. Foster, develop, organize, conduct or provide for the conduct of training programs for all persons in the field of treating alcoholics and intoxicated persons and drug abusers;

14. Coordinate activities and cooperate with drug abuse prevention programs in this and other states for the common advancement of drug abuse prevention and alcoholism programs;

15. Establish and maintain a principal office at the department's general headquarters, and such other office within the State as it may deem necessary;

16. Do other acts and exercise such other powers necessary or convenient to execute and carry out the purposes and authority expressly granted in this chapter.

B. ADVISORY COUNCIL (See Addenda Section)

§ 7107. Maine Council on Alcohol and Drug Abuse Prevention and Treatment

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, hereinafter in this chapter referred to as the "council", is created. The council may appoint from its membership subcommittees relating to particular problem

areas or to other matters, provided that by January 1, 1975 the council shall function as an integrated committee. The office shall provide the council any administrative or financial assistance that from time to time may be reasonably required to carry out its activities. Any reasonable and proper expenses of the council shall be borne by the office out of currently available state or federal funds. The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the advisory councils on alcoholism heretofore established in the department and by section 1352, as amended, shall, by this Act and implementation of it, be reconstituted and unified into a single unit.

§ 7108. Membership

The council shall consist of no more than 17 members who, excepting members representing the Legislature, shall be appointed by the Governor with the advice and consent of the Executive Council. To be qualified to serve, members shall have education, training, experience, knowledge, expertise and interest in drug abuse prevention and training. Members shall be residents of different geographical areas of the State, who reflect experiential diversity and concern for drug abuse prevention and treatment in the State.

They shall be selected from outstanding people in the fields of education, health, law, law enforcement, manpower, medicine, science, social sciences and related areas. Members shall have an unselfish and dedicated personal interest demonstrated by active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research into drug abuse and alcohol abuse.

Membership shall include representatives of nongovernmental organizations or groups and of public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. At least 2 members of the council shall be current members of the Legislature, consisting of one member from the House of Representatives appointed by the Speaker of the House to serve at his pleasure and one member from the Senate appointed by the President of the Senate to serve at his pleasure. Two of the private citizen members shall be between the ages of 16 and 21. At least 3 members shall be persons recovered from alcoholism chronic intoxication, drug abuse or drug dependence. At least 3 members shall be officials of public or private nonprofit community level agencies who are actively engaged in drug abuse prevention or treatment in public or private nonprofit community agencies. Membership may also include, but not be limited to, representatives of professions such as law, law enforcement, medicine, pharmacy and teaching.

Members shall be appointed for a term of 3 years, except that of the members first appointed, 5 shall be appointed for a term of 3 years, 5 shall be appointed for a term of 2 years and 5 shall be appointed for a term of one year, as designated by the Governor at the time of appointment; except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term, and except that members who are members of the current Legislature and who are appointed by the President of the Senate or the Speaker of the House shall serve at their pleasure. Any vacancy in the council shall not affect its powers, but shall be filled in the same manner by which the original appointment was made.

Members shall be eligible for reappointment for not more than one consecutive term and may serve after the expiration of their term until their successors have been appointed, qualified and taken office. The appointing authority may terminate the appointment of any member of the council for good and just cause and the reason for the termination of each appointment shall be communicated to each member so terminated. The appointment of any member of the council shall be terminated if a member is absent from 3 consecutive meetings without good and just cause that is communicated to the chairman. An official, employee, consultant or any other individual employed, retained or otherwise compensated by or representative of the Executive Branch of the Government of the State of Maine shall not be a member of the council; but shall assist the council if so requested. The director of the office or his representative shall attend all meetings of the council.

The Governor shall designate the chairman from among the members appointed to the council. The council may elect such other officers from its members as it deems appropriate.

§ 7109. Meetings, compensation, quorum

The council shall meet at the call of the chairman or at the call of ¼ of the members appointed and currently holding office. The council shall meet at least 5 times a year and at least once every 3 months. The council shall keep minutes of all meetings, including a list of people in attendance. Minutes of all meetings shall be sent forthwith to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

Members of the council shall serve without compensation, but they may be reimbursed on the same basis as employees of state deparmtnets for the actual travel and other necessary expenses incurred in the performance of their duties.

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

§ 7110. Powers and duties

The council, in cooperation with the office and coordinating committee, shall have the power and duty to:

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

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

al Government;

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

4. Serve, through a subcommittee of the council consisting of 5 persons including the chairman and 4 other members appointed by the chairman with the advice and consent of the Governor, as the review committee on behalf of the State of Maine responsible for analysis and recommendation to the director concerning the acceptability of proposals requesting award of state administered grant funds for drug abuse prevention and treatment under the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the United States Drug Abuse Office and Treatment Act of 1972, and in order to insure coordination and prevent duplication of services shall review and comment on, under its own initiative or at the request of any state or federal department or agency, any application from any agency or organization within the State to a state or federal department or agency for financial assistance related to meeting the needs of people who abuse or are dependent on drugs;

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

6. Inform the public in cooperation with the office, to develop a firm public understanding of the current status of drug abuse and drug dependence among Maine's citizens, including information on effective programs elsewhere in the State or Nation, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports;

7. Provide public forums, including the conduct of public hearings, sponsorship of conferences, workshops and other such meetings to obtain information about, discuss and publicize the need of and solutions to drug abuse and drug dependence. The council may hold a state-wide conference, regional conferences and meetings;

8. Administer in accordance with current fiscal and accounting regulations of the State, and in accordance with the philosophy, objectives and authority of this Act, any funds appropriated for expenditure by the council or any

grants or gifts which may become available, accepted and received by the council; and make, to be included in the annual report of the office, an annual report to the director, commissioner, Governor and Legislature not later than September 1st of each year concerning its work, recommendations and interests of the previous fiscal year and future plans; and shall make such interim reports as it deems advisable.

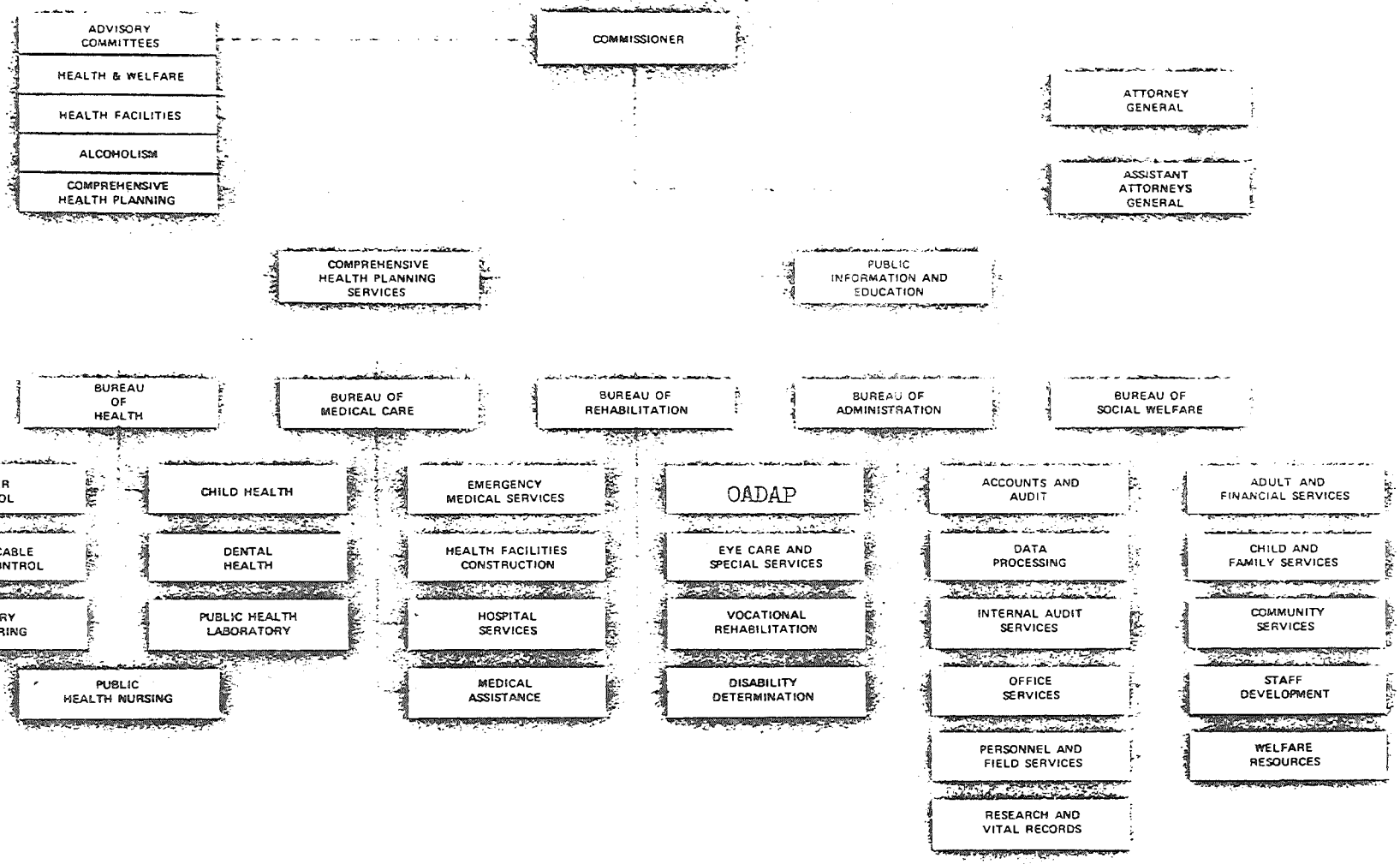
Advisory Council

The following list of people have accepted appointment to the new State Advisory Council on Alcoholism and Drug Abuse Prevention:

1. Rev. John J. Feeney, St. Mary's Rectory, 30 Cedar Street, Bangor 04401 (Chairman)
2. Dr. Einar Olsen, President, University of Maine, Farmington 04938
3. Mr. Stephen P. Simonds, Human Services Development Center, University of Maine, Portland 04101
4. Sister Mary Anastasia, Chief Pharmacist, Mercy Hospital, Portland 04101
5. Senator _____(to be selected by President of Senate)
6. Representative_____(to be selected by Speaker of the House)
7. Brendon Twoomey, Property Manager, Maremont Corp., Saco 04072
8. Dr. Frank Lawrence, Maine Medical Center, Portland 04101
9. Mr. Eaton W. Tarbell, c/o Eaton W. Tarbell & Associates, Inc., 8 Harlow Street, Bangor 04401
10. Mr. Thurman Millett, Maine State Federated Labor Council, 499 Broadway, Bangor 04401
11. Mr. Charles Sharpe, Sheriff's Office, 122 Federal Street, Portland 04101
12. Mrs. Eleanor Blais, 168 Fairview Avenue, Auburn 04210
13. Rev. James H. Word, 7 Epsworth Street, Presque Isle 04769
14. Dr. Robert Ohler, Chief of Staff, Veterans Hospital, Togus 04330
15. Miss Barbara Penney, Cony High School, Bond Brook Road, Augusta 04330
16. Mr. Jerry W. Bryant, ARU House, Box 88, Bowdoin College, Brunswick 04011

The seventeenth member will be selected in the near future. Tenure of each of the members will also be established through the Governor's office soon.

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

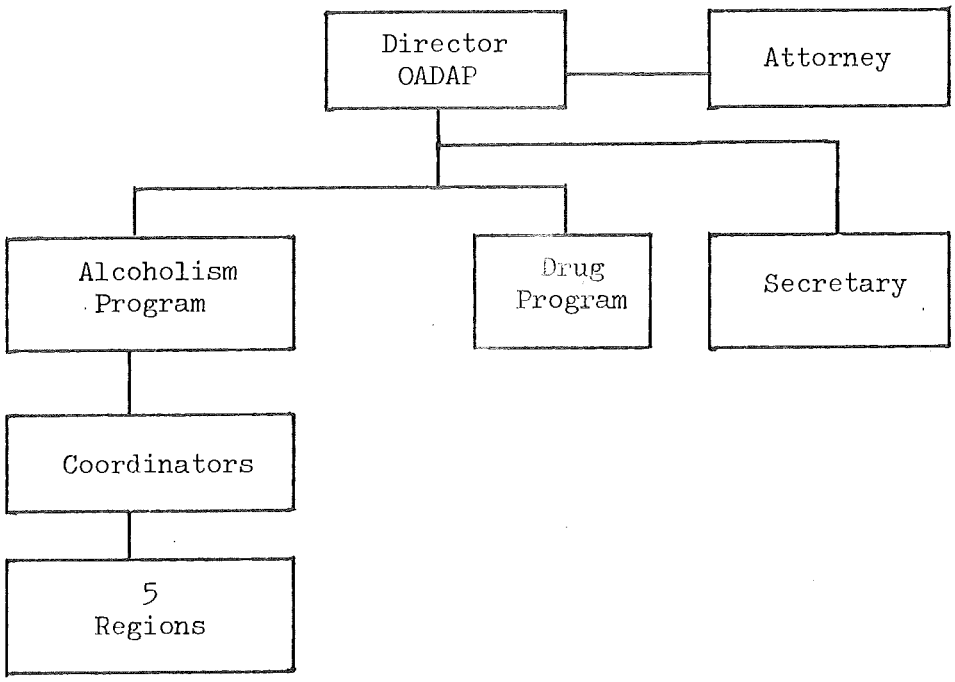


STATE OF MAINE

DEPARTMENT OF HEALTH AND WELFARE

OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

ORGANIZATION CHART



The Office of Alcoholism and Drug Abuse Prevention, being located in the Bureau of Rehabilitation, receives the services of its Business Office and the Research, Evaluation and Planning Unit in the same manner as the other Divisions of the Bureau.

II. STATE SURVEY

The State Survey section of the 1973 State Plan dealt in considerable detail with the demographic, socio-economic, geographic, and cultural factors peculiar to Maine. This revision and update will assume that these data are now well known and confine itself to more concentrated baseline data, so that more emphasis can be placed on new legislation and its effects on the State's alcoholism plans, changes and improvements in the State's alcoholism prevention, treatment, and rehabilitation resources and facilities, development of the 1973 Action Plan, and other significant information.

Implementation of New State Legislation

The Alcoholism and Drug Abuse Act of 1973 (described in Administration) became effective and was implemented on January 1, 1974. The Uniform Alcoholism and Intoxication Treatment Act will become law on July 1, 1974. The effect of this new legislation will be to assist in the development of more effective, more coordinated, more efficient administration of resources and services in the field of alcoholism prevention, treatment, and rehabilitation. Implementation of the up-to-date information, research, and evaluation methodology will be made possible by newly available state funds. Further development of uniform methods of keeping statistical information by public and private agencies, organizations and individuals will be made possible. The collection, maintenance, and dissemination of such knowledge, data, and statistics will be aided, we will be able to better determine the extent of the problem, maintain an inventory of the types and quantities of available facilities, programs, and services, and conduct a continuous evaluation of their impact, quality, and value.

We are requesting a total of $1,054,029 from the present legislature to fulfill both the requirements of implementing the Uniform Act and to develop sound and comprehensive treatment, rehabilitation, and prevention programming for alcohol abusers. The current services budget for alcoholism is $365,269. In addition we are requesting $688,750 to further our grant-in-aid process and provide such medically related services as physical examinations under the Uniform Act.

DESCRIPTIVE STATISTICS OF ALCOHOLISM PLANNING REGIONS

REGION I

Region I comprises the lower coastal counties of Maine, the most densely populated areas, the most attractive to seasonal visitors, and the most economically vigorous in the state. It has more wholesale, retail, manufacturing, and service businesses than any other region, it dominates the salt water fishing industry, and lags behind only in amount and value of stumpage, for obvious reasons.

Average mean family income in Region I is $8,102. The percentage of families living below the poverty level is fairly high at 10.5%. Approximately 23% of its housing units are renter occupied at a median rent of approximately $74. per unit. Population density for the region is 108.1 persons per square mile. 54.3% of 1969 high school graduates in Region I were enrolled in post high school education. 8,961 of the 1969-70 students were enrolled in colleges.

Medical standards in the region vary, with physician and medical facilities concentrated in densely populated, high income areas. There are 18 hospitals in the region, only one, Maine Medical Center, offering a full range of health care facilities from out-patient to mental health services.

Region I has more telephones, more radios, and more television sets than any other. It is well blanketed by all manner of broadcasting facilities, including those in the Boston area, and it has extensive newspaper service ranging in outlook from the Gannett dailies in Portland, to the weekly Maine Times in Topsham.

REGION II

Three of Maine's inland counties, Oxford, Franklin, and Androscoggin, compose this region which contains one major metropolitan area (Lewiston-Auburn), a number of small mill towns, and considerable farm and woodland.

The area ranks third among regions in wholesale, retail, manufacturing and service industries, and fourth in stumpage dollar value of all wood cut.

However, average mean family income is $8,109, slightly higher than Region I, while the percentage of families living below the poverty level is lower (9.3%). Approximately 27% of its housing units are renter occupied at a median rent of

approximately $65 per unit. Population density for the region is considerably below that of Region I at 36.5 persons per square mile. That figure can be misleading, however, because one county of the three, Androscoggin, has a population density of 189.1 persons per square mile. 49.5% of 1969 high school graduates were enrolled in post-high school education. 3,149 of the 1969-70 students were enrolled in colleges.

Medical standards in the region vary according to pattern with the Lewiston-Auburn metropolitan complex offering the widest choice of physicians and hospital facilities. St. Mary's General Hospital has a full range of health care facilities, from out-patient to mental health services.

Regional communications include wide television and radio coverage, while print media is largely dominated by the two Lewiston dailies.

REGION III

Two counties make up this region: Kennebec--small, but comparatively dense in population--and Somerset--large, extending to the Canadian border on the north and northwest, but with most of its population concentrated in the southerly portion. Economically, the region is fifth in wholesale annual sales, fourth in retail sales, fourth in service industry annual receipts. However, in keeping with the woodland character of northern Somerset county, stumpage dollar values of all wood cut places it in third place among the five regions.

Average mean family income is slightly higher than in Regions I and II, approximately $8,185. The percentage of families living below the poverty level is approximately 10% of the total number of families. Approximately 23% of its housing units are renter occupied at a median rent of $65 per unit. Population density for the region is 28.4 persons per square mile, a misleading figure when broken down by county. Somerset's population density is actually 10.4 persons per square mile as against 109.0 for Kennebec. 54% of 1969 high school graduates were enrolled in post-high school education. 2,988 of the 1969-70 students were enrolled in colleges.

Medical facilities, including the V.A. Hospital at Togus, are concentrated in Kennebec and lower Somerset counties, and the average physician in northern Somerset carries a patient load equalled only in Washington and Waldo counties. Communications in the northern part of the region can be described as poor.

REGION IV

This area contains the most extreme demographic and socioeconomic factors

of any region, embracing the almost totally forested Piscataquis county, the third largest metropolitan area in the state (Bangor), the wildland and blueberry barrens of Washington county, and the popular and seasonally populous Mt. Desert Island resort area, and the fisheries of Hancock and Washington counties.

Regional economic totals will have little meaning here unless broken down into county figures, but for the sake of consistency this brief regional summary is included. Region IV is second in total annual wholesale sales, second in annual retail sales, second in manufacturing product value, second in total receipts of service industries, and first in stumpage dollar value of all wood cut. Its fisheries, particularly those of Hancock county, are economically important.

Average mean family income for the region is $7,316, considerably lower than the mean for other regions. (However, one of the counties, Penobscot, has a mean family income of $8,301) The percentage of families living below the poverty level is 12.9%. About 17% of its housing is renter occupied at a median rent of $68 per unit. Population density for the region is 18.4 persons per square mile. 48% of 1969 high school graduates were enrolled in post-high school education, and 10,434 of the 1969-70 population were enrolled in colleges.

Medical standards in Region IV follow the accustomed pattern, with the greatest concentration of facilities and physicians in the urban and resort areas. One hospital, Eastern Maine Medical Center in Bangor, offers a full range of medical services from out-patient to mental health.

The region is second to Region I in number of telephones, radio sets, and television sets. The three major radio and television networks have outlets in Bangor, and the Bangor Daily News blankets the area with a circulation of about 80,000.

REGION V

Aroostook, largest of Maine counties, is the sole occupant of Region V. The famed potato lands of the county, and most of its urban centers, are located in an easterly section of the county. The major part of the region is heavily forested.

Economically, Region V ranks fourth in wholesale annual sales, fifth in retail sales, fifth in manufacturing, fifth in service businesses, and second among regions in stumpage dollar value of all wood cut. (But for lack of adequate transportation, Aroostook would very likely exceed all regions in this category.)

Mean family income is lowest of all regions at $6,929. The percentage of families living below the poverty level is highest among regions at 16.3%. About 25% of its housing is renter occupied at a median rent of $74 per unit. Population density for the region is lowest for all regions at 14.6 persons per square mile, but there are four other counties in the state with lower population densities. 52.2% of 1969 high school graduates were enrolled in post-high school education, and 1,913 of the 1969-70 students were enrolled in colleges.

There are 8 hospitals in the region, with one offering Mental Health services. There are 80 physicians to care for the 92,533 population, a ration of 1,157 persons per physician.

One television station serves Region V, one FM radio station, and four AM radio stations, all supplemented by Canadian broadcasting facilities. The region has one newspaper with a circulation of more than 5,000--the Madawaska weekly, St. John Valley Times.

Tables are appended in which economic data have been broken down by regions and counties. Others show population figures on a statewide basis by sex, age, education, incomes of families, individuals, and type of income by families, occupations of persons 16 years of age and over, ethnic, language, and racial characteristics, marital status, and a breakdown of urban and rural populations. These tables are included for background and reference, but the statistics therein will be related in the narrative to the action plan.

TABLE ECONOMIC PROFILE BY COUNTY

1. Wholesale (Data for 1967 is lates available.)

Region/ County	Number of Establishments	Annual Sales (Million $)	Number Employed	Average Wage ($)
REGION I				
York	61	25.7	344	5,233
Cumberland	410	577.4	5,504	6,105
Sagadahoc	17	6.9	73	5,479
Lincoln	31	7.3	121	4,959
Knox	59	23.0	303	4,950
Waldo	17	14.6	133	4,511
TOTAL	595	654.9	6,478	5,206
REGION II				
Oxford	44	16.2	175	5,714
Franklin	11	3.3	78	3,846
Androscoggin	141	113.5	1,484	5,526
TOTAL	196	133.0	1,737	5,028
REGION III				
Somerset	38	16.5	204	4,902
Kennebec	111	102.0	1,039	4,909
TOTAL	149	118.5	1,243	4,905
REGION IV				
Piscataquis	16	4.8	82	3,656
Penobscot	189	150.0	2,003	5,691
Hancock	55	34.6	285	4,561
Washington	44	17.0	264	4,167
TOTAL	304	206.4	2,634	4,519
REGION V				
Aroostook	196	120.6	1,730	4,393
STATE OF MAINE	1,440	1,233.4	13,822	5,484

TABLE ECONOMIC PROFILE BY COUNTY

2. Retail (Data for 1967 is latest available.)

Region/ County	Number of Establishments	Annual Sales (Million $)	Number Employed	Average Wage ($)
REGION I				
York	1,270	135.8	3,610	4,119
Cumberland	1,805	352.9	10,935	3,835
Sagadahoc	177	17.9	461	3,575
Lincoln	303	28.4	629	4,156
Knox	367	44.9	1,190	3,914
Waldo	253	24.0	572	3,734
TOTAL	4,175	603.9	17,397	3,889
REGION II				
Oxford	478	55.1	1,399	3,523
Franklin	264	27.8	699	3,459
Androscoggin	888	146.8	4,455	3,682
TOTAL	1,630	229.7	6,553	3,555
REGION III				
Somerset	453	48.3	1,261	3,748
Kennebec	924	148.8	4,310	3,732
TOTAL	1,377	197.1	5,571	3,740
REGION IV				
Piscataquis	200	19.7	476	3,475
Penobscot	1,132	204.9	5,731	3,880
Hancock	472	52.2	1,276	3,974
Washington	385	32.4	750	3,664
TOTAL	2,189	309.2	8,233	3,748
REGION V				
Aroostook	960	132.4	3,348	3,758
STATE OF MAINE	10,331	1,471.4	41,102	3,764

TABLE ECONOMIC PROFILE BY COUNTY

3. Manufacturing (Data for "Value of Product" is from 1971. All other data is for 1970.)

Region/ County	Number of Establish.	Value of Product (Millions)	Number Employed	Workers on Union	Average Wage
REGION I					
York	177	214.5	19,503	3,360	7,217
Cumberland	316	445.0	18,327	6,326	5,818
Sagadahoc	50	83.2	3,786	3,004	6,514
Lincoln	75	16.2	943	7	4,877
Knox	100	63.2	2,479	891	5,259
Waldo	82	69.1	1,993	889	4,910
TOTAL	800	891.2	47,031	14,477	5,766
REGION II					
Oxford	170	138.2	6,559	3,200	6,089
Franklin	103	129.0	4,531	1,127	5,985
Androscoggin	253	220.7	13,460	4,076	4,804
TOTAL	526	487.9	24,550	8,403	5,626
REGION III					
Somerset	161	92.7	6,096	599	5,173
Kennebec	139	262.1	9,575	5,848	5,605
TOTAL	300	354.8	15,671	6,447	5,389
REGION IV					
Piscataquis	82	34.5	2,737	255	5,195
Penobscot	205	331.2	11,355	4,293	6,627
Hancock	92	71.2	2,030	772	6,031
Washington	136	77.0	2,548	1,017	5,792
TOTAL	515	513.9	18,670	6,337	5,911
REGION V					
Aroostook	218	184.5	6,308	2,398	6,213
STATE OF MAINE	2,359	2,432.3	112,230	38,062	5,781

TABLE ECONOMIC PROFILE BY COUNTY

4. Service Businesses (Data for 1967 is latest available.)

Region/ County	Number of Establishments	Total Receipts (Million $)	Number Employed*	Average Wage ($)
REGION I				
York	946	15.8	569	6,151
Cumberland	1,341	51.1	3,400	4,176
Sagadahoc	119	2.3	254	2,362
Lincoln	189	3.3	121	6,612
Knox	222	4.6	275	4,364
Waldo	136	2.2	133	3,759
TOTAL	2,953	79.3	4,752	4,377
REGION II				
Oxford	301	6.6	359	5,292
Franklin	183	3.4	278	2,878
Androscoggin	595	14.2	946	3,700
TOTAL	1,079	24.2	1,583	3,917
REGION III				
Somerset	285	4.8	224	4,911
Kennebec	630	15.0	1,033	3,679
TOTAL	915	19.8	1,257	3,898
REGION IV				
Piscataquis	132	2.0	119	4,202
Penobscot	713	17.6	1,264	3,560
Hancock	331	6.9	263	6,084
Washington	217	3.7	155	7,742
TOTAL	1,393	30.2	1,801	4,331
REGION V				
Aroostook	519	8.8	640	3,438
STATE OF MAINE	6,859	162.4	10,033	4,176

* Week of March 12

TABLE

STATE OF MAINE

FAMILY INCOME DATA BY COUNTY

Regions/ Counties	Number of Families	Mean Size of Family	Mean Income	Families Below Poverty Level	Families Below 75% of Poverty Level	Families Below 125% of Poverty Level
REGION I						
York	28,067	3.51	$8,495	9.2%	5.4%	14.6%
Cumberland	48,498	3.75	9,289	7.9%	5.0%	12.0%
Sagadahoc	6,186	3.67	8,112	10.8%	6.6%	16.4%
Lincoln	5,588	3.59	7,847	12.0%	7.0%	17.2%
Knox	7,608	3.49	7,362	11.3%	6.8%	17.9%
Waldo	5,878	4.21	7,510	12.1%	6.5%	19.3%
TOTAL	101,825					
REGION II						
Oxford	11,213	3.90	8,060	9.9%	5.6%	16.0%
Franklin	5,508	3.59	7,993	9.0%	4.8%	15.3%
Androscoggin	22,922	3.84	8,273	9.0%	4.1%	14.6%
TOTAL	39,643					
REGION III						
Somerset	10,077	4.07	7,516	12.1%	7.0%	18.7%
Kennebec	23,171	3.87	8,853	7.8%	4.5%	13.0%
TOTAL	33,248					
REGION IV						
Piscataquis	4,330	4.00	7,220	10.6%	5.6%	18.7%
Penobscot	29,864	3.88	8,301	9.9%	5.8%	15.6%
Hancock	9,134	3.69	7,607	12.0%	6.1%	18.7%
Washington	7,802	3.70	6,137	19.0%	11.4%	29.2%
TOTAL	51,130					
REGION V						
Aroostook	22,308	4.29	6,929	16.3%	9.7%	25.6%
STATE TOTALS	248,154	3.57	9,045	10.3%	6.0%	16.3%

TABLE

STATE OF MAINE
INCOME AND POVERTY STATUS IN 1969 FOR COUNTIES
INCOME LESS THAN POVERTY LEVEL*

*Includes only those with incomes below poverty level.

County	Families	Percent Of All Families	Mean Family Income	Mean Family Size	Families With Female Head	Persons	Percent of All Persons	Percent Living With Both Parents
Androscoggin	2052	9.0	$2,315	3.84	634	11,211	12.5	58.9
Aroostook	3636	16.3	1,878	4.29	631	17,742	19.5	77.4
Cumberland	3816	7.9	1,992	3.75	1,559	19,994	10.7	45.2
Franklin	493	9.0	2,271	3.59	138	2,507	11.6	64.6
Hancock	1095	12.0	2,207	3.69	246	5,725	16.9	73.5
Kennebec	1796	7.8	2,196	3.87	663	10,121	11.2	50.3
Knox	862	11.3	1,900	3.49	260	4,450	15.7	54.6
Lincoln	671	12.0	2,021	3.59	172	3,103	15.3	70.6
Oxford	1110	9.9	2,238	3.90	314	5,659	13.1	59.6
Penobscot	2971	9.9	2,243	3.88	907	15,662	13.3	58.6
Piscataquis	459	10.6	2,408	4.00	121	2,418	14.9	75.7
Sagadahoc	670	10.8	2,063	3.67	234	3,076	13.3	58.3
Somerset	1218	12.1	2,164	4.07	338	6,364	15.9	58.2
Waldo	714	12.1	2,528	4.21	134	3,913	17.0	78.8
Washington	1481	19.0	2,108	3.70	397	6,758	23.2	64.1
York	2578	9.2	1,898	3.51	918	12,568	11.7	52.5

TABLE

STATE OF MAINE, 1970

Age by Sex

All Ages	Total	Male	Female
Under 5	84,511	43,005	41,506
5 to 9	101,179	51,500	49,679
10 to 14	101,462	52,049	49,413
15 to 19	94,360	47,496	46,864
20 to 24	74,328	36,773	37,555
25 to 29	58,446	29,013	29,433
30 to 34	51,899	25,308	26,591
35 to 39	52,639	25,832	26,807
40 to 44	55,905	27,339	28,566
45 to 49	56,826	27,285	29,541
50 to 54	53,265	26,086	27,179
55 to 59	48,588	23,121	25,467
60 to 64	45,663	21,613	24,050
65 to 69	37,973	16,887	21,086
70 to 74	30,830	12,991	17,839
75 and over	45,789	17,775	28,014
TOTALS	993,663	484,073	509,590

TABLE

STATE OF MAINE, 1970

Years of School Completed

Ages 25 and Over

		Male	Female	Total
No school years completed		2,692	2,058	4,750
Elementary:	1 to 4 years	5,893	4,557	10,450
	5 and 6 years	11,451	10,231	21,682
	7 years	10,286	8,984	19,270
	8 years	42,000	38,673	80,673
High School:	1 to 3 years	49,321	57,386	106,707
	4 years	82,168	106,718	188,886
College:	1 to 3 years	23,588	36,836	60,424
	4 years	15,076	14,294	29,370
	5 years or more	10,775	4,836	15,611
Population TOTALS		253,250	284,573	537,823
Median school years completed		12.1	12.2	12.1

TABLE STATE OF MAINE, 1970

Income

Income of Families and Unrelated Individuals

All Families	248,154
Less than $1,000	4,944
$1,000 to $1,999	7,756
$2,000 to $2,999	12,535
$3,000 to $3,999	13,743
$4,000 to $4,999	16,667
$5,000 to $5,999	20,619
$6,000 to $6,999	20,960
$7,000 to $7,999	22,273
$8,000 to $8,999	22,340
$9,000 to $9,999	19,245
$10,000 to $11,999	32,437
$12,000 to $14,999	26,902
$15,000 to $24,999	22,708
$25,000 to $49,999	4,359
$50,000 or more	666
Median income	$8,205
Mean income	$9,045

All Unrelated Individuals	94,650
Median income	$1,954
Mean income	$2,959
Per capita income of persons	$2,550

Type of Income of Families

All Families	248,154
With wage or salary income	214,605
Mean wage or salary income	$8,314
With non-farm self-employment income	30,062
Mean non-farm self-employment income	$6,526
With farm self-employment income	6,958
Mean farm self-employment income	$2,939
With Social Security income	54,580
Mean Social Security income	$1,597
With public assistance or public welfare income	13,362
Mean public assistance or public welfare income	$1,189
With other income	76,952
Mean other income	$1,829

TABLE STATE OF MAINE, 1970

Occupation of Persons 16 Years Old and Over

Professional, technical, and kindred workers	44,924
Managers and administrators, except farm	32,234
Sales workers	21,005
Clerical and kindred workers	50,611
Craftsmen, foremen, and kindred workers	55,148
Operatives, except transport	68,978
Transport equipment operatives	15,085
Laborers, except farm	22,195
Farmers and farm managers	4,806
Farm laborers and farm foremen	5,340
Service workers, except private household	39,875
Private household workers	5,649
TOTAL	365,850

TABLE STATE OF MAINE, 1970

Ethnic, Language, and Racial Characteristics

1. Nativity, Parentage, and Country of Origin

TOTAL POPULATION	993,663
Native of native parentage	800,903
Native of foreign or mixed parentage	149,746
Foreign born	43,014
TOTAL FOREIGN STOCK	192,760
United Kingdom	12,073
Ireland	6,528
Norway	1,234
Sweden	2,740
Denmark	1,050
Netherlands	448
Switzerland	222
France	1,052
Germany	4,488
Poland	2,532
Czechoslovokia	741
Austria	826
Hungary	240
Yugoslavia	133
U.S.S.R.	2,878
Lithuania	1,172
Greece	1,281
Italy	6,083
Other Europe	2,986
Asia	2,511
Canada	136,801
Mexico	277
Cuba	223
Other America	808
All other	616
Not reported	2,817

(Continued)

TABLE

2. Mother Tongue for Selected Groups

TOTAL	993,663
English	786,920
French	141,489
German	4,428
Polish	2,515
Russian	624
Yiddish	1,746
Italian	5,462
Spanish	1,850
All other	14,735
Not reported	33,894

3. Population by Race[1]

TOTAL, ALL RACES	992,048
White	985,276
Negro	2,800
Indian	2,195
Other Specified[2]	1,202
Other, Not Specified	575

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1. Figures do not include 1615 persons of Limestone, Aroostook Co., for whom detailed data were not available.

2. "Other specified" includes Japanese, Chinese, Filipino, Hawaiian, and Korean.

TABLE STATE OF MAINE, 1970

Estimated Urban and Rural Population (in thousands)[1]

TOTAL	992.0
Urban	504.2
Rural	487.9
% Urban	50.8%

TABLE STATE OF MAINE, 1970

Marital Status, 14 Years Old and Older[1]

TOTAL MALE	346,929
Single	97,253
Married	224,170
Separated	2,965
Widowed	12,156
Divorced	10,385
TOTAL FEMALE	379,054
Single	84,104
Married	225,107
Separated	4,260
Widowed	50,078
Divorced	15,505

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1. Figures do not include 1615 persons of Limestone, Aroostook Co., for whom detailed data were not available.

Number of Hospital Admissions of Male and Females with Diagnoses of Alcoholic Psychosis (1); Alcoholism (2); and Alcoholic Cirrhosis of the Liver (3) For First Quarter, 1973.

	ONE						TWO						THREE					
	January		February		March		January		February		March		January		February			
Region I	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
York	0	0	1	0	1	0	2	1	4	1	3	0	1	1	0	0	1	
Cumberland	0	0	0	1	1	0	6	1	5	1	5	2	0	0	4	1	0	
Sagadahoc	0	0	0	0	0	0	0	0	2	0	3	1	0	1	1	0	1	
Lincoln	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	
Knox	0	0	0	0	0	0	0	1	1	0	2	0	0	0	0	0	0	
Waldo	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	0	
Total	1	0	1	1	3	0	9	5	12	3	14	3	1	2	5	1	2	
Region II																		
Oxford	0	0	0	0	0	0	5	0	1	0	1	0	1	0	0	0	2	
Franklin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Androscoggin	0	0	0	0	2	0	3	1	3	0	5	3	7	2	2	0	7	
Total	0	0	0	0	2	0	8	1	4	0	6	3	8	2	2	0	9	
Region III																		
Somerset	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	
Kennebec	0	0	0	0	0	0	0	0	0	1	1	1	0	1	0	0	0	
Total	0	0	0	0	0	0	0	0	0	1	2	2	0	1	0	0	0	
Region IV																		
Piscataquis	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	
Penobscot	0	0	1	0	0	0	8	4	8	0	6	2	1	1	0	2	3	
Hancock	2	0	0	0	0	0	2	0	2	0	3	0	2	1	0	0	0	
Washington	0	0	0	0	0	1	3	0	3	1	5	0	0	0	1	0	1	
Total	2	0	1	0	0	1	13	4	13	1	16	2	3	2	1	2	4	
Region V																		
Aroostook	1	0	1	1	0	0	21	1	14	0	14	0	0	0	2	0	2	
State Total	2	0	3	2	5	1	51	11	43	5	52	10	12	7	10	3	17	

Number of Hospital Admissions of Male and Females with Diagnoses of Alcoholic Psychosis (1): Alcoholism (2); and Alcoholic Cirrhosis of the Liver (3)
For Second Quarter, 1973.

	ONE						TWO						THREE					
	April		May		June		April		May		June		April		May		Ju	
Region I	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
York	0	0	1	0	0	0	1	0	1	1	2	0	1	0	1	0	0	
Cumberland	0	0	0	0	0	0	6	1	3	0	3	1	0	2	1	1	1	
Sagadahoc	0	0	0	0	0	0	4	0	3	0	2	0	0	0	0	0	0	
Lincoln	0	0	0	0	0	0	0	1	2	0	0	2	0	0	0	0	0	
Knox	0	0	0	0	0	0	0	1	3	2	2	1	0	0	0	1	1	
Waldo	0	0	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	
Total			1				11	3	13	3	9	5	1	3	2	2	2	
Region II																		
Oxford	0	0	0	0	0	0	0	0	2	3	2	0	1	0	3	1	1	
Franklin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Androscoggin	0	0	0	1	0	0	8	4	8	2	6	1	0	0	6	1	1	
Total				1			8	4	10	5	8	1	1	0	9	2	2	
Region III																		
Somerset	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	1	
Kennebec	0	0	0	0	1	0	4	0	1	0	1	1	0	0	0	0	0	
Total					1		4	1	1	0	2	1					1	
Region IV																		
Piscataquis	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	
Penobscot	0	0	0	0	0	1	9	1	6	0	6	2	1	2	0	1	1	
Hancock	0	0	0	0	0	0	0	0	1	0	2	0	0	0	0	1	1	
Washington	0	0	0	0	0	0	2	0	2	0	6	0	0	0	2	1	1	
Total							11	1	9	1	14	2	3	2	2	3	3	
Region V																		
Aroostook	1	0	2	0	0	0	12	1	6	1	18	1	0	0	1	1	3	
State Total	1	0	3	1	1	1	46	10	39	10	51	10	5	5	14	8	11	

Number of Hospital Admissions of Males and Females with Diagnoses of Alcoholic Psychosis (1); Alcoholism (2); and Alcoholic Cirrhosis of the Liver (3)
For Third Quarter, 1973.

	(ONE)						(TWO)						(THREE)				
	July		August		September		July		August		September		July		August		Septemb
Region I	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
York	0	0	0	0	0	0	3	0	1	0	2	0	3	0	1	1	1
Cumberland	1	0	0	0	0	0	1	2	1	2	4	1	0	0	1	2	0
Sagadahoc	0	0	0	0	0	0	3	1	2	3	1	1	0	0	1	0	0
Lincoln																	
Knox	0	0	0	0	0	0	2	1	1	1	1	2	2	0	0	0	0
Waldo	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Total	1	0	0	0	0	0	10	4	5	6	8	4	5	0	3	3	2
Region II																	
Oxford	0	0	0	0	0	0	0	1	0	1	2	0	3	0	1	1	1
Franklin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Androscoggin	0	0	0	0	0	0	7	3	3	5	6	3	2	0	2	3	2
Total	0	0	0	0	0	0	7	4	3	6	8	3	5	0	3	3	3
Region III																	
Somerset	1	0	0	0	0	0	3	0	1	0	0	0	2	1	0	0	0
Kennebec	0	0	0	0	0	0	0	0	1	1	2	1	1	0	0	1	0
Total	1	0	0	0	0	0	3	0	2	1	2	1	3	1	0	1	0
Region IV																	
Piscataquis	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Penobscot	2	0	1	0	0	1	14	2	5	0	9	0	1	0	0	3	1
Hancock	0	0	0	0	1	0	9	1	3	0	5	0	0	0	0	1	1
Washington	0	0	0	0	0	0	4	0	3	1	2	3	0	0	1	0	0
Total	2	0	1	0	1	1	28	3	11	1	16	2	1	0	1	4	2
Region V																	
Aroostook	2	1	2	0	1	0	15	2	11	1	8	2	1	0	0	1	1
State Total	6	1	3	0	2	1	63	13	32	15	42	12	15	1	7	12	8

Unemployment Rate by County By Month for 1972

Region/County	Jan.	Feb.	Mar.	Apr.	May.	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
I.												
York	8.5	9.1	8.6	8.3	7.2	7.2	7.5	6.8	7.5	7.5	6.1	6.3
Cumberland	7.0	6.8	6.7	6.2	5.7	5.8	6.3	4.8	3.8	4.9	4.7	4.9
Sagadahoc	8.7	8.2	7.7	7.2	8.2	6.4	8.0	6.2	5.1	5.2	5.7	7.9
Lincoln	8.5	9.7	10.6	9.4	9.4	7.2	8.6	5.3	4.3	4.4	7.0	8.2
Knox	9.6	10.3	9.7	8.8	7.0	6.6	6.9	4.7	4.3	4.5	6.7	7.5
Waldo	12.8	12.7	13.1	11.2	9.4	7.4	10.0	7.7	6.5	4.1	6.6	7.7
II.												
Oxford	8.0	8.9	8.3	8.9	9.4	6.5	9.5	5.6	4.9	4.4	5.0	5.9
Androscoggin	9.7	10.3	10.6	10.3	8.3	8.0	11.5	6.0	6.3	6.1	6.1	6.2
Franklin	12.3	10.1	9.2	9.3	8.3	10.2	11.4	6.5	5.6	4.6	4.5	5.0
III.												
Somerset	15.1	14.9	15.1	14.6	11.7	9.5	10.0	7.0	7.0	7.5	8.8	11.5
Kennebec	5.4	6.0	6.3	5.6	5.2	5.5	6.6	4.7	4.3	4.0	4.7	5.2
IV.												
Piscataquis	10.7	9.0	10.3	10.0	9.2	9.5	9.4	8.0	6.0	6.0	6.1	6.0
Penobscot	8.6	9.0	8.9	9.0	7.7	6.3	7.5	6.5	5.6	5.9	5.5	5.8
Hancock	8.5	12.3	12.6	9.9	7.7	5.4	4.8	3.5	3.7	3.7	5.0	6.7
Washington	14.1	12.7	17.7	18.3	17.8	12.7	9.1	5.5	4.8	7.4	7.8	11.0
V.												
Aroostook	9.7	10.0	9.3	8.6	9.2	10.2	16.6	16.1	8.8	8.0	7.9	8.4
State Totals	8.2	8.8	8.8	8.5	7.5	7.0	8.4	6.5	5.6	5.7	5.8	6.4

Unemployment Rate by County: By Month for 1973

Region/County	Jan.	Feb.	Mar.	Apr.	May.	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
I.												
York	7.0	6.8	5.5	5.2	4.5	4.3						
Cumberland	5.0	4.4	4.9	4.5	4.4	4.8						
Sagadahoc	9.4	9.2	10.1	8.9	9.0	9.6						
Lincoln	10.2	11.7	11.5	10.1	11.2	8.7						
Knox	8.8	8.5	7.9	7.9	7.7	6.0						
Waldo	8.5	10.3	9.7	8.4	10.0	10.1						
II.												
Oxford	5.6	5.7	5.6	6.2	6.3	6.7						
Androscoggin	7.2	8.3	8.2	7.3	6.2	6.7						
Franklin	6.2	5.8	6.3	5.8	5.1	6.3						
III.												
Somerset	11.7	11.6	11.5	10.8	9.3	7.4						
Kennebec	5.6	5.8	5.5	4.9	4.4	4.7						
IV.												
Piscataquis	7.7	8.5	9.3	8.5	7.6	7.4						
Penobscot	5.8	6.2	5.8	5.7	5.1	5.0						
Hancock	10.2	10.6	9.5	8.2	7.6	5.4						
Washington	15.6	16.5	16.0	17.0	15.0	9.4						
V.												
Aroostook	8.2	9.4	10.2	10.5	10.4	12.4						
State Totals	7.0	7.2	7.0	6.7	6.3	6.1						

Number of Unemployed by Region and Month for 1973

Region	Month J	F	M	A	M	J	J	A	S	O	N	D
Region I	10700	10000	9850	91000	9250	9580	11360	7890	7540	7760		
Region II	4100	4500	4450	4150	3750	4150	6200	3350	3390	3620		
Region III	3950	4000	3850	3500	3200	3220	3880	3040	2560	2670		
Region IV	6400	6900	6550	6450	5850	5110	5000	4030	3490	4400		
Region V	2700	3150	3300	3450	3460	4640	5370	4450	4570	2400		
State Total	27850	28550	28000	26650	25510	26700	31810	22760	21550	20850		

Total Separation Rates (Quits, Layoffs) per 100 Employees For Various Industries

By Month for 1972

Industry	Jan.	Feb.	Mar.	Apr.	May.	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Total Manufacturing	4.9	5.2	6.1	6.3	5.9	7.4	6.0	7.4	9.7	6.3	6.1	5.9
Durable Goods	4.6	5.2	7.9	6.0	6.4	5.9	4.6	6.7	7.3	5.7	5.3	5.6
Lumber and Wood Products	5.7	7.9	14.1	9.7	9.5	7.4	6.2	8.6	8.8	7.2	7.1	7.5
Metals and Machinery	4.3	3.9	4.7	4.7	5.0	4.8	3.4	6.0	7.0	5.2	3.8	3.9
Other Durable Goods	2.9	2.4	2.4	2.7	4.0	4.8	3.3	4.3	5.3	3.9	4.0	4.6
Nondurable goods	5.0	5.2	5.3	6.4	5.6	8.1	6.7	7.8	10.8	6.6	6.5	6.1
Food and Kindred Products	4.6	9.4	6.7	12.9	7.4	18.4	8.0	9.2	17.6	7.8	12.2	9.6
Textile Mill Products	9.0	6.6	6.7	8.7	8.1	7.9	8.6	10.2	12.3	10.2	6.6	7.3
Apparel	7.5	5.6	7.0	5.7	5.8	8.0	8.1	9.1	9.7	6.2	4.8	9.4
Paper and allied Products	1.4	1.1	1.1	1.3	1.2	1.4	1.4	2.1	5.0	1.9	1.2	1.8
Leather & leatherProducts	6.0	5.8	7.5	7.4	7.6	9.3	8.9	11.1	12.2	8.8	8.4	6.9
Other Nondurable goods	5.2	4.7	4.3	4.2	4.5	5.2	8.2	6.2	8.2	5.4	5.6	5.7

Total Separation Rates (Quits, Layoffs) per 100 Employees For Various Industries

By Month for 1973

Industry	Jan.	Feb.	Mar.	Apr.	May.	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Total Manufacturing	6.0	5.6	6.3	6.9								
Durable Goods	6.3	6.6	7.9	6.0								
Lumber and Wood Products	7.1	9.2	12.3	8.0								
Metals and Machinery	5.0	3.9	4.4	4.6								
Other Durable Goods	6.9	5.5	5.1	4.9								
Nondurable goods	5.8	5.2	5.5	7.3								
Food and Kindred Products	9.4	6.6	5.6	13.9								
Textile Mill Products	6.5	6.8	7.8	9.1								
Apparel	5.8	4.7	6.6	11.8								
Paper and allied Products	1.6	1.8	1.3	1.6								
Leather & leatherProducts	7.1	7.0	7.8	7.4								
Other Nondurable goods	5.8	4.6	5.8	7.1								

Amount of AFDC Money Paid Out by Month for 1973 - By Region and County

Region/County	Jan.	Feb.	March	April	May	June	July	August	Sept.	Oct.	Nov.
REGION I											
York	242,807	243,449	245,807	244,291	246,142	249,187	248,934	248,119	253,748	253,147	254,209
Cumberland	520,097	521,967	525,078	525,581	522,553	526,071	527,414	525,246	531,664	537,415	542,811
Sagadahoc	67,871	67,984	67,888	68,367	70,350	70,987	71,808	70,944	73,610	73,304	73,022
Lincoln	51,233	51,576	52,076	52,613	53,692	54,919	54,986	56,965	56,433	57,045	57,343
Knox	86,095	86,722	86,710	86,962	85,614	85,101	87,740	88,773	89,197	88,817	90,039
Waldo	80,528	82,846	84,194	86,249	86,783	85,846	88,053	86,855	88,306	87,582	88,672
TOTAL	1,048,631	1,054,544	1,061,753	1,064,063	1,065,134	1,072,111	1,078,935	1,076,902	1,092,958	1,097,310	1,106,096
REGION II											
Oxford	97,445	100,016	99,865	99,813	98,271	99,028	100,124	99,683	101,311	101,855	105,067
Androscoggin	227,736	227,808	227,881	229,635	228,734	234,375	234,765	237,547	236,007	239,494	242,710
Franklin	49,740	50,327	49,731	48,840	50,247	51,223	50,585	51,709	51,522	53,152	54,324
TOTAL	374,931	378,151	377,477	378,288	377,252	384,626	385,474	388,539	388,840	394,501	402,101
REGION III											
Somerset	148,847	149,642	151,532	151,621	151,512	151,855	154,579	153,245	154,013	151,968	153,289
Kennebec	255,501	256,315	256,666	257,856	258,148	259,676	262,247	265,658	269,327	274,017	276,465
TOTAL	404,348	405,957	408,198	409,477	409,660	411,531	416,826	418,903	423,340	425,985	429,754
REGION IV											
Piscataquis	40,328	40,085	39,574	39,620	39,232	39,680	39,810	41,132	41,594	42,273	42,292
Penobscot	321,226	320,997	319,624	322,334	320,417	323,890	324,567	321,787	329,858	334,916	337,200
Hancock	68,167	70,042	70,203	72,094	72,617	74,833	76,299	76,449	74,853	76,267	77,477
Washington	95,308	96,284	98,332	99,236	99,043	100,877	101,097	102,053	102,300	101,893	100,055
TOTAL	525,029	527,408	527,733	533,284	531,309	539,280	541,773	541,421	548,605	555,349	557,024
REGION V											
Aroostook	224,452	227,629	228,078	231,451	232,138	234,765	233,071	232,514	232,582	234,643	229,729
STATE TOTAL	2,577,391	2,593,693	2,603,239	2,616,561	2,615,493	2,642,313	2,656,079	2,658,279	2,686,325	2,707,788	2,724,704

Number of Recorded Arrests for Assault and Battery by Region and County: by Month for 1972

	Month											
Region/County	J	F	M	A	M	J	J	A	S	O	N	D
Region I												
York	11	22	17	13	24	35	47	48	39	21	21	33
Cumberland	20	19	19	26	31	45	33	26	21	18	18	19
Sagadahoc	1	0	5	1	5	2	3	6	6	2	5	1
Lincoln	1	1	0	5	1	6	3	4	2	1	3	8
Knox	3	4	1	3	3	3	3	4	1	2	1	1
Waldo	2	3	10	1	1	4	4	6	3	7	4	3
TOTAL	38	49	52	49	65	95	93	94	72	51	52	65
Region II												
Oxford	2	5	10	5	14	4	11	6	12	8	9	2
Androscoggin	5	8	14	14	18	11	14	10	11	9	7	3
Franklin	3	4	9	1	3	2	3	2	2	3	3	0
TOTAL	10	17	33	20	35	17	28	18	25	20	19	5
Region III												
Somerset	5	5	4	5	5	10	7	10	13	9	9	3
Kennebec	11	15	16	12	11	12	17	17	19	25	26	20
TOTAL	16	20	20	17	16	22	24	27	32	34	35	23
Region IV												
Piscataquis	1	2	1	0	3	1	4	0	4	2	0	9
Penobscot	14	10	19	24	30	27	11	21	22	20	16	21
Hancock	4	2	7	10	2	4	12	5	2	3	9	4
Washington	3	3	4	10	3	4	3	6	8	2	3	7
TOTAL	22	17	31	44	38	36	30	32	36	27	28	41
Region V												
Aroostook	20	11	21	19	22	25	31	21	16	24	23	23
STATE TOTAL	106	114	157	149	176	195	206	192	181	156	157	157

Number of Recorded Arrests for Assault and Battery
by Region and County: by Month for 1973

	Month											
Region/County	J	F	M	A	M	J	J	A	S	O	N	D
Region I												
York	18	15	34	19	27	33	54	33				
Cumberland	30	21	41	29	32	20	26	23				
Sagadahoc	4	2	2	4	2	5	5	2				
Lincoln	2	1	9	3	2	3	6	3				
Knox	2	3	3	3	1	2	2	6				
Waldo	4	5	10	2	5	4	9	8				
TOTAL	60	47	99	60	69	67	102	75				
Region II												
Oxford	3	4	1	5	5	11	13	14				
Androscoggin	16	16	18	8	11	10	14	5				
Franklin	3	1	2	1	7	1	2	2				
TOTAL	22	21	21	14	23	22	29	21				
Region III												
Somerset	9	12	7	5	8	8						
Kennebec	15	20	13	12	14	25						
TOTAL	24	32	20	17	22	33						
Region IV												
Piscataquis	0	0	1	0	2	1	3	2				
Penobscot	10	14	24	18	18	13	25	21				
Hancock	7	4	6	4	13	1	1	11				
Washington	4	1	1	4	3	19	4	3				
TOTAL	21	19	32	26	36	34	33	37				
Region V												
Aroostook	20	11	21	19	22	27	31	17	13			
STATE TOTAL	147	130	193	136	172	183						

Number of Divorces by Region and County: by Month for 1972

Region/County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
Region I												
York	46	46	65	74	51	75	51	84	54	66	56	44
Cumberland	86	92	114	101	100	103	108	102	80	103	93	87
Sagadahoc	14	9	19	14	9	19	10	8	20	12	14	8
Lincoln	14	12	14	10	21	11	12	14	8	11	7	11
Knox	13	19	8	11	11	10	11	17	1	9	11	9
Waldo	9	9	5	11	15	9	6	6	7	5	4	10
TOTAL	182	187	225	221	207	227	198	231	170	206	185	169
Region II												
Oxford	8	7	7	4	5	13	17	7	6	13	4	4
Androscoggin	28	24	30	33	35	39	36	34	26	26	22	32
Franklin	6	4	6	3	7	11	4	7	4	4	9	6
TOTAL	42	35	43	40	47	63	57	48	36	43	35	42
Region III												
Somerset	14	21	33	24	18	21	20	16	16	11	23	7
Kennebec	42	36	43	47	40	47	35	60	42	45	39	24
TOTAL	56	57	76	71	58	68	55	76	58	56	62	31
Region IV												
Piscataquis	7	3	3	4	10	5	2	5	4	6	5	8
Penobscot	41	42	53	35	43	44	55	39	43	45	42	39
Hancock	16	9	12	11	9	9	13	15	10	15	12	8
Washington	6	7	10	11	10	16	5	19	8	3	6	5
TOTAL	70	61	78	61	72	74	75	78	65	69	65	60
Region V												
Aroostook												
STATE TOTAL												

Number of Divorces by Region and County: by Month for 1973

Region/County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
Region I												
York	62	51	58	61	67	62	52	75				
Cumberland	72	86	122	102	108	100	109	97				
Sagadahoc	15	12	12	11	21	17	18	21				
Lincoln	15	10	11	11	7	8	7	18				
Knox	12	6	10	10	19	14	14	15				
Waldo	7	17	13	7	8	8	9	9				
TOTAL	183	182	226	202	230	209	209	235				
Region II												
Oxford	5	7	13	7	11	12	2	8				
Androscoggin	33	32	43	32	46	47	35	31				
Franklin	8	2	10	8	8	7	3	5				
TOTAL	46	41	66	47	65	66	40	44				
Region III												
Somerset	11	11	18	13	18	14	20	18	16	17	20	14
Kennebec	58	42	65	58	63	49	74	75	44	58	47	39
TOTAL	69	53	83	71	81	63	94	93	60	75	67	53
Region IV												
Piscataquis	4	2	5	4	9	3	7	10				
Penobscot	58	48	60	36	56	62	53	65				
Hancock	16	14	8	7	17	15	12	13				
Washington	3	11	12	12	7	7	12	11				
TOTAL	81	75	85	59	89	87	84	99				
Region V												
Aroostook												
STATE TOTAL												

Number of Mental Health Facility Clients with Alcohol Abuse Problems Reporting Troubled Family (Spouse) Relations: By Region and County of Facility: by Month for 1972.

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	1	1	0	0	0	1	0	0	0	1	1	1
Cumberland	3	1	4	6	9	10	7	13	6	5	10	14
Sagadahoc	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0
Knox.	1	0	0	0	0	1	1	1	0	0	1	0
Waldo	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	5	2	4	6	9	12	8	14	6	6	12	15
REGION II												
Oxford	1	0	0	0	0	1	0	0	0	0	1	0
Franklin	1	5	2	3	6	4	1	3	8	1	7	4
Androscoggin	2	2	3	0	2	3	7	7	3	2	1	0
TOTAL	4	7	5	3	8	8	8	10	11	3	9	4
REGION III												
Somerset	0	0	0	0	0	0	0	0	0	0	0	0
Kennebec	0	0	0	4	3	2	0	2	0	2	0	1
TOTAL	0	0	0	4	3	2	0	2	0	2	0	1
REGION IV												
Piscataquis	0	0	1	0	2	0	0	3	1	2	2	4
Penobscot	10	9	14	10	6	12	8	11	4	12	11	0
Hancock	0	0	2	1	0	0	0	1	1	1	1	0
Washington	0	0	0	0	1	1	0	3	1	2	3	1
TOTAL	10	9	17	11	9	13	8	18	7	17	17	5
REGION V												
Aroostook	9	11	7	5	10	2	6	6	0	7	2	5
STATE TOTAL	28	29	33	29	39	37	30	50	24	35	40	30

Number of Mental Health Facility Clients with Alcohol Abuse Problems Reporting Troubled Family (Spouse) Relations: By Region and County of Facility: by Month for 1973.

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	2	2	1	2	1	0	0	0	0			
Cumberland	14	7	10	13	7	14	16	13	13			
Sagadahoc	0	0	0	0	0	0	0	0	0			
Lincoln	0	0	0	0	0	0	0	0	0			
Knox	3	0	0	0	0	1	0	0	0			
Waldo	0	0	0	0	0	0	0	0	0			
TOTAL	19	9	11	15	8	15	16	13	13			
REGION II												
Oxford	1	2	2	0	2	1	0	1	2			
Franklin	4	0	7	1	3	11	7	2	4			
Androscoggin	4	8	3	11	1	3	0	4	2			
TOTAL	9	10	12	12	6	15	7	7	8			
REGION III												
Somerset	0	0	0	0	0	0	0	0	0			
Kennebec	1	1	2	2	4	1	2	0	2			
TOTAL	1	1	2	2	4	1	2	0	2			
REGION IV												
Piscataquis	1	1	3	3	0	0	0	2	1			
Penobscot	7	13	9	9	3	8	12	13	10			
Hancock	1	1	4	0	1	0	3	2	2			
Washington	1	2	5	4	2	1	0	1	0			
TOTAL	10	17	21	16	6	9	15	18	13			
REGION V												
Aroostook	12	2	1	5	0	0	2	3	3			
STATE TOTAL	51	39	47	50	24	40	42	41	39			

Number of Mental Health Facility Clients with Alcohol Abuse Problems Reporting Troubled Family (Children) Relations: By Region and County of Facility: by Month for 1972.

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	0	2	0	0	0	0	0	0	0	0	0	0
Cumberland	1	0	3	4	7	8	3	9	2	4	7	14
Sagadahoc	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0
Knox.	0	0	0	0	0	0	0	0	0	0	0	0
Waldo	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1	2	3	4	7	8	3	9	2	4	7	14
REGION II												
Oxford	0	0	0	0	0	0	1	0	0	0	0	0
Franklin	1	1	1	3	2	0	1	1	5	0	0	3
Androscoggin	0	0	0	0	0	1	1	0	2	0	0	0
TOTAL	1	1	1	3	2	1	3	1	7	0	0	3
REGION III												
Somerset	0	0	0	0	0	0	0	0	0	0	0	0
Kennebec	0	0	0	3	1	3	0	1	0	0	0	0
TOTAL	0	0	0	3	1	3	0	1	0	0	0	0
REGION IV												
Piscataquis	0	0	0	0	0	0	0	1	0	0	0	0
Penobscot	3	3	9	5	4	3	4	3	2	2	1	0
Hancock	0	0	1	1	0	0	0	0	0	1	0	0
Washington	0	0	0	0	0	1	0	0	0	0	0	1
TOTAL	3	3	10	6	4	4	4	4	2	3	1	1
REGION V												
Aroostook	3	3	2	1	0	1	1	0	0	0	0	1
STATE TOTAL	8	9	16	17	14	17	11	15	11	7	8	19

Number of Mental Health Facility Clients with Alcohol Abuse Problems Reporting Troubled Family (Children) Relations: By Region and County of Facility: by Month for 1973.

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	0	2	1	0	1	0	0	0	0			
Cumberland	12	7	7	11	5	11	15	10	10			
Sagadahoc	0	0	0	0	0	0	0	0	0			
Lincoln	0	0	0	0	0	0	0	0	0			
Knox	0	0	0	0	0	0	0	0	0			
Waldo	0	0	0	0	0	0	0	0	0			
TOTAL	12	9	8	11	6	11	15	10	10			
REGION II												
Oxford	0	0	2	0	0	1	0	1	0			
Franklin	0	0	2	0	0	5	5	1	3			
Androscoggin	1	2	0	2	0	0	0	1	0			
TOTAL	1	2	4	2	0	6	5	3	3			
REGION III												
Somerset	0	0	0	0	0	0	0	0	0			
Kennebec	0	1	2	1	1	1	1	0	2			
TOTAL	0	1	2	1	1	1	1	0	2			
REGION IV												
Piscataquis	0	2	0	0	0	1	0	0	1			
Penobscot	3	4	3	2	0	1	1	2	2			
Hancock	0	0	3	0	0	0	1	0	0			
Washington	0	0	2	1	1	1	1	1	0			
TOTAL	3	6	8	3	1	3	3	3	3			
REGION V												
Aroostook	3	0	0	2	0	0	1	0	0			
STATE TOTAL	19	18	22	19	8	21	25	16	18			

Net Enrollment and Drop-Outs for Maine Schools by Region and County for 1971-1972

Region/County	Grade 9		Grade 10		Grade 11		Grade 12		D.O. Rate
	Enr.	D.O.	Enr.	D.O.	Enr.	D.O.	Enr.	D.O.	
Region I									
York	1915	62	1786	106	1632	115	1592	61	4.90
Cumberland	3602	119	3518	261	3220	252	2897	139	5.82
Sagadahoc	321	10	298	14	293	18	264	7	4.17
Lincoln	374	15	306	13	294	21	272	18	5.42
Knox	476	24	423	20	419	35	403	31	6.39
Waldo	428	6	396	21	349	20	338	12	3.90
TOTAL	7116	236	6727	435	6207	461	5766	268	5.42
Region II									
Oxford	1044	18	936	40	925	51	820	27	3.65
Franklin	429	7	429	13	414	16	380	10	2.78
Androscoggin	1454	12	1556	89	1416	107	1231	77	5.04
TOTAL	2927	37	2921	142	2755	174	2431	114	4.23
Region III									
Somerset	772	17	764	36	675	34	598	25	3.99
Kennebec	1729	85	1539	71	1463	96	1310	59	5.15
TOTAL	2501	102	2303	107	2138	130	1908	84	4.78
Region IV									
Piscataquis	275	7	229	11	200	9	189	4	3.47
Penobscot	2612	80	2518	155	2225	153	1951	102	5.27
Hancock	260	19	614	18	563	18	513	16	3.64
Washington	558	30	524	28	419	19	440	17	4.84
TOTAL	3705	136	3885	212	3407	199	3093	139	4.89
Region V									
Aroostook	1454	12	1556	89	1416	107	1231	77	5.04
STATE TOTALS	18353	552	17844	988	16371	1074	14833	652	4.90
Drop-Out Rate by Grade	3.0		5.5		6.6		4.4		
Statewide Enrollment	67401								
Statewide Drop Outs	3267								
Statewide D.O. Rate	4.9								

Net Enrollment and Drop-Outs for Maine Schools
by Region and County for 1972-1973.

Region/County	Grade 9		Grade 10		Grade 11		Grade 12		D.O.
	Enr.	D.O.	Enr.	D.O.	Enr.	D.O.	Enr.	D.O.	Rate
Region I									
York	1994	105	1873	130	1645	142	1498	67	6.3
Cumberland	3803	144	3497	229	3311	261	2949	154	5.8
Sagadahoc	305	4	266	14	252	22	249	19	5.5
Lincoln	363	14	361	20	280	18	284	10	4.8
Knox	485	3	453	10	412	7	369	9	1.7
Waldo	409	8	416	19	366	27	324	19	4.8
TOTAL	7359	278	6866	422	6266	477	5673	278	5.3
Region II									
Oxford	1041	52	1004	39	880	72	845	45	5.5
Franklin	478	19	424	14	408	17	372	16	3.9
Androscoggin	1495	33	1543	84	1427	111	1234	56	4.9
TOTAL	3014	104	2971	137	2715	200	2451	117	5.0
Region III									
Somerset	893	24	764	31	705	32	606	25	3.7
Kennebec	1719	15	1594	46	1445	77	1348	52	3.1
TOTAL	2612	39	2358	77	2150	109	1954	77	3.3
Region IV									
Piscataquis	250	10	256	7	217	9	187	4	3.3
Penobscot	2631	59	2503	159	2271	145	2061	106	4.9
Hancock	621	19	587	24	585	16	534	21	3.4
Washington	603	37	486	25	492	25	402	13	5.1
TOTAL	4105	125	3832	215	3565	195	3184	144	4.6
Region V									
Aroostook	2162	40	2174	71	1864	108	1789	89	3.8
STATE TOTALS	19252	586	18201	922	16560	1089	15051	709	4.7
Drop-Out Rate by Grade	3.1		5.1		6.6		4.7		
Statewide Enrollment	69,064								
Statewide Drop Outs	3.302								
Statewide D.O. Rate	4.7								

Number of Recorded Arrests for Operating Under the Influence, by Region and County: by Month for 1972

Region/County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	88	66	82	81	59	97	109	99	116	86	87	66
Cumberland	91	99	113	137	139	127	100	123	140	115	91	88
Sagadahoc	5	10	4	24	12	13	11	8	14	18	10	7
Lincoln	13	11	5	11	14	15	14	12	14	5	5	4
Knox	8	9	6	4	9	9	7	12	12	8	10	7
Waldo	13	13	19	10	13	11	28	37	20	22	13	10
TOTAL	218	208	229	267	246	272	269	291	316	254	216	182
REGION II												
Oxford	9	7	11	15	9	8	16	19	14	9	11	8
Androscoggin	22	23	21	32	34	11	30	23	20	29	41	34
Franklin	5	6	7	3	6	5	16	7	15	10	9	4
TOTAL	36	36	39	50	49	24	62	49	49	48	61	46
REGION III												
Somerset	15	20	26	23	24	35	19	32	29	32	32	9
Kennebec	31	26	34	23	38	41	43	43	27	38	32	31
TOTAL	46	46	60	46	62	76	62	75	56	70	64	40
REGION IV												
Piscataquis	6	3	2	7	8	5	5	8	13	10	6	2
Penobscot	49	59	44	70	66	50	46	48	59	66	58	41
Hancock	14	8	15	17	17	17	20	24	15	22	10	10
Washington	5	12	9	11	7	18	18	21	22	19	17	16
TOTAL	74	82	70	105	98	90	89	101	109	117	91	69
REGION V												
Aroostook	40	38	51	40	77	56	56	72	68	75	62	60
STATE TOTAL	414	410	449	508	532	518	538	588	598	564	494	397

Number of Recorded Arrests for Operating Under the Influence, by Region and County: by Month for 1973

Region/County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	54	55	75	63	64	74	105	74				
Cumberland	142	137	162	134	136	91	109	123				
Sagadahoc	10	11	11	18	15	22	13	14				
Lincoln	3	7	12	11	4	3	7	7				
Knox	11	10	7	8	6	17	19	15				
Waldo	30	15	20	16	24	25	37	27				
TOTAL	250	235	287	250	249	232	290	260				
REGION II												
Oxford	8	12	13	17	8	16	25	10				
Androscoggin	26	34	39	48	34	46	25	29				
Franklin	6	7	9	8	17	9	3	12				
TOTAL	40	53	61	73	59	71	53	51				
REGION III												
Somerset	16	23	23	39	33	35						
Kennebec	52	32	46	43	51	56						
TOTAL	68	55	69	82	84	91						
REGION IV												
Piscataquis	2	9	9	8	5	9	12	6				
Penobscot	38	50	67	68	66	58	76	70				
Hancock	13	8	16	25	35	23	19	10				
Washington	18	9	27	11	18	34	42	33				
TOTAL	71	76	119	112	124	124	149	119				
REGION V												
Aroostook	35	49	37	36	41	43	44	33	30			
STATE TOTAL	464	468	573	553	557	561						

Number of Admissions to Mental Health Facilities for Treatment of Problem Drinking. By Region and County for 1972.

Region / County	Months										
	J	F	M	A	M	J	J	A	S	O	N
Region I											
York	1	3	0	0	0	2	0	0	0	1	1
Cumberland	8	8	12	17	13	15	12	15	7	6	10
Sagadahoc	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0
Knox	1	0	3	0	1	1	2	1	2	1	1
Waldo	0	0	0	0	0	0	0	0	0	0	0
Total	10	11	15	17	14	18	14	16	9	8	12
Region II											
Oxford	1	1	0	1	0	1	1	0	1	0	1
Franklin	5	5	4	3	8	5	3	5	10	1	8
Androscoggin	4	5	4	3	3	7	12	9	6	3	2
Total	10	11	8	7	11	13	16	14	17	4	11
Region III											
Somerset	0	0	0	0	0	0	0	0	0	0	0
Kennebec	0	0	0	5	3	4	0	3	0	2	1
Total	0	0	0	5	3	4	0	3	0	2	1
Region IV											
Piscataquis	0	0	2	0	2	1	0	5	1	2	3
Penobscot	26	21	30	19	17	23	28	48	20	16	24
Hancock	2	2	3	2	0	2	0	2	3	2	1
Washington	0	0	0	0	3	0	0	8	1	3	4
Total	28	24	35	21	22	26	28	63	25	23	32
Region V											
Aroostook	21	16	21	22	23	16	12	19	13	7	7
State Total	69	61	79	72	73	77	70	115	64	44	63

Number of Admissions to Mental Health Facilities for Treatment of Problem Drinking. By Region and County for 1973.

	Months											
Region / County	J	F	M	A	M	J	J	A	S	O	N	D
Region I												
York	3	2	1	3	2	1	0	0	1			
Cumberland	16	12	14	15	9	19	24	16	17			
Sagadahoc	0	0	0	0	0	0	0	0	0			
Lincoln	0	0	0	0	0	0	0	0	0			
Knox	4	1	2	2	0	1	1	0	0			
Waldo	0	0	0	0	0	0	0	0	0			
Total	23	15	17	20	11	21	26	16	18			
Region II												
Oxford	4	3	5	2	2	3	0	3	2			
Franklin	4	1	8	3	4	12	11	2	5			
Androscoggin	10	12	8	14	6	7	7	8	6			
Total	18	16	21	19	12	22	18	13	13			
Region III												
Somerset	0	0	0	0	0	0	0	0	0			
Kennebec	1	2	3	3	7	3	8	0	13			
Total	1	2	3	3	7	3	8	0	13			
Region IV												
Piscataquis	3	2	3	5	1	1	0	4	1			
Penobscot	21	40	33	25	15	27	28	28	25			
Hancock	3	2	6	1	4	1	8	4	2			
Washington	1	2	8	7	6	4	1	3	0			
Total	28	46	50	38	26	33	37	39	28			
Region V												
Aroostook	19	7	5	13	4	9	6	4	10			
State Total	89	86	96	93	60	88	94	72	82			

Number of Terminations from Mental Health Facilities for Treatment of Problem Drinking. By Region and County for Jan. - Dec., 1972.

Region/ County	Months											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	0	0	0	0	2	0	0.	0	0	0	0	0
Cumberland	8	10	8	4	16	15	10	6	5	8	10	16
Sagadahoc	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0
Knox	0	0	1	0	0	0	0	0	1	1	2	2
Waldo	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	8	10	9	4	18	15	10	6	6	9	12	18
REGION II												
Oxford	2	0	0	0	1	0	0	2	0	0	1	0
Franklin	0	0	0	4	3	2	0	0	0	6	0	0
Androscoggin	7	2	2	3	5	4	8	9	7	5	8	:
TOTAL	9	2	2	7	9	6	8	11	7	11	9	0
REGION III												
Somerset	0	0	0	0	0	0	0	0	0	0	0	0
Kennebec	2	0	4	0	2	2	1	0	2	0	1	0
TOTAL	2	0	4	0	2	2	1	0	2	0	1	0
REGION IV												
Piscataquis	1	0	0	4	0	2	0	0	2	1	1	5
Penobscot	24	19	32	14	24	16	23	30	19	11	23	12
Hancock	2	3	0	1	1	1	1	2	1	2	3	4
Washington	0	0	0	0	0	0	0	1	3	0	0	0
TOTAL	27	22	32	19	25	19	24	33	25	14	27	21
REGION V												
Aroostook	11	16	16	17	27	14	12	11	11	15	17	12
STATE TOTAL	57	50	63	47	81	56	55	61	51	49	66	51

Number of Terminations from Mental Health Facilities For Treatment of Problem Drinking. By Region and County for 1973

	Month											
Region / County	J	F	M	A	M	J	J	A	S	O	N	D
Region I												
York	1	2	1	2	1	1	0	0	0			
Cumberland	17	9	11	13	9	19	25	20	17			
Sagadahoc	0	0	0	0	0	0	0	0	0			
Lincoln	0	0	0	0	0	0	0	0	0			
Knox	1	1	2	1	3	0	1	0	0			
Waldo	0	0	0	0	0	0	0	0	0			
Total	19	12	14	16	13	20	25	20	17			
Region II												
Oxford	3	2	6	6	4	1	3	7	1			
Franklin	3	2	0	1	1	4	0	5	0			
Androscoggin	8	8	12	9	3	10	6	11	5			
Total	14	12	18	16	8	15	9	23	6			
Region III												
Somerset	0	0	0	0	0	0	0	0	0			
Kennebec	0	2	2	1	1	1	3	2	6			
Total	0	2	2	1	1	1	3	2	6			
Region IV												
Piscataquis	0	4	3	4	4	0	1	0	1			
Penobscot	26	23	33	23	17	19	23	28	15			
Hancock	2	0	1	4	2	2	2	6	0			
Washington	5	0	2	2	0	1	3	1	0			
Total	33	27	39	33	23	22	29	35	16			
Region V												
Aroostook	23	10	5	8	9	10	9	3	11			
State Total	89	63	78	74	54	68	75	83	56			

Number of Recorded Arrests for Intoxication, by Region and County: by Month for 1972

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	16	19	35	22	39	29	66	44	31	26	21	21
Cumberland	57	91	83	97	128	100	113	128	100	104	95	97
Sagadahoc	3	2	3	6	9	1	1	4	3	6	3	2
Lincoln	2	0	1	2	4	3	4	7	4	4	4	3
Knox	10	11	12	13	19	19	17	22	6	15	8	10
Waldo	1	2	4	3	5	3	0	3	5	1	1	0
TOTAL	89	125	138	143	204	155	201	208	149	156	132	133
REGION II												
Oxford	5	5	11	6	7	7	13	16	16	8	8	7
Androscoggin	17	19	24	25	30	30	34	25	29	37	32	27
Franklin	2	2	5	2	1	3	1	5	7	0	3	0
TOTAL	24	26	40	33	38	40	48	46	52	45	43	34
REGION III												
Somerset	9	8	11	17	10	18	12	26	14	7	10	4
Kennebec	31	32	22	26	33	45	50	62	50	54	45	34
TOTAL	40	40	33	43	43	63	62	88	64	61	55	38
REGION IV												
Piscataquis	12	3	6	5	5	6	9	4	4	6	5	5
Penobscot	32	15	32	29	25	28	22	34	18	39	27	13
Hancock	7	2	6	7	8	12	5	16	6	6	1	5
Washington	8	2	7	6	4	4	10	7	8	5	8	6
TOTAL	59	22	51	47	42	50	46	61	36	56	41	29
REGION V												
Aroostook	40	33	37	42	67	77	55	65	70	62	46	41
STATE TOTAL	252	246	299	308	394	385	412	468	371	380	317	275

Number of Recorded Arrests for Intoxication, by Region and County: by Month for 1972/3

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	17	21	33	44	35	36	46	21				
Cumberland	120	101	115	126	142	144	139	126				
Sagadahoc	3	4	4	1	1	7	1	3				
Lincoln	1	2	5	1	2	1	0	2				
Knox	13	10	9	21	10	8	15	10				
Waldo	1	0	2	6	10	4	18	5				
TOTAL	155	138	168	199	200	200	219	167				
REGION II												
Oxford	9	9	20	11	13	14	13	8				
Androscoggin	27	29	17	30	26	30	19	21				
Franklin	5	3	2	2	2	1	10	1				
TOTAL	41	41	39	43	41	45	42	30				
REGION III												
Somerset	12	6	12	10	13	18						
Kennebec	31	26	41	32	51	61						
TOTAL	43	32	53	42	64	79						
REGION IV												
Piscataquis	8	7	9	11	4	7	8	5				
Penobscot	27	25	25	9	37	28	25	50				
Hancock	5	1	8	8	5	6	4	5				
Washington	9	4	14	19	14	16	24	11				
TOTAL	49	37	56	47	60	57	61	71				
REGION V												
Aroostook	40	34	37	38	29	27	28	31	35			
STATE TOTAL	328	282	353	369	394	408						

Number of Recorded Arrests for Disorderly Conduct, by Region and County: by Month for 1972

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	3	4	7	4	10	11	38	27	27	8	9	11
Cumberland	17	15	14	12	21	25	22	21	18	22	32	22
Sagadahoc	0	1	1	5	2	1	3	2	0	1	4	1
Lincoln	0	2	0	0	0	1	1	2	2	2	3	1
Knox	6	2	6	5	11	9	3	11	10	7	3	6
Waldo	1	7	7	0	1	0	1	4	6	4	0	1
TOTAL	27	31	35	26	45	47	68	67	63	44	51	42
REGION II												
Oxford	3	5	1	2	5	5	9	4	1	9	6	1
Androscoggin	12	14	13	3	8	14	19	35	10	19	9	5
Franklin	0	0	2	0	1	1	1	1	2	1	0	1
TOTAL	15	19	16	5	14	20	29	40	13	29	15	7
REGION III												
Somerset	4	5	4	3	0	8	4	9	8	2	2	1
Kennebec	8	11	22	2	8	14	13	19	28	19	10	13
TOTAL	12	16	26	5	8	22	17	28	36	21	12	14
REGION IV												
Piscataquis	2	3	3	0	1	4	7	5	1	1	0	4
Penobscot	6	3	3	9	19	12	7	12	7	8	7	20
Hancock	4	3	1	3	4	12	10	11	10	6	0	4
Washington	2	4	3	2	4	6	6	4	3	8	5	9
TOTAL	14	13	10	14	28	34	30	32	21	23	12	37
REGION V												
Aroostook	12	14	12	15	15	17	16	14	24	23	32	17
STATE TOTAL	80	93	99	65	110	140	160	181	157	140	122	117

Number of Recorded Arrests for Disorderly Conduct, by Region and County: by Month for 1973

Region/ County	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
REGION I												
York	10	18	12	26	44	27	59	62				
Cumberland	21	9	32	26	29	27	55	75				
Sagadahoc	0	2	2	1	2	4	1	4				
Lincoln	1	2	2	0	1	0	3	0				
Knox	5	6	5	9	7	7	13	17				
Waldo	1	4	4	1	4	0	3	6				
TOTAL	38	41	57	63	84	65	134	164				
REGION II												
Oxford	5	6	5	12	9	13	20	3				
Androscoggin	13	15	22	4	14	16	7	14				
Franklin	0	3	3	0	0	0	2	1				
TOTAL	18	24	30	16	23	29	29	18				
REGION III												
Somerset	1	1	2	4	6	3						
Kennebec	13	9	14	17	16	16						
TOTAL	14	10	16	21	22	19						
REGION IV												
Piscataquis	0	5	6	3	3	3	4	5				
Penobscot	8	11	15	9	9	15	9	29				
Hancock	7	4	4	6	9	17	3	14				
Washington	1	3	4	3	9	11	4	4				
TOTAL	16	23	29	21	30	46	20	52				
REGION V												
Aroostook	29	31	42	24	22	21	19	21	29			
STATE TOTAL	115	129	174	145	181	180						

- Number of Families Receiving Aid to Families with Dependent Children
By Region and County: By Month for 1973.

Region/ County	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.
REGION I											
York	1,706	1,713	1,721	1,733	1,743	1,766	1,766	1,775	1,814	1,810	1,805
Cumberland	3,670	3,688	3,711	3,711	3,713	3,738	3,759	3,739	3,811	3,855	3,906
Sagadahoc	482	482	483	490	501	501	511	503	517	512	513
Lincoln	385	388	391	392	399	407	405	416	415	421	423
Knox	652	650	653	658	654	655	673	682	686	684	695
Waldo	568	578	589	603	608	608	622	618	625	626	632
TOTAL	7,463	7,499	7,548	7,587	7,618	7,675	7,746	7,733	7,868	7,908	7,974
REGION II											
Oxford	712	727	723	726	718	719	724	726	741	750	776
Androscoggin	1,683	1,688	1,691	1,703	1,688	1,719	1,721	1,731	1,735	1,755	1,769
Franklin	380	387	384	379	392	395	390	395	346	405	415
TOTAL	2,775	2,802	2,798	2,808	2,798	2,833	2,835	2,852	2,872	2,910	2,950
REGION III											
Somerset	1,039	1,038	1,054	1,058	1,053	1,057	1,077	1,068	1,074	1,072	1,084
Kennebec	1,220	1,825	1,844	1,850	1,859	1,875	1,907	1,934	1,949	1,983	2,012
TOTAL	2,859	2,863	2,898	2,908	2,912	2,932	2,984	3,002	3,023	3,055	3,096
REGION IV											
Piscataquis	313	309	304	303	297	298	296	300	306	312	317
Penobscot	2,375	2,380	2,376	2,405	2,385	2,423	2,410	2,417	2,449	2,482	2,501
Hancock	517	524	531	543	550	562	574	580	579	592	602
Washington	677	682	702	710	712	720	719	724	726	728	719
TOTAL	3,882	3,895	3,913	3,961	3,944	4,003	3,999	4,021	4,060	4,114	4,139
REGION V											
Aroostook	1,565	1,582	1,598	1,615	1,621	1,631	1,629	1,633	1,643	1,663	1,643
STATE TOTAL	18,544	18,641	18,755	18,879	18,893	19,074	19,193	19,241	19,466	19,650	19,812

Data on 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 has been difficult to assess because of the limited data available, the lack of any standardized system of reporting, and--more commonly--of any reporting system at all.

During 1973, under stimulus of the Action Plan, a system was developed for locating, collecting, storing, and retrieving data on a uniform basis through the activities of the five Regional Councils and the cooperation of other state agencies. The full impact of the system will not be felt until its implementation in 1974, but there have already been problem descriptive benefits accruing from the development of the system, some of which follow.

Surveys of selected professional groups were conducted, designed to determine the attitudes toward alcoholics and alcoholism held by the members of certain carefully chosen community service groups. Each group was chosenbecause its members were exposed to the problem being studied, had developed some insights to the problem, were concerned about the problem, and conceivably would be able to contribute useful information for inclusion in the Community Monitoring System. It was also thought that each group, because of the special nature of its relationship to the problem would add the diversity of outlook necessary to the formation of a more complete picture.

Cooperation was remarkably good in most cases, the return rate was better than average for mail surveys, most data were supplied as requested, and most respondents seemed to answer questions seriously.

Cross-tabulations of data in each survey showed little difference in attitude between urban and rural members of specific groups, or among group members working in different planning regions. However, comparisons did reveal difference in attitude among members of different professional groups surveyed. These difference (and similarities) between groups are the focus of the following review:

Introduction

It was reasonable to assume that, since the community groups surveyed have varying degrees of contact with different types of alcohol-related

problems, different configurations of extent, cause, symptomatic expression, preferred treatment, and prognosis would be associated with the professional responsibilities of each. For example, police chiefs come into contact with alcohol-related problems as a function of both their service-related and law enforcement responsibilities. Judges do not enter the service-related aspect of the law enforcement system, but are charged with seeing that justice is administered in a manner that satisfies as well as possible the rights of society and the accused or convicted individual. Physicians and hospital administrators are charged primarily with response capability to the physical damage resulting from alcoholism and alcohol abuse. Social workers and the clergy are intimately involved with the entire spectrum of alcohol-related or alcohol generated problems. Social workers, or course, have broad-spectrum response capability not available to the clergy. Employers are least directly affected of the groups surveyed and are charged with little responsibility beyond the dictates of personal social conscience.

Perceived Extent of the Problem

The extent of the perceived problem depends heavily on the manner in which the problem behavior impinges upon the professional specialty. Police, judges, and social workers, in their professional capacities, deal almost exclusively with individuals who exhibit, or are victims of socially problematic phenomena. All three of these groups are in remarkably close agreement as to the extent of alcohol-related problems in their areas of responsibility. They estimate that forty percent of the individuals with whom they have professional contact are either alcoholics, alcohol abusers, or have family members who fall into either of those two categories. Hospital administrators' and physicians' estimates depend on whether the focus is on the diagnosis of the problem or the larger context in which the problem manifests itself. Three percent or less of the hospital admissions are viewed as alcohol-related diagnoses, but up to 30% of those admitted are seen to manifest symptoms of alcoholism or alcohol abuse.

When we examine the responses of the clergy and employers, the extent of the estimates drop even further. Among the clergy the estimate of extent of alcoholism in the congregation drops to about five percent. Among employers, the rate is seen as less than two percent. It is clear that the differenct community groups surveyed all deal with different subsets of the population.

Among employers the population is probably a random sample of the general population, and hence the lowest estimate of extent of the problems. The church-going or clergy contacted population is not characteristically problem-ridden but is still an identifiable subset of the general population. Hence it is not surprising that the estimated incidence is higher than in the general population but still significantly lower than in the population seen and served by physicians and hospital administrators. In these latter groups, the population contacted is that subset who experience physical symptoms of a magnitude sufficient to warrant a contact with physical medicine. The fact that alcoholism is rarely the diagnosis obscures the fact that alcohol abuse is involved in a significant proportion of persons admitted to hospitals and/or treated by physicians, and is testimony to the accuracy of the observation of all groups that alocholics tend to have more physical problems than non-alcoholics. The extent of this problem runs up to about 20% of hospital admissions and 30% of all patients, whether admitted or out-patient. With police, judges, and social workers, the multi-faceted social problems associated with alcoholism are brought into sharp focus. In that problem-ridded population, about four cases in ten are estimated to involve alcoholism or alcohol abuse.

The Cause of the Problem

Despite the varying contacts with different manifestations of the problems, all groups surveyed consider alcoholism to be a disease. Two-thirds of all police chiefs, hospital administrators, physicians, employers, and almost two-thirds of social workers adhere to the disease concept. Judges and the clergy tend to favor the disease concept, but a significant portion of the clergy (38%) favor a non-disease definition. Half the judges favor disease but the other half either favor the non-disease concept or are undecided.

It is noteworthy, however, that for all groups, the disease in this sense is a psychological construct for 40% or more of social workers, employers, police chiefs, judges and physicians. The psychological construct is also the most favored causal factor for the clergy and hospital administrators, but only about one-third of the members of those groups selected that response category. Further light on the perception of the "psychological disease" is seen in the analysis of the etiological factors. Physicians, social workers, clergy, employers, and judges rate physiological disposition and learned behavior as secondary and tertiary factors in the disease construct. Thus it

may be that for these groups, as groups, the disease is seen as a physiological predisposition to alcoholism that manifests itself under certain environmental influences. It is important to emphasize, however, that these influences are not seen as poor socio-economic conditions. Rather the evidence suggests, but does not firmly indicate, that a predisposed individual is likely to become an alcoholic by virtue of being exposed to alcohol and encouraged to drink by environmental pressures. Hospital administrators and police chiefs take a different point of view. Hospital administrators place social learning in a socio-economically deprived environment as the secondary element (to the universal psychological problem factor), and physiological disposition a close third. Police chiefs see the psychological etiology as a learned habit in the context of moral and/or religious weakness.

The Recognition of the Problem

The preceding observations have implications related to the way in which different groups identify alcoholism in an individual. Social workers and clergy observe that physical, social and economic problems are the principal signs by which alcoholism is recognised, along with the inability to abstain and/or stop short of drunkenness. Employers hold essentially the same view but tend to put much more emphasis on the abstention stopping factors than do social workers and clergy. The frequency of drunkenness is not a cardinal sign of alcoholism to the three groups mentioned. Police chiefs recognize alcoholism primarily on the basis of inability to abstain, followed by frequent drunkenness. Judges, hospital administrators, and physicians were not surveyed on the recognition items.

The implication is that for police the inability to abstain is the primary sign of an alcoholic, and that this inability is the product of a learned behavior in a morally, spiritually weak individual. For social workers, and economic deprivation resulting from a learned behavior based on a physiological substrate that predisposes the individual to alcoholism. By implication, then, police tend to place the ultimate basis of the problem on a moral defect while social workers, clergy, and employers place it on the interaction of a physiological defect and the easy accessibilty and irresistible lure of alcohol.

The Treatment of the Problem

All groups except judges are most likely to prefer Alcoholics Anonymous as the primary treatment agency in referrals. Judges are most likely to refer to mental health clincs with AA a somewhat distant second choice.

Mental health clinics are the second most frequently chosen treatment agencies among police chiefs (a poor second), hospital administrators (a very close second), physicians (a moderate second), social workers (a poor second, and clergy (a far distant second). Employers give second preference to physicians. It is interesting to note that social workers who consider treatment of alcoholism within their expertise, refer about equally to AA, mental health clinics, and alcoholism counselors. The clergy, which considers treatment beyond its expertise, refers primarily, and far more than any other group to AA.

Thus, it appears that regardless of etiological and symptomatical beliefs, all groups except judges (who are least sure of etiology) prefer AA as the primary referral for treatment, with mental health clinics second. Physicians are rarely used except by employers. Hospitals receive negligible or no mention at all. Interestingly enough, specialists in the treatment of alcoholism other than AA, i.e., alcoholism counselors and alcohol treatment facilities, are rarely used. This is probably due to their relatively recent development or to their general unavailability in comparison to other more publicized programs such as AA. Social workers and judges choose alcoholism counselors as a rather poor third, while other groups rarely refer to those experts. Alcohol treatment facilities are a distant fourth for all groups. These findings would seem to indicate that the majority of respondents regard the assumed psychological predisposition to alcoholism to be a fact about which little or nothing can be done, and that the treatment approach must therefore be aimed at increasing the ability to abstain. Abstention, in turn, is best accomplished by exposure to those who have been able themselves to succeed in becoming abstainers, i.e., AA. This appears to be entirely consistent with the generally held disease theory that elaborates into the psycho-physiological construct, i.e., the physiological predisposition toward development of a self-destructive habit, rather than a more purely psychological etiology stemming from personal or interpersonal frustrations and conflicts.

Prognosis

Despite the reasonably consistent perception of cause, symptoms and appropriate treatment across the groups surveyed, there are group differences in the view of prognosis. The clergy is far and away the most optimistic in

that 48% feel that alcoholics can usually or always recover, In this connection, it is recalled that the clergy considers itself to lack the ability to treat, and refers most heavily to AA. The clergy also has little exposure to alcoholism (about 5% of congregation). Employers are next most optimistic with 29% reporting that alcoholics usually recover. Here again is a low exposure group that puts faith in AA, and also is the only group that refers significant numbers to physicians. Social workers tend to be guardedly optimistic as a group, with 25% estimating that alcoholics usually or always recover, but 75% choose the more cautious "sometimes" category. It is significant, however, that no social worker was so pessimistic as to use the "rarely" or "never" recover category. Police chiefs, physicians, and hospital administrators give varied responses. Although most professionals in all three groups give a guarded prognosis, the "rarely" recover prognosis is given by about 17% of each group. These groups have considerable exposure to alcohol-related problems and as such see both hard-core and milder physical and social manifestations. Thus it may be that the presence of optimistic, pessimistic, and guarded prognoses in these groups reflects their actual experience. All judges were guarded, being neither optimistic nor pessimistic but, rather, estimating that "sometimes" alcoholics can recover. This may be the most accurate prognosis, especially for first offenders.

However, looking at all groups, it appears that there is a trend toward guardedness and pessimism as involvement with alcoholics increases.

Social workers and police have broad-spectrum contact with a large number of alcoholics. Police, however, do not treat in the usual sense of the term, while social workers do. In these two groups we find equal optimism shown in the number estimating "usually" or "always" in the recovery category. The difference is that among social workers there is more guardedness while among police there is less guardedness and more pessimism. Police experience the individual who never changes regardless of his status in or benefits from the community. They therefore possess the knowledge which enables them to state that some alcoholicswill not recover. The philosophy of the social worker does not permit such pessimism, and probably assumes the possibility of change under better social conditions. It may be noteworthy that when social workers referred, they more likely used mental health centers and alcoholism counselors in additon to AA. Police chiefs, although using AA to the same degree as social workers, used mental health centers less and

alcoholism counselors negligibly. This point is made because it is clear that even though AA is the most frequently referred treatment of all groups save judges it is nevertheless true that by and large the prognosis for recovery for a given alcoholic is guarded. The obvious implication is that AA is seen by most as the best hope, but that even there the outlook is very much a matter of chance at best. Thus, among the two groups with wide experience social workers are less pessimistic, feel competent to treat, and, when referring, are more likely to employ alcoholism counseling addition to AA. Police, who do not treat, tend to use AA to the virtual exclusion of mental health clinics.

Summary and Conjecture

A case could be made that most respondents were first members of the culture and second members of a profession. Most individuals in the culture view alcoholism as a form of psychological disease. Some stress the predisposing physiological basis to the disease, while others stress the environmental determinants, such as social and economic conditions. One might call this an informed layman's view in the sense of the dominant message presented in the media. This attitude encounters problems when it approaches the question of treatment, as there is among professionals no great faith in the traditional psychological treatment techniques, possibly because there are few reports of such methods yielding any substantial success rates.

The question which must be answered for the Office of Alcohol and Drug Abuse Prevention is not which of the groups is right in its conception of the cause of alcoholism, but rather what treatment will be effective. It is believed that the concept of alcoholism and its prognosis will change when a particular treatment is shown to work. Therefore, what is needed is the development of novel treatment approaches. All groups feel the burden of the problem; they do not feel optimistic about solving the problem. The conjecture is that the available treatment procedures are not satisfactory for all types of problem drinkers who are not helped by the traditional methods, including AA, who consistently bounce around in the treatment system from one agency to another and hence create the impression of the non-treatable alcoholic. It is conjectured that novel treatment approaches such as religious expression, group encounter sessions, behavior modification, disruption of powerlessness sessions, etc., would remove some of the treatment failures out of the system and hence increase the optimism of treatment.

It is therefore recommended that besides funding the traditional methods, the Office of Alcohol and Drug Abuse Prevention should encourage newer forms of treatment by allocating a portion of alcoholism treatment resources to the funding of such programs. The need to fund specific programs with specific treatment goals is obvious. Program planning of this order would allow the professionals in each area to develop their own skills, formulate their own treatment objectives, and possibly develop a statement that specifies for whom their treatment seems to succeed.

This survey indicates that all groups sorely need information regarding the effects of treatment. Such information can only be provided when we know what treatment is most effective. Without information as to effective modes of treatment, the traditional model, the poor prognosis, the customary referral without much hope will all evolve into a static conception of alcoholism.

Perception of Alcoholics and Alcoholism held by Survey Respondents

Item/Response	Social Workers	Empl.	Police Chiefs	Dist. Judges	Clergy	Hosp. Adm.	Physicians
Do you feel alcoholism is primarily the result of: (in % of total resp.)							
1. moral/religious weakness	2%	6%	14%	8%	10%	5%	6%
2. physiological disposition	24%	21%	9%	25%	22%	17%	21%
3. psychological problems	40%	44%	43%	42%	32%	35%	40%
4. a learned habit	17%	16%	16%	17%	23%	18%	19%
5. poor social and/or economic conditions	11%	12%	9%	8%	9%	18%	9%
6. an attempt to gain control over one's life	7%	0	5%	0	4%	3%	3%
7. all	0	1%	2%	0	1%	5%	2%
Do you feel alcoholism is:							
1. a chronic "disease" manifested by repeated drinking which causes injury to the drinker's health and/or economic functioning	65%	67%	83%	50%	60%	76%	69%
2. not a "disease". Rather the term "problem drinking" should be used and always in connection with a specific problem.	28%	31%	17%	33%	38%	21%	20%
Blank	4%	2%	0	17%	2%	0	2%

Perception of Alcoholics and Alcoholism held by Survey Respondents - (continued) -

Item/Response	Social Workers	Empl.	Police Chiefs	Dist. Judges	Clergy	Hosp. Adm.	Physicians
In your opinion, which of the following behaviors almost certainly indicate that a person is an alcoholic? (in % of total reponses)							
1. frequent drunkenness	8%	10%	22%	0	6%	0	0
2. inability to keep from starting drinking	25%	26%	39%	0	26%	0	0
3. inability to stop drinking until drunk	21%	25%	20%	0	22%	0	0
4. drinking which harms the drinker physically, socially, or economically	42%	29%	20%	0	39%	0	0
5. all	2%	10%	0	0	7%	0	0
6. item not asked	0	0	0	100%	0	100%	100%
Blank	5%	4%	0	0	1%	0	

Treatment and Referral of Alcoholics by Survey Respondents

Item/Response	Social Workers	Empl.	Police Chiefs	Dist. Judges	Clergy	Hosp. Admin.	Phys.
Do you believe alcoholics can recover with treatment?							
1. Always	2%	0	0	0	6%	8%	2%
2. Usually	23%	29%	24%	0	42%	16%	17%
3. Sometimes	72%	64%	59%	100%	48%	59%	61%
4. Rarely	0	4%	17%	0	1%	17%	16%
5. Never	0	0	0	0	0	0	2%
Blank	2%	4%	0	0	3%	0	3%
Treatment of alcoholics is beyond the skill of/social workers/clergy.							
1. Yes	14%	0	0	0	52%	0	0
2. No	84%	0	0	0	42%	0	0
Blank	2%	0	0	0	5%	0	0
Item not asked	0	100%	100%	100%	0	100%	100%
Where do you refer alcoholics for treatment? (in % of total responses)							
1. Local physicians	6%	18%	4%	0	9%	7%	6%
2. Alcoholics Anonymous	30%	22%	30%	25%	42%	27%	31%
3. Mental health clinics	20%	10%	13%	38%	22%	25%	25%
4. State alcoholism counselor	18%	4%	9%	19%	5%	9%	5%
5. Alcohol treatment facility	9%	7%	11%	19%	14%	13%	11%
6. General hospital	2%	3%	9%	0	2%	4%	5%
7. Psychiatric hospital	2%	0	9%	0	4%	7%	9%
8. Other	0	3%	2%	0	1%	0	1%
9. All	2%	1%	0	0	0	4%	0
10. Do not refer / NA	10%	33%	13%	0	1%	2%	4%
Blank	7%	2%	0	0	0	0	1%
Do you counsel and/or refer alcoholics?							
1. I counsel and refer when necessary	56%	0	0	0	91%	0	55%
2. I counsel only	0	0	0	0	1%	0	5%
3. I refer only	16%	0	0	0	5%	0	29%
4. I neither counsel nor refer	7%	0	0	0	2%	0	7%
5. NA	14%	0	0	0	0	0	2%
Blank	7%	0	0	0	2%	0	2%
Item not asked	0	100%	100%	100%	0	100%	0

The foregoing, as has been stated, represents estimates of "educated guesses" by professionals who are in more or less regular contact with alcoholism and its related problems. At this stage in Maine's development of a coordinated, unified attack on the problem they may well be the most reliable data available.

However, such data do not provide a number estimate of the state's alcoholic population. For this we must turn to the Jellinek Formula. In the original formula developed by the late E. M. Jellinek in the early 1940's, R (presumed ratio of alcoholics to alcoholics-with-complications in a given place at a given time) was given a value of 4: that is, three alcoholics without complications for each alcoholic with complications. But, in a 1972 publication issued by Rutgers Center of Alcoholic Studies* the authors, Efron, Keller, and Gurioli have adjusted for changes in population since 1945 and given R a value of 5.3. If the rate of the 1940-45 period has remained substantially the same, then, with correction of R to 5.3 the numbers of alcoholics and rates of alcoholism in recent years can be calculated. Using this correction on the 1970 population base we find Maine ranked 14th among the states in estimated numbers of alcoholics; also in rate per 100,000 adult population, i.e., 20 years and over.

Total number of alcoholics in the state's 1970 population was estimated as 26,300, of which 21,000 were thought to be men and 6,300 women. Rates per 100,000 (on which the ranking by states was computed) was given as 7,220 for men and 1,640 for women.

In preparing for future needs, regional and state planners should be armed with as much informational data as possible. In an effort to assist in this important area a special tool was devised; the Alcoholism Potential Indicator.

Basis for the indicator was the fact that national studies have shown that persons in certain age, sex, income, occupation and marital categories are more often heavy drinkers than persons in other categories.

The characteristics most often found among heavy drinkers are: 1) being male, 2) being in the age groups 30-34 or 45-49 for men, and between 21-24, or 45-49 for women, 3) having a high school or partial college education,

*Statistics on Consumption of Alcohol and on Alcoholism.
Vera Efron, Mark Keller and Carol Gurioli, RCAS, New Brunswick, New Jersey, 1972.

4) earning $15,000 a year or more, 5) being in one of the following ocupations: semi-professional, technician, manager, proprietor, official, operative or laborer, 6) being single, divorced, or separated.

Using 1970 census data the statewide, planning region, and county population percentages having each of the above characteristics was determined. To compare regions and counties, Alcoholism Potential scores were calculated by comparing the regional or county percentage with the state percentage on each characteristic. When the regional percentage was higher than the state percentage, one point was added to the regional alcoholism potential score. When a county's percentage was higher than the state percentage, one point was added to that county's score.

Since there are six characteristics, 6 is the highest score and 0 the lowest. Regions or counties scoring 5 or 6 have a high potential concentration of problem drinkers, those scoring 3 or 4 a moderate potential, and those scoring 2 or less a low potential. The alcoholism potential scores for regions and counties are as follows:

Region I=3	Cumberland=	4
	York=	2
	Sagadahoc=	2
	Lincoln=	2
	Knox=	1
	Waldo=	2
Region II=2	Oxford=	3
	Franklin=	3
	Androscoggin=	3
Region III=4	Somerset=	2
	Kennebec=	3
Region IV=4	Piscataquis=	3
	Penobscot=	5
	Hancock=	3
	Washington=	1
Region V=1	Aroostook=	1

Comparisons of these estimates with known social problem indicators reveals that the Alcoholism Potential Indicator seems to be reasonably accurate in all but one region. Aroostook County (Region V), with an Indicator score of 1, generally has a greater number of alcohol-related social problems per capita

than Cumberland, which scores 4 on the Indicator. This suggests that Aroostook may have a high concentration of problem drinkers whose personal characteristics differ markedly from those of heavy drinkers used as the basis for the national surveys. This would seem to show a need for correction in the Indicator to include variables as yet unknown. It also reveals, to our mind, the wisdon of regional planning, in that Aroostook planners now know they must make a special effort to recognize the missing factor(s).

Aside from this deviation, the Alcoholism Potential Indicator, having closely approximated the problem in all other regions (as measured by other social problem indicators) adds yet another dimension to our efforts to accurately assess the extent of the problem of alcohol abuse in Maine.

Existing Resources

Until recently services aimed at the prevention, treatment, and rehabilitation of alcoholics have been provided almost entirely by the Division of Alcoholism Services and the Division of Vocational Rehabilitation in the Department of Health and Welfare, counseling and therapy provided through the eight community mental health areas, Alcoholics Anonymous, Al-Anon and Al-Ateen, the Salvation Army, Portland Model Cities, the Diocesan Bureau of Human Relations, and the Alcohol Safety Action Project.

With the creation of the Office of Alcoholism and Drug Abuse Prevention, the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, and the State Government Drug Abuse Coordinating Committee, the scope of potential services and the possibility for development of new resources is considerably enlarged. The implementation of these new resources will be discussed in the Action Plan.

As for the following list of Existing Resources it must be noted here, in order to comply with the Guidelines for the State Alcoholism Formula Grant Program, that the methods by which they will be made an integral, coordinated part of the overall State program are set forth in detail in section 7106 of the 1973 Alcoholism and Drug Abuse Act, reproduced in ADMINISTRATION, subsection 4., Functions.

State Department of Health and Welfare

(a) Office of Alcoholism and Drug Abuse Prevention

The scope of this agency'a activities, powers, and functions has been set forth in detail in the ADMINISTRATION section of this report.

Carried over from the preceding State Plan is the system of five Regional Planning Organizations. These were organized in 1973, Regional Coordinators were selected, Regional Councils set up, grants funded, and a start made, through creation of a statewide system of data collection, storage, retrieval, and evaluation, toward reaching the goals and objectives described in the 1973 Action Plan.

(b) State Alcoholism Services

Current operations are channeled through five area Alcoholism Counseling Centers located in Portland, Lewiston, 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 State 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 institutions are visited while incarcerated to initiate a program to be activated upon their release.

(c) Division of Vocational Rehabilitation

This division administers a program of rehabilitation services to persons handicapped by physical, mental, or psycho-social impairments, with the aim of helping them prepare for and acquire suitable employment. It is a State-Federal grant-in-aid program, funded on the basis of four dollars federal for each State dollar. The Division has given strong support to the halfway house concept of treatment for alcoholics, and has assisted in the funding of Bangor's Halfway House and Serenity House in Portland.

Department of Mental Health and Corrections

(a) The Bureau of Mental Health

1. The Bureau of Mental Health and the Office of Alcoholism and Drug Abuse Prevention (then the Bureau of Rehabilitation) entered into agreement

October 30, 1972 to collaborate in the planning and delivery of alcoholism services. The agreement, which remains effective, is reproduced in full herewith:

A COOPERATIVE AGREEMENT BETWEEN THE BUREAU OF REHABILITATION, 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 population.

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 provison 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 funtion 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 Rehabilitation 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 Rehabiliation 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 Menatl 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

William E. Schumacher, M.D., Director
Bureau of Mental Health
Department of Mental Health and Corrections

Dean Fisher, M.D., Commissioner
Department of Health and Welfare

C. Owen Pollard, Director
Bureau of Rehabilitation
Department of Health and Welfare

Date: October 30, 1972

2. 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

Completion Date	
	1. Stimulate further development of joint collaborative relationship between Bureau of Rehabilitation and Bureau of Mental Health regarding Alcoholism Services.
	a) Implementation of cooperative agreement.
Oct. 1, 1972	1) Sign agreement
Jan. 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.
Nov. 1, 1972	f) Advisory Council review and comment on MH/Alcoholism SPD goals and objectives.
Nov. 1, 1972	g) Advisory Council participation in SPD input for Alcoholism Services.

Completion Date

Oct. 2, 1972 — h) Joint review of Uniform Intoxication Act.

Nov. 1972 — i) Joint testimony on Uniform Intoxication Act.

Jan. 1, 1973 — 2. 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 — 3. 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. (Only $224,000 actually appropriated.)

2) Mobilization of the Bureau of Mental Health and community mental health centers in support of legislation and budget at the legislative hearings.

July 1, 1973 — 4. The initiation and expansion of collaborative Alcoholism-Mental Health services in selected areas.

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.

May 1974 — b) Submission of alcoholism service grant proposals in all five (5) regions.

1) Utilization of the Regional Alcoholism Councils for review and comment of all grants submitted.

2) Utilization of the State Alcoholism Council for review and comment of alcoholism proposals approved by the Regional Councils.

Completion Date

July 1975

3) The implementation of approved Alcoholism Services Projects in all five (5) regions, if possible, either separately or in conjunction with other programs within available resources.

5. Develop a compatible inter-bureau data system for alcoholism services.

Nov. 1974

a) Insure maximum compatibility 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 Divison of Alcoholism Services.

July 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 recuritment, 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.

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3. Division of Community Services

This division now has eight fully operational community mental health centers, all of which offer some services to alcoholics and their families. The Counseling Center in Bangor, however, offers the only Comprehensive Community Alcoholism Services Program among the eight facilities.

Alcoholics Anonymous

There are some 75 local Alcoholics Anonymous groups in Maine. Because of the loose-knit nature of this organization it is impossible to estimate its membership. Its reputation, as is documented elsewhere in this report, is that of great success with those alcoholics willing to adopt its program.

Peripheral to A.A., and not formally affiliated with it, are Al-Anon and Al-Ateen which work with husbands and wives, parents, children, and relatives of alcoholics.

Salvation Army

One of the early temperance and reform movements, the Salvation Army offers rehabilitative programs, food and shelter to homeless alcoholics.

Model Cities

Portland Model Cities, whose program expires this year, has partially funded two facilities for alcoholics, Serenity House, and the 24 Hour Club. Model Cities funding for these facilities will end June 30, 1974.

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 "division". The districts correspond to the major geographical divisions of the State planning agencies, with offices in the following locations: Portland, Lewiston, Waterville, Bangor, Caribou and Biddeford.

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.

District One involvement in the probem is reflected in its comprehensive alcoholism services program in conjunction with the Alcohol Safety Action Project in Cumberland County. CAS is in effect the treatment component of ASAP.

Alcohol Safety Action Project

This three year project in York and Cumberland counties is primarily aimed at getting drunk drivers off the highways. Now in its final year, the project has been funded throughout by the Federal Department of Transportation through contract with the State Motor Vehicle Division. It has funded the use of Special Prosecutors from the State Attorney General's office, specially assigned State Troopers, and a number of local police officers. Aimed primarily at the detection, removal from the highways, and court trials of drinking drivers, it has also provided counseling aimed at rehabilitation and, as previously mentioned, some treatment from the separately funded and controlled CAS. The project is unique in that it is the first such Federal program in Maine to have a built-in evaluation component, designed by Social Systems Research Corporation of Bangor.

StateComprehensive 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 agency staff consists of a director, three fulltime 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.

State Planning Office, Executive Department

This department's eight planning and development districts are set up by state law, and in accordance with federal requirements that states use, as far as possible, coterminous boundaries for planning the various federally assisted programs within the states. The districts were delineated by the State Planning Office on the basis of the physical, economic, and human resource relationships existing within the State.

Despite the lesser number (5) of Alcoholism Planning Regions, a cooperative relationship has been set up between the State Planning Office district heads and the regional coordinators of the Office of Alcoholism and Drug Abuse Prevention. A mutual information system has been developed, and to the extent possible State Planning Office representatives will be included in the Regional Advisory Councils. There has already been established to some degree a system of coordination functions in various municipalities.

Facilities

Following is a list of the various Alcoholism Treatment Facilities located throughout the State of Maine:

ALCOHOLISM SERVICES
BUREAU OF REHABILITATION
32 Winthrop Street
Augusta, Maine 04330
(207) 289-2141

TYPE OF PROGRAM: Facility provides outpatient treatment, information/referral and court program. The office maintains five counseling centers listed below. No fee.

SERVICES: Individual counseling, therapy. Also, emergency medical, family counseling, therapy, antabuse and other medication, vocational and social rehabilitation, A.A. services, in-service training to staff of this facility and general public education.

PERSONNEL: 8 (including the centers)

Alcoholism Counseling Centers:

32 Winthrop Street
Augusta, Maine
289-2141

117 Broadway
Bangor, Maine
947-0511

179 Lisbon Street
Lewiston, Maine
783-9154

509 Forest Avenue
Portland, Maine
774-4581

Kennebec Mental Health Center
North Street
Waterville, Maine
872-8011

ALCOHOLIC REHABILITATION CENTER
68 Hogan Road
Bangor, Maine 04401
(207) 947-0366, Extension 305 or 942-9719, Extension 254

TYPE OF PROGRAM: Center provides inpatient treatment. Variable fee.

SERVICES: Medical, individual, group and family counseling, therapy, antabuse and other medication, therapeutic community, sensitivity and/or awareness groups, occupational and recreational therapy, vocational and social rehabilitation, A.A. services, in-service training to staff of this facility and general public education.

BANGOR HALFWAY HOUSE, INC.
98 Cumberland Street
Bangor, Maine 04401
(207) 945-3163

TYPE OF PROGRAM: Facility inpatient treatment, diagnostic services, drop-in center, halfway house and information/referral.

SERVICES: Vocational rehabilitation. Also, medical, individual and group counseling, therapy, antabuse and other medication, therapeutic community, occupational and recreational therapy, social rehabilitation, A.A. services, in-service training to staff of this facility and general public education.

PERSONNEL: 5

DR. FRANK L. DENNIS
COUNSELING CENTER
43 Illinois Avenue
Bangor, Maine 04401
(207) 947-0366, Extension 214

TYPE OF PROGRAM: Center provides inpatient and outpatient treatment, diagnostic services, drop-in center, temporary shelter, quarterway house, information/referral, police program, court or probation program and industrial programs. Variable fee. The Center maintainsseven counseling centers listed below.

SERVICES: Emergency and other medical, detoxification, individual, group and family counseling, therapy, antabuse medication, therapeutic community, occupational and recreational therapy, vocational rehabilitation, A.A. services, in-service training to staffs of this facility and community agencies and general public education.

PERSONNEL: 52 (includes the branches)

Counseling Centers:

COUNSELING CENTER (The)
River Road
P.O. Box 325
Calais, Maine 04619
454-2163 and 454-2164

COMMUNITY COUNSELING CENTER
70 East Main Street
Dover-Foxcroft, Maine 04426
564-8176

COUNSELING CENTER (The)
17 West Maple Street
Ellsworth, Maine 04605
667-5357

MACHIAS COUNSELING CENTER
49 Main Street
Machias, Maine 04654

COUNSELING CENTER (The)
276 Katahadin Avenue
Millinocket, Maine 04462
723-9739

MT. DESERT FAMILY COUNSELING CTR.
322 Main Street
Bar Harbor, Maine 04609
288-5466

SPENCER WINSOR
George Stevens Academy
Blue Hill, Maine 04614
667-5357

UTTERBACK PRIVATE HOSPITAL
31 Kenduskeag Avenue
Bangor, Maine 04401
(207) 947-4555

TYPE OF PROGRAM: Facility provides inpatient and outpatient treatment, diagnostic services, detoxification center, temporary shelter, aftercare, residential care, information/referral, police program and court or probation program. Fixed fee.

UTTERBACK PRIVATE HOSPITAL (continued)

SERVICES: Emergency and other medical, individual, group and family counseling, therapy, antabuse and other medication, A.A. services and in-service training to staff of community agencies.

MILESTONE FOUNDATION
88 Union Avenue
Old Orchard Beach, Maine 04064
(207) 934-9615 and 883-2815

TYPE OF PROGRAM: Facility provides inpatient and outpatient treatment, diagnostic services, drop-in center, detoxification center, residential care (including foster homes), information/referral and education information. Fixed fee.

SERVICES: Therapeutic community. Medical, individual, group and family counseling, therapy, antabuse medication, sensitivity and/or awareness groups, recreational therapy, social rehabilitation, A.A. services, in-service training to staffs of this facility and community agencies, general public education and educational follow-up classes for industry/labor, and family therapy and education.

PERSONNEL: 10

ALCOHOLISM EMERGENCY DETOXIFICATION UNIT
(Twenty-Four Hour Club)
65 India
Portland, Maine 04101
(207) 773-7881

TYPE OF PROGRAM: Facility provides inpatient treatment, diagnostic services, drop-in center, detoxification center, temporary shelter, and information/referral. No fee.

SERVICES: Detoxification, individual and group counseling, therapy, medication, occupational therapy, A.A. services, and in-service training to staff of this facility.

PERSONNEL: 11

COMMUNITY COUNSELING CENTER
187 Middle Street
Portland, Maine 04111
(207) 774-5727

TYPE OF PROGRAM: Center provides outpatient treatment, aftercare and information/referral. Variable fee.

SERVICES: Individual counseling, therapy, and in-service training to staff of this facility.

COMMUNITY ALCOHOLISM SERVICE
HUMAN RELATIONS SERVICES, INC.
Diocese of Portland
317 Congress Street
Portland, Maine 04112
(207) 775-5671

TYPE OF PROGRAM: Facility provides outpatient treatment, diagnostic services, aftercare, information/referral and court or probation program. No fee.

SERVICES: Emergency and other medical, individual, group and family counseling, therapy, occupational therapy, vocational rehabilitation, A.A. service, in-service training to staff of this facility and general public education.

PERSONNEL: 15

SERENITY HOUSE
30 Mellen Street
Portland, Maine 04101
(207) 774-2722

TYPE OF PROGRAM: Facility provides inpatient and outpatient treatment, drop-in center, halfway house and information/referral. Variable fee.

SERVICES: Social rehabilitation. Also, individual, group and family counseling, therapy, antabuse medication, therapeutic community, vocational rehabilitation, A.A. services, in-service training to staffs of this facility and community agencies.

PERSONNEL: 6

MID-COAST MENTAL HEALTH CLINIC
22 White Street
Rockland, Maine 04841
(207) 596-6687 and 596-6688

TYPE OF PROGRAM: Clinic provides outpatient treatment. Variable fee.

SERVICES: Individual counseling, therapy. Also, group and family counseling, therapy, medication and in-service training to staff of this facility.

TRI-COUNTY MENTAL HEALTH SERVICES, INC.
6 High Street
Wilton, Maine 04294
(207) 645-2259

TYPE OF PROGRAM: Facility provides outpatient treatment and information/referral. No fee.

SERVICES: Individual counseling, therapy. Also, antabuse and other medication, A.A. services, in-service training to staffs of this facility and community agencies, general public education and transportation to detoxification.

HOPE HOUSE, INC.
Illinois Avenue
Bangor, Maine 04401
(207) 942-1808

TYPE OF PROGRAM: A shelter type facility sponsored by the Bangor Counseling Center for detoxification and short term supportive environment.

SERVICES: Admission with physical exam, bed and board, evaluation. For those seeking sobriety, exposure to therapy and participation in on-going rehabilitation programs.

MID-COAST REHABILITATION CENTER, INC.
66 Talbot Avenue
Rockland, Maine 04841

TYPE OF PROGRAM: A shelter type facility for detoxification short term supportive environment.

SERVICES: Medical exam, detoxification, shelter, resource connecting, education of the public in regard to alcoholism, counseling and therapy.

Financial Resources

The financial committment to alcoholism in Maine has been limited, as indicated in earlier editions of this plan. It should be noted, however, that the Legislature in its last session moved the appropriation for alcoholism from $100,000 to $300,000. If our requests are met this session, we should have a budget of approximately one million, most of which will be used for grants-in-aid to local communities. This year a state commitment of $135,000 has generated $218,000 in federal and community funds for direct treatment of alcoholics.

It is impossible to compute the financial commitment of general operating agencies which serve alcoholic people and their families as part of a general target population. We know, however, that a reasonable percentage of the operating budgets of such agencies as mental health centers, state hospitals, and Bureau of Social Welfare is spent serving alcoholic people and their families.

A list of Federal funds for alcoholism follows on the next page.

Special Occupational Alcoholism Programs	$46,620	(01)	6/1/72
	$42,460	(02)	7/1/73
	$89,080		
Maine Indian Alcoholism Field Survey	$36,157	(01)	3/1/72
	$30,900	(02)	11/1/73
	$67,057		
Comprehensive Community Alcoholism Services Program (Staffing Grant)	$360,515	(01)	1/1/71
	$ 22,533	(01S1)	1/1/71
	$443,136	(02)	1/1/72
	$393,894	(03)	1/1/73
	$1,220,078		
Waldo-Knox Alcoholism Counseling and Recovery Program	$27,500	(01)	9/1/72
	$27,500	(02)	9/1/73
	$55,000		
Aroostook Indian Alcoholism Prevention Program	$27,500	(01)	9/1/72
	$27,500	(02)	9/1/73
	$55,000		
Services for Problem Drinking Drivers	$188,530	(01)	6/15/72
	$194,616	(02)	6/1/73
	$383,146		
Alcoholic Information and Referral Services	$28,000	(01)	6/1/73

Volume of Services

Estimate of volume of services is only partial at this stage of development due to poor record keeping or none, lack of access to data, and inadequate cooperation. Implementation of the new data system throughout the State in 1974 will provide more complete data for future needs. At present we can only report on number of admissions to mental health facilities for treatment of problem drinking for 1972 and the first nine months of 1973:

	1972	1973
Region I	164	167
Region II	130	152
Region III	19	40
Region IV	345	325
Region V	188	77

Data on attendance at Alcoholics Anonymous meetings are presently available from only two regions, and only for the third quarter of 1973. Weighted data from Region IV indicate that 333 persons attend AA meetings for every 10,000 units of population age 15 and over. For Region II the indication is 10 per 10,000.

Other data is hard to come by at this stage of development. Data on general hospital alcoholism admissions are available from Blue Cross and Blue Shield, but these are incomplete because not all general hospitals are subscribers.

Our surveys of hospital administrators (shown elsewhere) indicated that hospital procedures related to data keeping on alcoholics and alcoholism are grossly inadequate, and that signs of alcoholism are more likely to develop during treatment of patients admitted for other ailments. Doctors, as shown in the same survey, are equally derelict in record keeping regarding alcoholics.

Implementation of the newly developed data system during 1974 will, it is hoped, help improve conditions in this critical area.

Survey of Need

1. Extent of the Problem

Earlier in this report we presented an estimate based on the Jellinek formula which showed 26,300 alcoholics in Maine. Other estimates were developed by the Alcoholism Potential Indicator, which provided data on a regional basis.

Surveys of selected professional groups also gave us an indication of the extent of the problem as seen by persons in close working contact with alcoholism and related problems. Implementation in 1974 of the newly developed system for collection, storage, retrieval and evaluation of data will supply us with more accurate statistics showing the extent of the problem statewide, and in each of the five planning regions.

However, we must at this stage of development rely on the available estimates. On that basis, the following conclusions may be drawn:

(a) Maine has a rather high rate of alcoholism, ranking 14th among states in estimated numbers of alcoholics, and in rate per 100,000 of the adult population.

(b) Police, judges, and social workers estimate that 40% of the persons with whom they have professional contact are either alcoholics, alcohol abusers, or have family members in those categories. Physicians and hospital administrators estimate that up to 30% of hospital admissions manifest symptoms of alcoholism or alcohol abuse.

(c) Estimates of the potential for alcohol abuse, made on a regional and county by county basis, indicate the likelihood of a growing problem in both urban and rural areas, unless a vigorous, well-funded attack is mounted with all available state and private resources and facilities cooperating to the fullest extent.

2. Demographic Context of Problem

The wide variety of lifestyles, economic conditions, and cultural systems in Maine make for substantial difficulties in developing a statewide approach to the prevention, treatment, and rehabilitation of alcoholics and alcohol abusers. This fact was one of the major reasons for deciding on a system of regional planning groups within a unified structure.

The state's sparse population, 993,663, is distributed throughout a more than 40,000 square mile area, much of which is agricultural and forest land, isolated in great part because of geography and poor communication facilities.

This isolation and simplicity of rural areas contrasts with the increasingly apparent pressures and sophistication of commercial-industrial areas such as Portland, Bangor, and Lewiston-Auburn. The traditionally independent coastal way of life contrasts with the interdependency which characterizes the mill and shoe factory economies of Biddeford, Rumford, and Newport. Thus, the varieties of conditions which may aggravate the problem of alcoholism are many in Maine. Poverty, urban pressures, rural isolation, cultural deprivation,

Social in-breeding, loneliness-all are present within the state. The demographic and socio-economic factors related to alcohol abuse and alcoholism are detailed in the State Survey section of this report.

3. Specific Needs of Specific Groups

Indians

Maine's Indians, like American Indians everywhere, form a distinct minority ethnic and cultural group. Alcoholism is a major problem among Indians but, because of the special, isolate nature of their relationship with the rest of the population, and because of their determination to maintain as far as possible their ancestral traditions, the prevention, treatment and rehabilitation of problem drinkers among them presents special problems. Understandably suspicious of whites who offer to help in the solution of their problems, they are not approachable by the usual methods, and the do not react to treatment and rehabilitation systems which are alien to their way of life.

For these reasons, the State Department of Indian Affairs has undertaken a field survey of alcoholism among Maine Indians in a project funded by a federal grant. Another federal grant has been awarded to the Aroostook Indian Alcoholism Prevention Program. Both these projects are controlled and administered by Indians--a manifestation of the State planning goal of delivering alcoholism services through the Indian cultural structure.

But the need continues. What has been done constitutes a small beginning. The problem is still imperfectly understood. State and regional planners are aware that they must learn to understand the unique problems involved in the designing and delivery of alcoholism services to Indians. The Counseling Center in Bangor and the Aroostook Mental Health Center are cooperating with Indian leaders and regional planners in developing the necessary resources and programs for services to be structured primarily within the tribal communities.

However, better than half of Maine's Indians live off reservations on the fringes of white communities--usually in bitter poverty. Although efforts are being made to reach this population through Indian cultural and social structures, the nature of the effort is even more difficult. The majority of off-reservation Indians who receive alcoholism services get them through normal channels. Efforts continue to develop a program of cooperation between these communities and regional planners.

Troubled Employee Programs

The Occupational Programs Branch of the former Division of Alcoholism Services (now Office of Alcoholism and Drug Abuse Prevention) employs two consultants whose function is the development of the potential in the public and private employee/employer relationship for prevention and early intervention in cases of alcohol abuse, and the development of employee assistance programs.

Employed alcoholics and problem drinkers on the job constitute a group that offers a special challenge to State treatement resources. The extent of the problem, as shown in the survey of selected professional groups, is difficult to assess since employers themselves, for the most part, have no idea of its magnitude. Only five of the firms surveyed were sufficiently aware of the problem to have developed treatment programs for alcoholic employees.

Analysis of survey results, however, showed that while most employers could only estimate the number of alcohol troubled employees in their firms, alcohol related accidents on the job were documented--one large firm acknowledged that 5% of such accidents were attributed to employees with alcohol problems. No data were available in Maine on the costs to industry of alcohol related absenteeism and lost production. National estimates, however, are well known, and it seems safe to assume that Maine, ranked 14th among states in rate of alcoholism by the Jellinek formula, has a significant problem in this area.

Some progress has been made in the development of alcohol-troubled employee programs. Great Northern Paper Company is involved in a program developed by OADAP consultants. Oxford Paper Company, and the S. D. Warren branch of the Scott Paper Company also have projects underway. The Postal Service Employees of Portland are involved, and there is an ongoing project at the Veterans Administration Center and Hospital at Togus.

Getting under way are programs at Augusta General Hospital, Diamond International Corporation, and Hillcrest Foods. Six other projects at major industries and agencies are in various states of development.

A supervisor training group is under development, OP consultants have established cooperative relationships with Regional Coordinators, and probing contacts have been made with the Maine State Employees Association, the University of Maine, and a number of State agencies.

Perhaps the most significant achievement of the Occupational Programs Branch, however, was the convening in November of a Labor-Management Conference

on Troubled Employee which included participation by Federal, State, industrial, legislative, and professional people concerned with the problem.

It can be said at this point that the groundwork for the establishment of meaningful troubled employee programs has been laid throughout the State.

Educational and Preventive Programs for Youth

One of today's major concerns is the fact that for the most part our legal, educational, social, and health care delivery systems are basically treatment oriented, and not preventive in scope. One result of this is that we frequently find ourselves unsuccessfully attempting to solve individual problems in living after they have become unmanageable. The abuse of alcohol and other drugs is a case in point.

The Maine Drug Education Program was originated within the State Department of Educational and Cultural Services in 1970 as an attempt to deal with aspects of this problem. While the program was funded for the first two years with Federal monies, it has subsisted this last year on limited State support. Current funds are limited, and there is serious concern for the survival of the program.

Philosophy: Overview

The Maine Drug Education Program is based on several important assumptions which have been supported since the program's inception:

1. The alcohol-drug abuse problem is basically a "people problem" - a sympton of family, social, inter-personal, psychological and/or other causative situations.

2. A meaningful preventive educational approach to the problem of alcohol abuse relies minimally upon the presentation of factual information. Rather, the approach centers upon the individual, his needs, feelings and his capacity to examine and express these openly and then make decisions or changes. This is the major approach that leads to healthy creative problem solving behavior and intra-personal growth.

3. Preventive education must begin in childhood, preferably within the family, but definitely with the school system, grades K-12. Preventive education must occur simultaneously on two fronts: (a) training and teaching educational systems personnel to create and become involved in a classroom environment which facilitates meaningful student-teacher interaction and growth; and (b) training and teaching the community at large (role groups,

parents) to utilize human resources in prompting growth of the community in terms of inter-personal/group relationships. (The MDEP has attempted to do both: the first through its Human Development Program and the second through its Social Seminar Program).

Program:

Since its inception in June 1970 the MDEP has implemented the following kind of programs:

1. November 1970 - April 1972, six seven-day live-in State regional leadership training institutes. A total of 410 individuals representing most role groups within the typical community were trained at this level (approximately 68 per workshop). These individuals then were encouraged to go back to local communities with action plans and involve all segments of the community in developing effective programs aimed at alcohol and other drug abuse prevention, education, and treatment. One direct result of this program was the involvement of 66 community based resource teams which did generate a number of significant new programs.

2. In February 1973 the MDEP began conducting 4-day Human Development Program workshops for teachers and school administrators. These workshops are now being implemented and have been conducted statewide. By the end of the 1973-74 school year approximately 10% of the K-8 teachers in the State will have attended such a workshop. Teacher response to this effective educational model has been enthusiastic, and the demand for advanced workshops is growing despite limited funding. This approach is viewed by the MDEP as a powerful test in the prevention of alcohol abuse and a means of building positive mental health within the classroom.

3. In September 1973 the MDEP initiated the Social Seminar program in Maine. Here we show the various segments and role groups of a community together for 5 days and develop skill in the areas of communication, team building, development of community resources, and action-planning. The reaction to workshop #1 has been enthusiastic and approximately 13 of these will have be conducted by July 1974. The geographic distribution of these workshops is statewide.

4. The MDEP has to date assisted 4 communities in writing grant proposals, all of which have been funded.

5. In January 1973 the MDEP assisted the Stevens School in implementing a major organizational development and inter-personal interaction program. Follow-up for this program ended in September 1973. Several immediate results of the program are improved inter-personal growth of staff and students, the evolution of a psychological-educational screening clinic at the school, and a half-way house based in Portland.

6. In the Spring 1973 the MDEP released the Policy Guide for Public School administration. To date 2,500 copies have been distributed.

7. The MDEP has since its inception collected, screened, evaluated and disseminated curricular materials pertaining to abuse of alcohol and other drugs.

8. In the Spring 1974 the MDEP will release its new alcohol-drug education film catalogue. Last year 580 film loans were made to public and private groups over the State.

9. The MDEP is currently planning approaches to a more productive relationship with the Office of Alcoholism and Drug Abuse Prevention.

III. ACTION PLAN

Prologue

The State of Maine has enacted into law without change the Federal model for a Uniform Alcoholism and Intoxication Treatment Act, provisions of which become effective July 1, 1974. The 1973 Maine Alcoholism and Drug Abuse Act creating a single state agency to integrate the state's approach to prevention, treatment, and rehabilitation of both alcohol and drug abuse within the state, became law January 1, 1974. Taken together, these actions represent a constructive step in coordination of the planning and operation of all state drug abuse services, including those related to the abuse of alcohol, which is the target of this State Plan.

However, enactment of this legislation made administrative adjustments necessary. Establishment of the Office of Alcoholism and Drug Abuse Prevention (OADAP) which replaces the Division of Alcoholism Services, required a substantial reorganization process in order to include the resources, functions, and services of the former Maine Commission on Drug Abuse. The State Advisory Council on Alcohol Abuse and Alcoholism was disbanded and reconstituted into the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. It was necessary, in order to satisfy Federal requirements, to develop a system of split agendas for council meetings so that alcohol abuse matters before the council can be reviewed and discussed within that single context without the intrusion of matters concerned with drugs. Similar rules were adopted governing the meetings of the Review and Comment Committee of the council, which is responsible for analysis and recommendations concerning the acceptability of applications for state administered grant funds under the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

Because of certain Federal and State funding requirements it was necessary to establish financial procedures which clearly separate the administration of those funds to be devoted to alcohol abuse purposes from those designed for use in drug abuse programs. It was necessary to prepare two State Plans--one for drugs, one for alcohol. Personnel within OADAP had to be assigned functions in line with their clear responsibilities to one or the other branch.

All this has been accomplished, yet there remains, over all, one administration responsible for the coordination of all state resources, programs, and functions in both areas: alcohol abuse, and drug abuse. A totally functioning central authority has taken over its new duties with the utmost dispatch and a minimum of disruptive effect on operational programs. All efforts are now being directed toward refining the functioning of the department while making certain that absorption of new duties relating to drug abuse does not in any way impede the efficient planning, utilization of resources, and delivery of services related to alcohol abuse.

The successful transformation of the Division of Alcoholism Services into its new format has been due in large part to the fact that the former State Alcoholism Planning Coordinator was appointed Director of the Office of Alcoholism and Drug Abuse Prevention, and the former Director of the Division of Alcoholism Services simply carried over his considerable knowledge and long experience to the new post of Alcoholism Program Specialist. Each has thus been able to carry on her/his special skills while working to effect an orderly changeover.

PLAN

Recommendations Based on a Survey of Need

The Survey of Need supplied estimates of the extent of the problem of alcoholism and alcohol abuse in Maine. The estimates were based 1) on the so-called "Jellinek Formula," 2) on a demographic device designed to estimate

the potential for alcohol abuse by counties and regions, and 3) surveys of professional groups (doctors, social workers, police chiefs, hospital administrators, judges, and clergymen) to determine their conceptions of the problem of alcoholism. Additional demographic and socio-economic data found in the State Survey tables, including new baseline data developed by Regional Coordinators using OADAP's new Alcohol Abuse Management Information System, were also included in the approach to designing priorities for the current Action Plan.

Certain conclusions were drawn from the aggregate data which indicated that the extent of the problem of alcohol abuse and alcoholism has very likely increased in Maine. One indicator is the number of admissions to mental health facilities for treatment of problem drinking. Data for 1972 and 1973, as shown in table 15, were compared for the first nine months of each year (the only months for which data were available in 1973), and the comparison showed an increase in such admissions for all regions but Region V. (The decrease in Region V is undoubtedly due to the fact that it sends most such problems to the Counseling Center in Region IV.) These and other considerations have led to the discernment by OADAP of certain action priorities.

Coordination of all State Agencies

Progress in the developing of more effective administration of all resources, facilities and services for alcohol abuse, treatment, and prevention depends on immediate coordination of the activities of all State departments, agencies, and organizations concerned with alcoholism services. Therefore, the Office of Alcoholism and Drug Abuse Prevention must establish the overall planning, policy, objectives, and priorities for all alcohol abuse prevention functions, encourage and assist development of more effective, better coordinated, more efficient administration of available resources and facilities, expand integration of regional planning

activities within the total system, and encourage the development of new approaches to the solution of alcohol abuse problems.

It is also recommended that the Office of Alcoholism and Drug Abuse Prevention implement and exercise its authority under State law to supervise through a review process all state plans related to alcohol abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government for federal funding under Federal legislation.

Development of Educational and Preventive Programs

The ever increasing social acceptance of the use of alcoholic beverages, their expanding availability, and the constant exposure of young people to advertising of alcoholic products in all media is certain to increase desire among the young for participation in this apparently important social activity.

(a) There is, therefore, a critical need to develop throughout the state early childhood education within the school system that relates to the prevention of alcohol abuse later in life.

(b) Baseline data (Table 4) on numbers of mental health facility clients with alcohol abuse problems who report troubled family relations, particularly the increase in those numbers for the first nine months of 1973, support the conclusion that there is an urgent need for training and education of families in sound preventive educational and growth skills that tend to prevent alcohol abuse, and

(c) a need to work with target low income groups and minority groups (notably Maine Indians) within the educational system, the home and the community, in the prevention of alcohol abuse, and

(d) a critical need to fund research and evaluation in the area of preventive education, within both the school system and the home.

(e) Finally, there is a need to continue and reinforce the coordination of the Human Development and Guidance Unit (Department of Education) and OADAP, and to continue building a resource team that can implement and evaluate preventive education in alcohol abuse, assist OADAP in developing and training alcoholism staff and programs, and assist regional councils in team building skills and development of community resources.

Another resource for developing education and prevention programs is the University of Maine. The University has proposed establishing a Clearinghouse to perform the following duties:

A. Seek out, evaluate or record existing evaluations, and catalogue all educational and/or training materials relating to alcoholism and alcohol abuse - these materials will include printed materials, film in all forms, slides, audio and visual tapes, transparencies, and mixed-media presentations;
B. The Clearinghouse will acquire free materials appearing of value and place them in the Clearinghouse library for easy access; certain other materials promising to be of high use in the estimation of Clearinghouse personnel and of OADAP will be purchased and brought into the Center; all materials whether lodged at the Clearinghouse or out-of-state will be catalogued for fast retrieval and the Clearinghouse will assume responsibility for retrieval upon request;
C. The Clearinghouse will issue regular bulletins through OADAP to all persons or agencies known to be engaged to some degree or another in educational activities regarding alcohol and alcohol abuse, to keep these persons or agencies aware of services and/or materials available through the Clearinghouse, and to inform them of new developments, materials and techniques relevant to their educational activities;
D. The Clearinghouse will serve as a center, on behalf of OADAP, to organize and sponsor training programs for professionals and laymen concerned with alcoholism and alcohol abuse.

These general functions would be exclusive of those performed by the Human Development and Guidance Unit.

It is recommended that we establish a Clearinghouse.

It is further recommended that we continue to fund and utilize the resource development experience of the Human Development and Guidance Unit for the purpose of implementing the following educational priorities.

Schools and Children

1. Kindergarten to Grade 6

Fund the development and implementation of programs for early childhood education, to be accomplished through teacher/educational models which focus on helping the individual understand his/her emotional development, subsequent behavior, the decision making process, and the relationship of the processes to alcohol use and abuse.

2. Junior High and High School

Develop primary intervention and education programs, provided through youth training systems and the development of youth peer group teaching and relationship development processes aimed at better understanding their decision-making methods, contemporary societal pressures, and the relationship of these to alcohol use and abuse.

3. An ongoing, in-depth research and evaluation of these programs as an essential part of the process.

Community and Community Resources

1. Development of parent effectiveness training and similar processes in conjunction with the school developmental programs so that alcohol use and abuse will be better understood by the whole family.

2. Development of local education teams representing a cross-section of the community. Such teams would possess congenital skills as well as skills for gaining community participation in broad alcohol education programs, and leading interested citizens into local action planning and problem solving.

Indian Needs

The delivery of alcoholism services to Maine Indians must, as has been observed elsewhere, be done through the Indian cultural structure.

Mistrust of the motivations of whites, difficulties in communication based on that mistrust and on basic cultural differences, and a heritage of separation from the mainstream of American life--all have for years frustrated attempts at the inclusion of Maine Indians in the social services structure of the State. Services for the prevention, treatment, and rehabilitation of alcoholism and alcohol abuse are no exception. Despite very real problems of alcohol abuse among Maine Indians, it has been difficult until recently to approach the problem within the context of a coordinated State/Regional program.

However, recent approaches in the form of community grant-in-aid to be administered by the Department of Indian Affairs providing for Indian Alcoholism Counselors on the Penobscot and one Passamaquoddy reservation, poverty program funds devoted to the off-reservation Indian alcoholism problem and channeled through Indian cultural sources, and plans for the establishment on reservations of mini-halfway houses, show promise. Priorities for this year include: grant-in-aid to recruit a third Indian Alcoholism Counselor for the other Passamaquoddy reservation, to be a recovered alcoholic, if possible, and chosen from the Passamaquoddy Indian community; training for all existing Indian Alcoholism Counselors; and a shelter program for off-reservation Indians.

Certain educational approaches (see Development of Educational and Preventive Programs), if made through the funding of Indian administered programs, should prove rewarding.

Troubled Employee Programs

There are two Occupational Programs Consultants at work for OADAP in this field. Both have completed the NIAAA training course. At this point, their joint efforts have resulted in the development of prevention and early intervention programs in a number of Maine industries, two general hospitals, and the Veteran's Administration Center and Hospital. As shown

in the Survey of Need, a number of programs are in various stages of development, and considerable supportive activity has been generated among regional planning groups, and alcoholism treatment and service providers. A statewide Labor-Management Conference was held in 1973, and plans and projections made for future activities in this extremely important and fertile field for alcoholism prevention, treatment, and rehabilitation action.

In short, progress has begun, but if the full potential of Industry as a source for earlier case finding, background for effective prevention and rehabilitation efforts, employment for recovering alcoholics, and financial support for alcoholism programs is to be realized, much more needs to be done.

It is therefore recommended that the Occupational Programs Consultants coordinate their efforts with those of the regional planning groups for the organization of a cadre of business and industrial community teams to develop techniques and approaches for identification of potential as well as actual alcohol troubled employees and employers, and gain the confidence and cooperation of these persons, once identified, in acceptance of appropriate help. Such teams should also develop community resources capable of providing aftercare follow-up support.

Ideally, such groups would function on a regional basis out of actual treatment and rehabilitation facilities, with each cycle involving alcoholics going through treatment, members of his/her family, and the business or industry involved.

Staffs of existing alcohol abuse and alcoholism treatment and rehabilitation units should be provided training in basic management skills, short and long-range planning, analysis of needs, and the development of action plans for unit operations. In this connection a management curriculum has

been developed for halfway house managers and it appears this will be started very soon, funded mostly by LEAA.

3. Implementation of the Uniform Act

When the Uniform Alcoholism and Intoxication Treatment Act becomes law on July 1, 1974, it will mean for many Maine citizens, physicians, police officers, judges, social workers and others, an overnight change from age-old formulas for the "processing" of cases of intoxication in which the subject was a lawbreaker and treated as such, to a "new" concept (to most citizens, as well as many of the professionals just mentioned) of the intoxicated person as a sick member of society who must be afforded treatment for his/her illness.

The "decriminalization" of intoxication under the Uniform Act has added a new dimension to the responsibilities of the Office of Alcoholism and Drug Abuse Prevention, and that will mean the devoting of a great deal of time and effort to the problems which will inevitably arise among policemen, judges, hospital administrators, doctors, and operators of facilities devoted in whole or in part to the treatment and rehabilitation of alcoholics.

Many of these difficulties have been foreseen and an effort has been made by the Office of Alcoholism and Drug Abuse Prevention to soften the impact of the new law on already overworked facilities. An attorney, originally assigned by LEAA to the Maine Drug Commission, is now assigned to law enforcement education for OADAP. He has been active in developing informational materials for distribution among concerned organizations and agencies. He has been an effective liaison between OADAP and the various concerned agencies and community groups. He has developed a handbook for policemen, to help them in interpreting and applying their responsibilities under the law. He has assisted in the preparation of

an OADAP publication called, The Involuntary Civil Commitment of Alcoholics in Maine.

However, despite these and other preparations, OADAP must plan to devote a considerable amount of its time, efforts, and resources, human and financial, to the implementation of the provisions of the Uniform Act.

Principal among the problems to be faced in implementation of these provisions is the shortage of adequate facilities for treatment and rehabilitation of alcoholics. Therefore, chief among OADAP's priorities must be the development of new facilities and the improvement of existing facilities. Existing resources are few in number, often unsuitably located for services to the population of the state at large, inadequately staffed (frequently with poorly trained and underpaid personnel), and inadequately supported by the regions they serve.

The organization during the past year of Regional Planning Councils, and their activities in assessing regional needs, the development of the uniform data system with its capacity for detecting areas of heavy alcohol abuse and alcoholism, have both begun the process of indicating to State planners the weaknesses of present practice, and the nature of response required to set up a uniform system of alcohol abuse and alcoholism prevention, treatment and rehabilitation. Using data already collected and that which will be acquired in coming months, OADAP must address itself to the problem of planning for the improvement of existing facilities, and the development of new ones. All of the resources of the State, under OADAP supervision and review, must be coordinated in a statewide program of designing and funding new alcoholism facilities, and training staffs, in order to absorb at least part of the burden imposed by the heavy caseloads implementation of the Uniform Act will inevitably force on all facilities.

As matters stand now, those needs will be only fractionally met. In the opinion of professionals involved in the provision of services to alcoholism, the costs of implementing the treatment provisions of the Uniform Act alone would amount to something between $6 million and $7 million. Last year the State allocated $200,000 for the administration of the total State Plan. Federal grants added another $200,000 formula grant and $50,000 occupational grant for a total of $450,000. Projected fiscal estimate for this year's programs will be included in a later portion of this Action Plan, but it can be said here that meeting the needs, to say nothing of the goals and objectives of the present State Plan, will require a financial commitment on the part of the State Legislature at least equal to its legislative intent.

Not the least of the problems faced by OADAP in enlarging its resource of alcoholism treatment facilities needed in response to provisions of the Uniform Act is the requirement that standards must be set(by OADAP) for the facilities to be approved. Certification standards, therefore, must be drawn up for all facilities and personnel employed in such facilities. Again, study, time and funding become necessary parts of the problem for which solutions must be found.

4. Development of Community Programs into a Statewide Network of Alcoholism Services

Community Alcoholism Programs were in existence in some degree long before the development of the Regional Planning Councils, but it can be said now that since the formation and activation of the councils there has been greater cooperation, more community involvement, better community understanding, and more treatment facilities and agencies than existed at the beginning of the program. Prominent citizens, physicians, community leaders, social workers, and others who formerly acted solely within the

confines of their own organizations, are now taking an active role in the creation, operation, and planning activities of the Councils by becoming members of the Councils and learning the benefits to the community of coordinated social service activity. Using the data system developed by Social Systems Research Corporation of Bangor, Regional Coordinators have begun the process of collecting the data that will provide the baseline information upon which the planning system must depend. Here the usefulness of the regional approach will become more apparent, but even now, on the basis of data already collected in social problem areas associated with alcohol abuse, i.e., divorces, number of families receiving counseling for alcohol related problems, number of families receiving aid to dependent children, disorderly conduct arrests, assault and battery cases, etc., it is possible to estimate the potential dimensions, region by region. (See tables at end of this section.)

Data more directly alcohol-related, such as admissions to mental health facilities for treatment of alcoholism and alcohol abuse, arrests for intoxication, hospital admissions for alcohol psychosis, alcoholism, and liver cirrhosis (see tables at end of this section) will be essential to the making of correct decisions in determining regional and community needs for treatment facilities.

These data on regional and local needs will be evaluated and fed into the total State system, which will form the basis for development of the statewide network of alcoholism services.

It is the belief of the Office of Alcoholism and Drug Abuse Prevention that, although regional and community planning are essential "grass roots" sources of information and furnishing impetus for action, a statewide total system approach to the solution of alcohol abuse problems is to be preferred over a grab-bag assortment of single solution approaches. Therefore, the

thrust of the Regional Planning Council's activity must be directed toward the development of regional and community programs which can be eventually absorbed into a coordinated statewide master plan under the administration of the designated State agency, OADAP.

Similarly, all other State agencies and organizations active in the field of alcohol abuse treatment, should also develop their programs with this basic aim in mind. Private non-profit groups such as Alcoholics Anonymous should also coordinate their activities with regional groups so that their total effort can be made to fit into the statewide network of alcoholism services, while maintaining their traditional independent methods and institutions.

It is the duty, under State law, of the Office of Alcoholism and Drug Abuse Prevention to coordinate the efforts of all public and private agencies, organizations and individuals, and to seek and receive funds from the Federal Government, and coordinate the disbursement of all State funds to further its activities. In carrying out those duties OADAP proposes a coordinated statewide integrated system devoted to the prevention, treatment, and rehabilitation of Alcohol Abuse and Alcoholism in Maine.

The priorities of the system will be:

1. Prevention of alcoholism before it starts.
2. Integration of alcoholism prevention and treatment into the health-social systems.
3. Detection of alcoholism in its early stages.
4. Treating the victims of alcoholism.
5. Training people in alcoholism prevention and treatment, and the developing of new approaches to prevention and Treatment.
6. Finding the psychosocial and physiological/chemical clues to prevention and treatment.

5. Implementation of an Ongoing Information and Reporting System

The appendix to this State Plan contains a report on the Alcohol Abuse Management Information System of the Office of Alcoholism and Drug Abuse Prevention. This is the uniform data collection, storage, and retrieval system, development of which was one of the priorities of the 1973 State Plan.

The System is composed of three elements: a Community Monitoring System, a Program Monitoring System, and a Treatment Effectiveness System. The first of the interdependent systems, the Community Monitoring System, provides tables and detailed descriptions of the socio-economic characteristics of each planning region, baseline data on demographic variables which have been identified with problem drinking: age, sex, marital status, occupation, income, education, etc. In preparation for use of the system, a Data System Guide was prepared consisting of all available U.S. Census and other reliable data on the complete demographic and socio-economic profiles of the State of Maine, compiled by counties and Alcohol Planning Regions. (Examples of the data and method of presentation will be found in tables of this report.)

A narrative description of the regions was included, and detailed instructions as to the use of the Guide in implementing the Community Monitoring System. Copies of this volume were distributed to members of State Alcoholism Council, State Alcoholism Counselors, State Alcoholism Planning Coordinator, Presidents of the regional Alcoholism Councils, and administrative staff of appropriate agencies.

The combined Program Monitoring System and Treatment Effectiveness System provides administrators with operating, decision-making, and descriptive data on prevention, treatment, and rehabilitation of alcoholism and alcohol abuse. It is organized to provide administrators

with periodic information, in a standard format, on who is providing what services to whom, and with what results. On the basis of this information alcoholism treatment resources may be managed efficiently, and in a manner responsive to community need.

With the development of this uniform data system OADAP will be provided with an ongoing reporting and information system compatible with existing Federal and State systems and the SRI system used by Mental Health Centers, and standardized for use by the five planning regions.

Although data collection under the system has already begun, total implementation of the system is necessary to the functioning of the coordinated, statewide, integrated system for the prevention, treatment, and rehabilitation of alcohol abuse and alcoholism in Maine. Thus, implementation and testing of the system becomes one of the priorities of this action plan.

6. Criteria for Priorities

The creation of the Office of Alcoholism and Drug Abuse Prevention as the single State agency to administer all State programs for prevention, treatment, and rehabilitation of alcoholism and alcohol abuse, and the wide authority and range of duties assigned to it, make imperative the coordination under its administration of all State agencies active in the field of alcoholism, and the first priority of this action plan, so that the agency may operate with maximum efficiency toward the achievement of its goals and objectives.

The spreading use of alcohol among young people, with its attendant dangers, the increased interest of industry in alcoholism problems, and the minimum attention paid thus far to the principle of prevention over treatment and rehabilitation, is sufficient reason for assignment of a high priority to this activity. The ambitious reach of the proposed

program, as described in Development of Educational and Preventive Programs, and the obvious understanding of and response to need were other criteria used in evaluation of this proposal.

The implementation of the Uniform Act was chosen by Applying the simple criterion of need. The impact of the Act's implementation will place urgent demands on practically all branches of State and local government and institutions. This urgency will demand immediate response, and OADAP is preparing to give it.

The formation, staffing, organization, and activation of the Regional Planning Councils and the way they have immersed themselves in community problems, established rapport with other community service groups and agencies, and responded to their obligations at the State level, have emphasized the desirability of developing our community programs into a statewide network of services as soon as possible before there is any possibility of loss of impetus. The concept of a coordinated statewide master plan is well understood; there is nothing to be gained by waiting. And the sooner OADAP can assume its State level administrative duties and functions through the coordinated efforts of its regional groups and the cooperation of other State agencies the better.

This year, for the first time, prevention, treatment, and rehabilitation components of the State alcohol abuse and alcoholism services will be able to operate with reliable baseline data gathered by Regional Coordinators and Social Systems Research Corporation. For the first time all State and private non-profit agencies will be supplying uniform data compatible with Federal and State systems, where in the past little or no data of any kind were available. For the first time a computerized, sophisticated system of data storage and retrieval will be available for the use of State planners. For these reasons, it was considered essential that the system be implemented and tested this year so that any possible kinks can be ironed out, and so that its use for badly needed planning can be begun.

State Formula Grant Budget

Administration	$20,000
Personal Service (10)	90,000
Fringe Benefits	17,100
Travel	15,000
Council and Planning Organization Expenses	
Regional Planning Organization (4)	10,000
Continuation of Contractural Commitments	73,000
Miscellaneous	
Rent and Communications - (supplies, duplication, computer time, postage, phone, printing, etc.)	16,524
Total	$241,624
Implementation of the Uniform Act	124,000

Grant-in-aid for facility, direct service, and educational development related to the Uniform Act. These funds will supplement the State grant-in-aid program presently operating.

It should be noted that the federal monies becoming available for alcoholism under the mental health centers is helpful in forming strong components of comprehensive, community based services. This is particularly true of the northern part of the State where services have historically been sparce. The State agency will continue to support this type of development.

IV. PARTICIPATION BY OTHER PUBLIC AND PRIVATE NON-PROFIT AGENCIES

There are in Maine no agencies which are supervised by the designated State agency, the Office of Alcoholism and Drug Abuse Prevention. There are, however, contractual arrangements and cooperative agreements between this agency and others, both governmental and non-governmental.

1. Cooperative Agreements

(a) As has been described elsewhere, a cooperative agreement between the designated agency and the Bureau of Mental Health of the Department of Mental Health and Corrections has been negotiated and implemented. This agreement has led in turn to further agreement between the two departments regarding a set of goals and objectives to be jointly met. This agreement, State Program Development (SPD), has been updated and revised, and a copy of that document has also been included elsewhere in this State Plan.

(b) 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 normally 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 State Advisory Council and staff of the designated agency.

2. Determination of Funds

The proposed budget for administering the State Plan has been shown under Action Plan, Section .

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972 make by allotment federal funds available to this State under a formula grant basis. The State Administrator may provide a portion of these funds to: State, regional and local public and private non-profit agencies and organizations for participation in programs under these Acts. In addition, some State funds are made available for the same purposes.

In determining which agencies, institutions and organizations are eligible for receipt of such funds, and the amount to be made available to each, the Office of Alcoholism and Drug Abuse Prevention (OADAP) must consider the extent to which the services to be provided will be directed to alcohol abuse prevention, treatment, and rehabilitation programs of high priority, will be of high quality, and will reach the people in local communities in greatest need of such services. In making such determinations, grant applications must, by State law, be submitted concurrently to regional planning and coordinating agencies and to OADAP central office. Regional review and comment data and OADAP recommendations will then be submitted to OADAP's State Advisory Council for final review and comment. OADAP then will make a final decision as to the disposition of the proposal.

Information as to the availability of Federal or State funds for the conduct of activities under the State Plan, including those locally initiated or sponsored, will be distributed among all concerned agencies by regional planning bodies and the OADAP central office.

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 occurrences 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 affected 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 consideration 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. The single state agency responsible for administering the State Plan is the Office of Alcoholism and Drug Abuse Prevention.

Section 247, Part C (2) of the Amended Community Health Centers Act reads as follows:

> Each applicant within a state, upon filing its application 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 agency was set up by state law, effective January 1, 1974, 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..."

2. OADAP is also authorized under State law to review applications submitted under Part C of the Community Health Centers Act, and all other alcohol abuse and alcoholism program grants submitted under other Acts.

B. Provisions for Review by other State Agencies

1. Applications for contruction grants, including those to be funded 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. However, 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 in the development of a comprehensive plan

for the community mental health services, including centers construction. Therefore, agreement has been made 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 Facilities approved under Maine's Community Mental Health Center Survey and Construction Plan.

2. The State Planning Office issues a weekly bulletin (Form 189) which alerts all State agencies, departments, and divisions to the existence of grants submitted for approval by the designated State agency, so that those, such as the Department of Mental Health and Corrections which shares authority for alcoholism staffing grant applications, and all State government human services agencies and their regional branches may review and comment on such applications, provide input, suggest modifications, and otherwise participate in the decision-making process with the State agency designated under Public Law 91--616.

Standards and Evaluation

The Office of Alcoholism and Drug Abuse Prevention is currently engaged in the development of standards for the operation of alcoholism and alcohol abuse prevention, treatment, and rehabilitation programs and facilities in addition to methods for evaluation of compliance with standards on an annual basis. Data from other states with similar programs has been solicited, and discussions within OADAP are leading toward the development of such standards and evaluation procedures.

VI. ADMINISTRATION OF PLAN

A. State Plan Administration Costs

The Office of Alcoholism and Drug Abuse Prevention certifies that it works within the boundaries set in Section 302 (c) of Title III, P.L. 91--616, which permits the expenditure, not to exceed 10% of the State allotment 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 traveling expenses incurred by the 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 contractual services related to administering, or supervising the administration of the State Plan.

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," 45 CFR 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.

C. Assurances

The Office of Alcoholism and Drug Abuse Prevention will follow professional standards in approving individuals (other than employees under a governmental merit system), agencies, institutions, and organizations to carry out activities under the plan, and schedules or other bases upon which payments are made to such individuals, agencies, institutions and organizations will be in accord with the usual and customary practices in the state.

Assurance is also given that OADAP and any other agency, organization, or institution administering and/or carrying out any activity under the plan shall not refuse employment to any qualified applicant solely on the basis that he or she has had or has not had a problem of alcoholism.

VII. ACCOUNTING PROCEDURES

Creation in Maine of the Office of Alcoholism and Drug Abuse Prevention has for the first time combined the alcohol abuse and drug abuse programs under one agency. It has been necessary, therefore, to develop a system of accounting which would keep separate, because of federal and state formula grant requirements, the funding mechanisms of the two programs. In this case it has been necessary to create procedures which will assure the proper disbursement of and accounting for funds paid to the state under this program, differentiating between alcohol formula grant funds allotted under Public Law 91--616 and those received from all other Federal formula and project grant programs. Accurate records of expenditures of alcoholism funds are maintained.

All accounting and auditing of expenditures and commitments made by the Office of Alcoholism and Drug Abuse Prevention, along with other Health and Welfare administrative components, are under the continuing review of the Department's Division of Accounts and Audit. Further State review on an ongoing basis is provided by the State Bureau of Accounts and Control.

All such records are available at all times to the inspection of Federal authorities concerned with the use of funds made available under Public Law 91--616, and to such other Federal agencies as the U.S. Office of the Budget, the U.S. Comptroller General, and to the Federal and regional representatives of NIAAA.

All other requirements found in Accounting Procedures, HEW Guidelines for the State Alcoholism Formula Grant Program are being, and will continue to be met.

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. In addition, Title VI of the Civil Rights Act of 1964 is applicable to services and programs provided under the State Plan.

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.

MAINTENANCE OF EFFORT

A. Assurance

The Office of Alcoholism and Drug Abuse Prevention hereby assures and certifies that Federal funds will not be used to supplant State, local, and other non-Federal funds otherwise available for providing the services and carrying out the activities under the Plan, and that such funds will, to the extent practicable, be used to increase the level of funds otherwise available for such services and activities.

(a) Compliance

The Office of Alcoholism and Drug Abuse Prevention hereby certifies that 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 approved State Plan (including State funds allocated to other public or non-profit agencies, institutions and organizations) is at least no lower for any fiscal year than it was for the immediately preceding fiscal year, except that the Secretary may also take into

consideration the extent to which the level of such funds for any fiscal year may have included funds for an activity of a nonrecurring nature.

(Section B., HEW Guidelines for the State Alcoholism Formula Grant Program does not apply here because formula grant funds are administered entirely by OADAP. However, written procedures will be developed to ensure that if and when such agencies receive such funds as described in B., safeguards will exist to assure strict compliance with the provisions of said section B. of the HEW Guidelines for the State Alcoholism Formula Grant Program.)

Accessibility

The services, resources and facilities of the Office of Alcoholism Drug Abuse and Prevention shall be fully publicized in all media so that the population needing such services cannot fail to be aware of their existence. Facilities, resources and services shall be made available and responsive to the needs of the people and shall be located to the extent possible in areas readily accessible to the population to be served.

Comprehensive alcohol abuse and alcoholism services such as emergency care, 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 inability to pay.

IX. OTHER REQUIREMENTS

A. Publicizing Plan

Due to the precipitous deadline for rewriting the third year Plan, it was not extensively advertised. The following legal notice will appear in the newspaper within a week of submitting the Plan for review. In addition, the Regional Alcoholism Councils have publicized the Plan as well as provided the planning base for its development.

Legal Notice (See Addenda Section)

> 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 updated. Upon approval of this Plan, fiscal year 1974 funds in the amount of $241,000 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 and the implementation of the Uniform Intoxification Act.
>
> A copy of the State Plan is available for examination at the Maine State Library in Augusta.

B. Governor's Review

The following form R0189 was submitted through the State Planning Office for the Governor's review and comment. As soon as his final approval is received, we will forward it for inclusion in the Plan.

Do not type to the left of dotted line.

OMB No. 80-R0

COVER SHEET for FEDERAL GRANT APPLICATION/AWARD NOTIFICATION

1 APPLICATION DATE (yr mo day): 19 74 2 15

ITEMS 1-31 TO BE COMPLETED BY APPLICANT OR CLEARINGHOUSE DEPENDING UPON STATE PROCEDURES

2 FEDERAL EMPLOYER ID N

APPLICANT – Organizational Unit: MAINE - Department of Health and Welfare

4. ADDRESS - Street or P. O. Box: State House

5. CITY: Augusta

6. COUNTY: Kennebec

7. STATE: Me.

8. ZIP CODE: 04330

9. PROG NO. (Catalog of Fed Domestic Assistance): 13.257

10. TYPE OF ACTION: a ☐ New c ☐ Modification b ☒ Continuation

TYPE OF CHANGE (Complete if 10b or 10c was checked)
11. a ☒ Increased Dollars b ☐ Decreased Dollars
12. a ☐ Increased Duration b ☐ Decreased Duration
13. a ☐ Other Scope Change b ☐ Cancellation

14. EXISTING FED GRAN: X23 9500 72

15. REQUESTED FUND START (yr mo): 19 73 7

16. FUNDS DURATION: 24 (Months)

17. EST. PROJECT START (yr mo): 19 74 4

18. EST. PROJECT DURATION: 15 (Months)

19. APPLICANT TYPE — Enter Letter: [A]
A. State; B. Interstate; C. Sub State Dist; D. County; E. City; F. School District; G. Community Action Agency; H. Sponsored Organization; I. Indian; J. Other (Specify in Remarks)

FUNDS REQUESTED (For Changes Show Only Amt. of Inc.(+) or De
20. FEDERAL ( ) $
21. STATE ( ) $ 241,624
22. LOCAL ( ) $
23. OTHER ( ) $
24. TOTAL (20, 21, 22, 23) ( ) $ 241,624

25. BRIEF TITLE OF APPLICANT'S PROJECT: Alcoholism State Plan

26. DESCRIPTION OF APPLICANT'S PROJECT (Purpose)

Provide for prevention, treatment, and rehabilitation programming for alcohol abuse and alcoholism in Maine.

27. AREA OF PROJECT IMPACT (Indicate City, County, State, etc.): Statewide

28. CONGRESSIONAL DISTRICT Of Applicant [1] Districts Impacted By Project [1 & 2]

29. Environmental Assessment Required By State/Federal Agency? ☐ Yes ☒ No

30. CLEARINGHOUSE(S) TO WHICH SUBMITTED: a ☒ State b ☐ Area Wide c ☐ None

a. NAME OF CONTACT PERSON: Michael D. Fulton

b ADDRESS -- Street or P. O. Box: 32 Winthrop Street, Augusta, Maine

c TELEPHONE NO.: 207-289-2141

ITEMS 32-38 TO BE COMPLETED BY CLEARINGHOUSE

32. CLEARINGHOUSE ID

MULTIPLE ☐ CLEARINGHOUSE

33. a ACTION BASED ON REVIEW OF: a ☐ Notification b ☐ Application

33. b ACTION TAKEN: a ☐ With Comment b ☐ Without Comment c ☐ Waived d ☐ Unfavorable

34. STATE APPLICATION IDENTIFIER (SAI): State ____ Number ____

35. CLEARINGHOUSE IMPACT CODE: STATE WIDE ☐ Yes ☐ No; County/ City Plng Area

36. STATE PLAN REQUIRED ☐ Yes ☐ No

37. RECEIVING DATE AT CLEARINGHOUSE (yr mo day): 19 ___ ___ ___

38. FINAL CLEARINGHOUSE ACTION DATE (yr mo d): 19 ___ ___ ___

ITEMS 39-42 TO BE COMPLETED BY APPLICANT BEFORE SENDING FORM TO FEDERAL AGENCY

39. 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 ☐

40. a NAME (Print or Type)

b TITLE

c SIGNATURE of Authorized Representative

d TELEPHONE NUMBER

41. DATE MAILED TO FEDERAL/STATE AGENCY (yr mo day): 19 ___ ___ ___

42. NAME OF FEDERAL / STATE AGENCY TO WHICH THIS APPLICATION SUBMITTED

ITEMS 43-54 TO BE COMPLETED BY FEDERAL OFFICE EVALUATING AND RECOMMENDING ACTION ON THE APPLICATION

43. GRANT APPLICATION ID (Assigned by Federal Agency)

44. GRANTOR AGENCY

45. ORGANIZATIONAL UNIT

46. ADMINISTERING OFFICE

52. Application Rec'd. (yr mo day): 19 ___ ___ ___

53. a Exp. Action Date (yr mo day): 19 ___ ___ ___

Always Complete 53. a OR b

53. b Rel. to Applicant (yr mo day): 19 ___ ___ ___

REVISION — Amended Applic. Received (yr mo day): 19 ___ ___ ___

REVISION — Rev. Expected Action Date (yr mo day): 19 ___ ___ ___

54. Exp. Action Revised As Of (yr mo day): 19 ___ ___ ___

REVISION — Subsequent Rel Applicant (yr mo day): 19 ___ ___ ___

A P P E N D I X

SOCIAL SYSTEMS RESEARCH CORPORATION

ALCOHOL ABUSE MANAGEMENT INFORMATION SYSTEM

ANNUAL REPORT

The work conducted on this management information system separates logically into the following components: Development of the Community Monitoring System; Alcoholism seminar; Attitude surveys; Development of the Program Monitoring and Treatment Effectiveness Systems; Final report on the Community Monitoring System.

Development of the Community Monitoring System

The development of this system began with a review of the literature on the etiology of problem drinking in the United States. This review indicated that in the population-at-large heavy drinkers possess certain personal characteristics more often than nondrinkers or low to moderate drinkers. Tables were compiled from the 1970 Census to reveal how the five Maine Planning Regions compared on the percentage of their populations possessing these high risk characteristics. These tables presented data on sex, education, marital status, income, and occupation. To aid in the comparison of regions or counties an Alcoholism Potential Indicator was developed to consolidate the census data into a score which would indicate where large concentrations of the high risk populations were centered.

In addition to census statistics, 33 social problem variables were identified. Each social problem is influenced to some extent by problem drinkers. Although the precise influence of problem drinkers cannot be measured, it can be assumed that a constant proportion of the incidence of each problem would be caused by problem drinkers and that successful treatment of a large number of problem drinkers

would logically affect the frequency of their occurrence.

A data source was located for each of these variables and a procedure for collection of the data was developed and placed in action. In general, the Regional Coordinators were responsible for obtaining court related data and estimates of attendance at AA meetings for their regions; the State Coordinator and her staff were responsible for collection of all centrally available data.

During the first and second quarter, data tables were compiled on the census data, available 1972 data on the 33 social problem variables, and additional social and economic information on the five planning regions. In May this collection effort culminated in the production of the Data System Guide for Alcohol Abuse Planning Regions. Throughout the remainder of the year the collection procedure for ongoing data monitoring of social problem indicators was refined, cost estimates were obtained for computer source data, and transcription of computer printout data to Data Guide tables begun.

Alcoholism Seminar

The final activity of the second quarter was a seminar given by Social Systems Research on June 28-29. It was attended by the State and Regional Coordinators and other members of the Bureau of Rehabilitation. The topics presented were: the data system to date, plus instructions for collection of data; general theories of disease and treatment; specific methods of treatment of alcoholism.

Attitude Surveys

Work began in May on the development of the attitude surveys. Surveys were constructed for seven professional groups: clergy, social workers, employers, hospital administrators, district court judges, police chiefs and physicians. The final drafts were completed in July. Samples were drawn, mailing labels printed, and all surveys except the physician surveys were mailed in August. The returns from the first six professions were processed, programmed, and computer analyzed in September. The chief administrator of

Fairfield Institute had agreed to print and mail the physicians' survey, but, personal circumstances interfered and Social Systems Research was obliged to take over the behind schedule mailing.

The results of the first six surveys were reported in October. The results of the physicians' survey were added in December, and the combined final report, A Report on Attitudes of Selected Professional Groups Toward Alcoholics, was printed that same month.

Development of the Program Monitoring and Treatment Effectiveness Systems

Work began in July on the development of the Program Monitoring System. The first step was to contact all actual treatment agencies to obtain copies of the data forms or record sheets currently in use across the State. Examination of the collected forms revealed that in order for a uniform data collection effort to be successful, a new short form was needed. The decision was made at this time to combine the Program Monitoring System with the Treatment Effectiveness System since the same data forms would be used to collect information on both systems.

The Problem Drinker Form was developed and field tested in the Maine Medical Center Emergency Room and the Portland Twenty-Four Hour Club. The form was expanded after testing to include more treatment items and pre-post comparisons. The form was constructed such that facilities using the expansive Stanford Research Forms (SRI), can opt to send in copies of their SRI forms plus partially completed Problem Drinker Forms for processing, or can send in copies of fully completed Problem Drinker Forms. An Admissions and Terminations form, treatment worksheet, and the Problem Drinker Form (completed at termination of the client) compose the battery of forms used in the combined Program Monitoring and Treatment Effective Systems. The forms, their coding manual, keypunch formats, and report formats are contained in the January 15th Final Report on the Program Monitoring and Treatment Effectiveness Systems.

Final Report on the Community Monitoring System

The tables containing data on the 33 social problem indicators begun earlier in the year were completed as far as possible in December and early January. Two variables were dropped because the State could not provide programming assistance to retrieve their centrally stored data. The remaining data tables were examined for baseline differences in regions or over time. As a result of this examination two variables were dropped and many were placed on hold; a condition where the data would continue to be collected until additional information established a baseline pattern. The remaining variables were weighted by population constants to express incidence per 10,000 regional population. Based on these weighted figures, the regions were examined for any predominent familial, social, driving, etc., difficulties which would reflect high concentrations of problem drinkers. Gaps in treatment were implied for such regions.

The Alcoholism Potential scores were calculated for each region and county; a summary of the results of the attitude surveys pertaining to the extent of the alcoholism problem, treatment, and gaps in treatment was prepared; and the completed tables and graphs were assembled in the Final Report on the Community Monitoring System.

A D D E N D A S E C T I O N

REVISED

Maine Council on Alcohol and Drug Abuse Prevention and Treatment

Name	Term of Office	Ending
Rev. John J. Feeney, Chairman St. Mary's Rectory 30 Cedar Street Bangor, Maine 04401	3 years	January 23, 1977
Dr. Einar Olsen, President University of Maine Farmington, Maine 04938	3 years	January 23, 1977
Mr. Stephen P. Simonds Human Services Development Center University of Maine Portland, Maine 04101	3 years	January 23, 1977
Sister Mary Anastasia Chief Pharmacist Mercy Hospital Portland, Maine 04101	3 years	January 23, 1977
Mr. Brendon Twoomey Property Manager Maremont Corporation Saco, Maine 04072	3 years	January 23, 1977
Mr. Thurman Millett Maine State Federated Labor Council 499 Broadway Bangor, Maine 04401	2 years	January 23, 1976
Mr. Eaton W. Tarbell c/o Eaton W. Tarbell & Associates, Inc. 8 Harlow Street Bangor, Maine 04401	2 years	January 23, 1976
Mr. Charles Sharpe Sheriff's Office 122 Federal Street Portland, Maine 04101	2 years	January 23, 1976
Mrs. Eleanor Blais 168 Fairview Avenue Auburn, Maine 04210	2 years	January 23, 1976

Maine Council on Alcohol and Drug Abuse Prevention and Treatment

Name	Term of Office	Ending
Rev. James Word 7 Epsworth Street Presque Isle, Maine 04769	2 years	January 23, 1976
Dr. Frank Lawrence Maine Medical Center 22 Bramhall Street Portland, Maine 04101	1 year	January 23, 1975
Miss Barbara Penney Bond Brook Road Augusta, Maine 04330	1 year	January 23, 1975
Mr. Jerry W. Bryant ARU House, Box 88 Bowdoin College Brunswick, Maine 04011	1 year	January 23, 1975
Dr. Robert Ohler Chief of Staff Veterans Hospital Togus, Maine 04330	1 year	January 23, 1975
Mr. Paul Adams Southern Maine Comprehensive Health Association 583 Forest Avenue Portland, Maine 04101	1 year	January 23, 1975
*Senator Walkine Tanous 29 Main Street East Millinocket, Maine 04430		
*Representative Olympia Snowe 114 Nottingham Road Auburn, Maine 04210		

*Members of the Legislature will serve at the pleasure of the President of the Senate and the Speaker of the House.

Legal Advertisement

LEGAL 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 updated. Upon approval of this Plan, fiscal year 1974 funds in the amount of $241,000 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 and the implementation of the Uniform Intoxification Act.

A copy of the State Plan is available for examination at the Maine State Library in Augusta.

KJ 2-22-74

Progress Report

Progess within the State Program Development process has been encouraging and profitable. The Bureau of Mental Health and the Office of Alcoholism and Drug Abuse Prevention have been able to successfully garner detailed cooperation in information system integration and program development, as the two most important areas. OADAP staff sit on the advisory committee established to provide input into the development of Mental Health's information system. Negotiations have begun to incorporate many of OADAP's data needs into the Mental Health information system, and we have assurances that the mental health centers will cooperate in gathering other data which OADAP requires.

In program development a much closer working relationship exists between central office staffs than at any time in the past. Staff from the Bureau of Mental Health and OADAP will be going into the mental health centers to begin defining in specific terms the relationship the centers will have in the emerging alcoholism treatment and rehabilitation systems in the various planning regions. These visits should result in mental health centers playing a more active and appropriate role in alcoholism treatment in those areas where they have been reticent to get involved with alcoholism programming.

An indicator of the increasing cooperation between mental health and the State alcoholism agency is the dollar contribution OADAP has committed to the Aroostook Mental Health Center for partial support of their comprehensive staffing grant. The process of arriving at an acceptable project proposal and financial support can best be characterized by close cooperation with OADAP and positive coordination with the community.

In addition to progress in the SPD effort and the general progress outlined in the State Plan in terms of legislation and an on line information system, OADAP has made strides in its community grant-in-aid program. Last year the alcoholism agency received its first supplemental appropriation in twenty years. The 106th Maine Legislature appropriated $200,000 for community grant-in-aid for alcoholism treatment and rehabilitation. Those funds have been variously matched with Title VI funds to create four new alcoholism treatment programs and to expand four already existing programs. Being familier with Maine's existing programs, you will remember Serenity House, Twenty-four Hour Club, Milestone Foundation, and Bangor Halfway House. These four facilities are expanding under the newly acquired State funding.

Mid-Coast Rehabilitation Center, Hope House and two grants to Mental Health Centers are the four new programs. The Tri-County Mental Health Center and the Aroostook Mental Health Center both have new counseling programs for alcoholics. These grants indicate the expanding role of the mental health system in alcoholism treatment and increased geographical coverage of services.

Hope House in Bangor is a facility created to serve the skid row alcoholic. Creation of this facility resolved a long standing problem in the Bangor area where the skid row population received shelter under the worst conditions possible. In addition, organizational conflict among service agencies precluded satisfactory resolution of problems around that segment of the alcoholic population. Hope House solved the former problem and lessened the latter.

Mid-Coast Rehabilitation Center in the Rockland area is a shelter/detoxification facility. Its creation provides increased geographic coverage of alcoholism services and a partial response to the implementation of the Uniform Act.

The Uniform Act becomes effective on July 1, 1974. Consequently, the grant-in-aid mechanism reflected the development of services which are responsive to the problems and opportunities created by the Act. Our facilities are, therefore, geared up for July.

During the past few months OADAP, The Maine Hospital Association, representatives of treatment approaches, the police, and a lawyer have been traveling as a team throughout the State. The effect of meeting in various areas of the State with effective use of the media and community organization techniques has been to reduce the hysteria and misinformation surrounding the Uniform Act and its implementation. A strong alcoholism constituency is emerging with sufficient interest, information and ability to make the goals of alcoholism prevention, treatment, and rehabilitation a reality.

We are encouraged with the progress being made in the service arena, in community development, on the legislative front, and in the emerging financial base for alcoholism. The past legislature increased the original $200,000 grant-in-aid program to $350,000. With increasing funds and cooperation at local and state levels, we look forward to an active and effective effort in the field of alcoholism in Maine.