Strategies to Enhance the Effectiveness of Alcoholism Services in Maine's Public and Private Agencies

prepared for the

Joint Select Committee
on
Alcoholism Services
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Foundation Associates *Plainfield New Hampshire*

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

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FINAL REPORT

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This work was supported by a contract from the Maine Legislature's Joint Select Committee on Alcoholism Services under Appropriation 4050.1

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter I:

EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

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ERRATA: Page I-2 On the first line, the figure, $700 should be $700 million

Chapter I:

EXECUTIVE SUMMARY

I-1. Introduction and Purpose

Alcohol abuse costs Maine citizens and organizations almost $700 million each year. Seven main categories are responsible for this loss:

- corporate expenditures on non-productive personnel and reduced income from the sale of inferior products total about $222 million.
- public expenditures on non-productive state employees amounts to almost $40 million.
- individuals lose about $150 million from reductions in personal equity in homes, expenditures on alcoholic drinks, and increased payments for household services.
- the state spends almost $135 million for school and correctional system personnel and facilities that could better be used to provide services unrelated to alcohol abuse are.
- losses to individuals, firms, and public agencies from property damage related to alcohol abuse totals nearly $10 million.
- almost $130 million is spent within the medical system for personnel, equipment, and facilities that could better serve other health needs within the state.
- nearly $11 million is spent on activities that provide education, research, prevention, and treatment related to alcohol abuse within Maine.

State programs already make important reductions in these costs, but the effectiveness of state expenditures can be raised. Through our work for the Select Committee we identified six measures that will lower the costs to Maine citizens and firms of alcohol addiction and abuse:

- alter the legislation so that responsibility for planning and assessment (but not management) of state alcohol expenditures is clearly vested in a small central staff outside any of the four state departments,

- implement a four-year planning cycle that includes four different reports - cost assessment, goal statement, activities description, and budget proposal,

- require that the state departments base their grants to service agencies in part on their compliance with a set of state-wide standards for data gathering. Special emphasis should be placed on the agencies' generation and use of follow-up data that measure the effectiveness of alternative treatment programs,

- achieve state-wide, comprehensive insurance coverage for health care costs related to alcohol abuse,

- revitalize state programs to facilitate development of corporate employee assistance programs.

- set and enforce new criteria governing the use of fees for service, and

- allocate funds to the central planning staff for a research program that will improve the quality of data and assessment techniques related to the incidence of alcohol abuse and the performance of alcohol programs in Maine,

I-2. Legislate New Planning Responsibilities

In theory the 1973 act creating OADAP provided a major new mandate for improved planning and coordination of activities related to alcohol abuse prevention, education, treatment, and research in the state. In practice that potential has not been realized. First, OADAP did not meet all the requirements of the act. Second, there has been growth in the alcohol service budgets of other departments. Third, many agencies have come to disregard OADAP's role as central coordinator. Finally,

the Premium Bill eliminated OADAP's authority to enforce its plan on the operational budgets of other agencies. That crucial authority has not been lodged elsewhere. Planning now effectively occurs within the diffuse process that the Commissioners use to develop a joint budget proposal acceptable to the Select Committee. The plan prepared by the Indepartmental Planning Committee does evidence more careful thought about state programs than the fiscal year 1982 submission. But it reflects the absence of any central authority that is empowered to resolve indepartmental conflicts over budget priorities.

We recommend that legislative action institute a small central coordinating staff, independent of the four departments. This group should have clear authority to:

- define the goals and priorities for alcohol services in Maine,
- establish performance indicators for evaluating individual programs and assess the overall progress of the alcohol service system, and
- review and approve the activities and budgets proposed by each of the four departments.

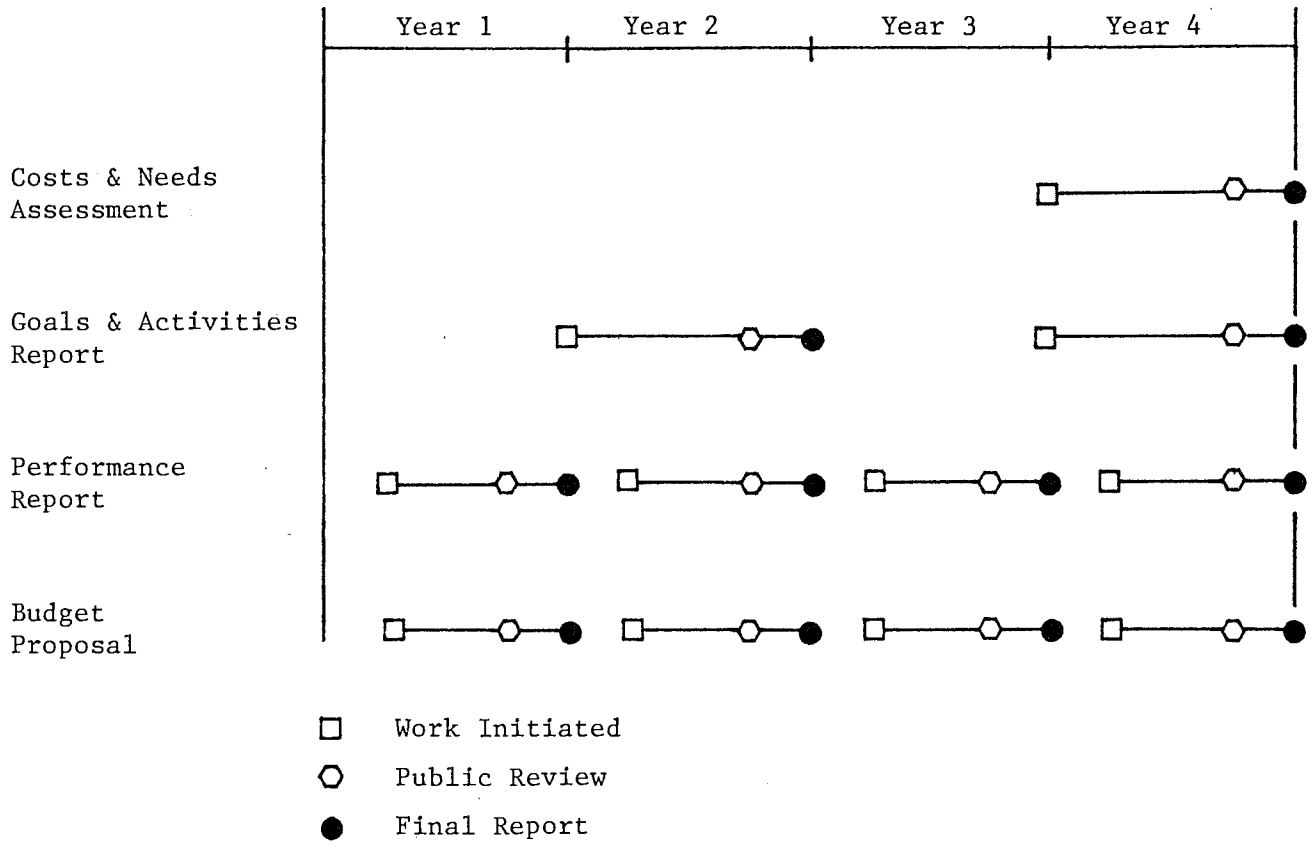
I-3. Implement a Planning Cycle

The coordinating staff should supervise the departments in the conduct of a four year planning cycle which involves four reports:

- a costs and needs assessment (every 4 years),
- a goals and activities report (every 2 years),
- a performance review (every year), and
- a budget proposal (every year).

Figure I-1 illustrates the schedule for these documents. The costs and needs assessment would be compiled by the coordinating staff with assistance from many state agencies. It would describe consequences of

Figure I-1: Proposed schedule for reports in the alcohol program planning cycle.



alcohol use in the state through use of data on many different economic and social consequences. It would incorporate the issues we address in Chapter II of this report, but it would go beyond purely economic issues. For example, it should attempt to estimate the extent of domestic violence associated with alcohol use. Efforts should be made to disaggregate the data by region, income category, demographic features, economic sector and related factors. This assessment must have enough detail for use in designing specific responses, which include goals, activities, and associated performance measures.

The goals and activities report should contain a comprehensive set of goals for each of the costs and needs identified in the current assessment. It is essential that the goals be defined relative to objective measurements. In other words, it must be possible for a third party to perform some measurement or analysis that would permit independent determination of the extent the goal has been achieved. "Improving the quality of life in Maine" would not be an adequate goal statement. "Lowering mortality of teen age drivers by 24 percent," would be a satisfactory goal statement.

A set of integrated service activities should be designed to achieve each goal. The report should include a set of performance indicators that can be used to measure the progress and impact of funded activities. Preparation of this report would be the responsibility of the coordinating staff.

The performance report and budget proposal should be submitted together annually. They would report on the past year's progress toward established goals, would evaluate individual programs, and would indicate the budgets required for the coming fiscal year. The program evaluations and budget proposals should be prepared by each of the departments for the programs they manage. The final reports should be reviewed and approved by the central coordinating group.

I-4. Require Compliance with State Data Standards

The Legislature has requested that, "uniform methods of keeping statistical information shall be be specified for use by public and private agencies, organizations and individuals." We have recommended a procedure for developing these methods, and we have given examples of methods used in other states. To provide maximum incentives for this measure we recommend that the Select Committee deny public funding in the FY 85 budget to any state or private agency that has not begun earnest efforts to comply with the state standards.

I-5. Achieve Insurance Coverage

The legislature should assure comprehensive health insurance coverage for health care costs related to alcohol abuse. Insurance currently bears a small fraction of the alcohol treatment costs in the state, only about 10 percent of treatment costs are currently reimbursed from that source. Insurance coverage will help offset the pressures from imminent reductions in federal support, now 36 percent of total direct expenditures in the state. Corporations would bear the direct costs of the coverage, but our analysis (and experience in other states) suggests that their investment in greater insurance coverage will be quickly repaid through lower rates of absenteeism, higher productivity, and reduced accidents.

Great care should be exercised in defining the conditions of reimbursement. There is already a tendency to use expensive hospital facilities for rehabilitation when much less costly residential or out-patient programs will suffice. One important step will be authorizing either physicians or registered substance abuse counselors to design the treatment plans that will qualify for insurance coverage. We would also suggest that the terms of coverage provide a small financial incentive for the patient to use less expensive programs. This could be done, for example, by making the level of the deductible proportional to the cost of the treatment program.

A side benefit of this policy will be the extra stimulus it provides to industry to create effective employee assistance programs. Currently these are not well developed in the state, even though firms have a significant, direct financial incentive to implement them.

I-6. Facilitate EAPs

In Chapter II we show that the largest single component of cost from alcohol abuse in the state is productivity losses within the corporate sector, $106 million annually. Yet our survey of active alcohol programs shows very little effort specifically directed to corporate employees. We recommend a vigorous effort to stimulate the creation and efficient operation of corporate EAPs. This would entail revitalizing OADAP's program in this area. We would also recommend creation of a "New Ventures Fund" that would provide several model grants each year to support cooperation between corporations and public service agencies in joint programs aimed directly at identifying and assisting alcohol abusers within firms. The annual disbursements under this effort need not amount to more than $50,000, and they could be allocated through competitive grant applications. The criteria to be applied in the program are spelled out in Chapter V.

I-7. Set Standards for Fees

Fees currently constitute a relatively small fraction of costs for treatment programs in the state, less than 10 percent in our survey. When all public services are under significant financial pressure, it seems appropriate for service agencies to define specific standards to guide them in levying and collecting fees. This will require better data on clients. Our survey of data systems suggests that most agencies have little confidence in the information they would need for assessing variable fees. We choose not to recommend specific fee policies, this should be left to joint action by members of MASAP in conjunction with their funding agencies. Of course care should be exercised that the new

policy is not regressive and that it does not deprive those in need of services but unable to pay.

I-8. Fund Planning Research

The 1973 legislation called for research on new planning techniques and tools, "Objective devices and research methodologies shall be continuously developed." However, there have not been significant allocations to efforts that would meet this requirement. With increased pressure on operating agencies, there will be great incentive to avoid public investment in "academic" research. However, modest investment in this area, probably under the discretion of the central planning staff, can do much to enhance the effectiveness of the state's overall program. We recommend explicit allocation of research funds, about $25,000 annually, for pragmatic research on new methods of data gathering, analysis, and performance evaluation.

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter II:

COSTS ASSOCIATED WITH ALCOHOL ABUSE IN THE STATE OF MAINE, 1980

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COSTS ASSOCIATED WITH ALCOHOL
ABUSE IN THE STATE OF MAINE, 1980

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COSTS ASSOCIATED WITH ALCOHOL
ABUSE IN THE STATE OF MAINE, 1980

II-1.Abstract

The current estimate of costs born by those in Maine as a result of alcohol abuse totals $213 million annually. This figure was derived by OADAP from a 1975 national study carried out for the National Institute for Alcohol Abuse and Alcoholism. The NIAAA estimate was adapted to represent Maine by using the ratio of Maine's population to the nation's total population.

To improve on the OADAP estimate, we worked with a group of 22 experts in the state to apply the NIAAA method. With them we:

- estimated the size of each group affected by alcohol abuse,
- estimated the cost of that group's total activity, and
- estimated the fraction of that cost caused by alcohol abuse within the group.

We also conducted an extensive review of the literature to incorporate in our assessment much more Maine-specific data than was used in the earlier estimate. We added several cost components omitted from the national study, and our calculations corrected for inflation. Five principal conclusions emerged from the effort.

1. The cost is extremely high in comparison with the money currently spent within the state to combat alcohol abuse - $700 million versus about $11 million, and every sector of society bears significant costs:

- corporate expenditures on non-productive personnel and reduced income from the sale of inferior products total about $222 million.

- public expenditures on non-productive state employees amounts to almost $40 million.

- individuals lose about $150 million from reductions in personal equity in homes, expenditures on alcoholic drinks, and increased payments for household services.

- the state spends almost $135 million for school and correctional system personnel and facilities that could better be used to provide services unrelated to alcohol abuse.

- losses to individuals, firms, and public agencies from property damage related to alcohol abuse totals nearly $10 million.

- almost $130 million is spent within the medical system for personnel, equipment, and facilities that could better serve other health needs within the state.

2. Well over 50 percent of the costs are related to the value of lost production by those whose efficiency is impaired in the private, public, and household sectors. The allocation of state expenditures does not seem to reflect the importance of lost production.

3. The second principal component of costs lie in health care and social responses - $110 million/year.

4. Motor vehicle accidents, crime, and fire related to alcohol abuse impose very significant personal tragedies in the state, but they together add up to only about 10 percent of the total cost.

5. The data currently gathered in the state do not permit careful analysis of differences in the incidence of alcohol's costs among geographical regions of the state or among all the subgroups of the population.

II-2. List of Figures

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter II:

COSTS ASSOCIATED WITH ALCOHOL ABUSE IN THE STATE OF MAINE, 1980

II-3. Introduction and Purpose

One way to assess the importance of efforts that counter alcohol abuse is to estimate the monetary costs imposed on Maine's citizens, firms, and public agencies by excessive alcohol consumption. When OADAP previously tried this, it employed a national estimate and reduced it in proportion to Maine's population. This exercise lead to an estimate of $213.75 million annually, the figure still used in budget submissions to the Joint Committee.

Part of our project has involved scrutiny of this number, elaboration on it, and adaptation of it to the special circumstances of Maine. In this report we summarize the OADAP study, point out the strengths and the limitations of procedures that use dollar measures for the consequences of alcohol abuse, and lay out our estimation procedures in detail. We indicate why $700 million per year seems to be a better estimate of alcohol's costs.

Even though many factors made our estimate incomplete and inaccurate, our results are nevertheless an important foundation for broad policy discussions in the state. Many of alcohol abuse's most serious consequences cannot be expressed usefully in dollar terms. The trauma of those whose relative has been killed by a drunken driver, the emotional stress of individuals who must live or work with alcoholics, and the lost potential of a child impaired by fetal alcohol syndrome are all

important costs that cannot be equated to a pile of dollars. Even where alcohol's costs are appropriately measured monetarily, the data generally preclude accurate estimates.

Despite these problems, state officials require some estimate of costs imposed on the state by excessive alcohol use. The state's budget is under stress, and federal support of alcohol programs is declining; difficult choices must be made in allocating general revenues between alcohol programs and competing demands. Even where funds are specifically consigned for use with alcohol programs, tough decisions must be made in allocating them among different options for research, prevention, treatment, and education. It may even become important to judge the level of the alcohol premium. All of these require some sense of the relative magnitude of costs imposed by alcohol abuse.

II-4. Past Estimates

Notwithstanding the importance of information about alcohol's costs, there has been little effort to determine their size. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) first brought national estimates to the fore by publishing them in their periodic special reports to the U.S. Congress on alcohol and health. These reports are based principally on an estimation method and on data described extensively in Berry et. al. (1977). Berry and his colleagues were hired by NIAAA to devise the methodology and to prepare the periodic updates. The last figures from this series of investigations are from 1975; they sum to an annual cost of $42.75 billion (Alcohol and Health 1981, pp.65-67).

In their 1982 report to the legislature (Commissioners 1982), the commissioners prorated this 1975 figure to Maine, reducing it by the ratio of Maine's population to the U.S. total. The result is shown in Figure II-1.

Figure II-1: Four components of alcohol's costs were estimated by OADAP to total about $213 million per year.

Component	Cost (million)	Percent
Lost Production	$98.2	46 %
Health Care	63.7	30 %
Motor Vehicle Accidents	25.7	12 %
Crime	14.3	7 %
Social Welfare	9.7	4 %
Fire	2.1	1 %
	$213.7	100 %

The NIAAA estimate contains the following cost elements:

1. Lost Production
   - lost market production of males age 19-59
   - lost military production
   - present value of lost future production of males age 20-64 who died prematurely in the present year

2. Health Care

3. Motor Vehicle Accidents
   - property damage
   - medical care
   - funeral expenses
   - legal and court costs
   - wage loss
   - insurance administration
   - miscellaneous costs

4. Fire
   - lost production
   - medical treatment
   - property damage

5. Crime

6. Social Welfare
   - social welfare
   - alcohol programs
   - criminal justice

Excluded from the NIAAA estimate are such factors as lost production of women, lost value of activities in the household, costs incurred in the school system, costs related to those operating motor vehicles under the influence of alcohol, robbery, and incarceration costs. We designed a procedure that added many of these factors to the estimate, relied more on state data, and gained the consensus of many experts within the state.

II-5. Estimation Procedure

Our effort to develop an improved estimate of costs for alcohol abuse in Maine involved three phases. First we reviewed the literature proposing cost estimation procedures. Then we convened a meeting of 17 Maine experts on different aspects of alcohol abuse within the state. This group worked through one, day-long meeting and a shorter follow up session to determine the principal components of the cost estimate. They developed the general procedure (usually in the form of an equation) for estimating each aspect of cost. They also gave us a preliminary set of estimates for those numbers on which reliable statistical data are missing, for example the percentage of the elderly who are alcohol abusers. Finally, we analyzed state records for data that could be used to carry out the analysis, and we presented the preliminary results of our efforts to the advisory group for their comments and suggestions. Our work was reviewed by the initial group plus five others in the state who had special expertise relevant to the task. The list of 22 advisors is provided in Figure II-2.

Of course we accept full responsibility for the resulting estimate, but it is drawn largely from the combined insights and practical experience of this group. None of our advisors will accept all components of our work without question, but the group agreed that the result of our work is the best currently available estimate of the monetary costs of alcohol abuse in Maine. In a later chapter of this report we will outline the need for and the methods for developing even better estimates of this important parameter.

II-6. The Estimate of Costs

Our analysis suggests the annual costs of alcohol abuse in Maine approximate $700 million annually. Two facts are principally responsible for the significant increase of our estimate over the NIAAA number. First, inflation averaged nearly 10 percent between the beginning of 1975 and the end of 1980. This alone would raise the figure to $379

million in current dollars. Second, our estimate includes lost production in the household at $153 million annually, and it incorporates a more comprehensive set of social response costs. As a result, the relative importance of different cost components is changed slightly. Lost production costs were 46 percent of the total in the original NIAAA figure; now they are 57 percent. Social response costs have grown from 4 percent to 17 percent of the total. The relative cost of health care has fallen from 30 percent to 16 percent of the whole. Motor vehicle accident costs are now estimated to be 5 percent of the total, compared with 12 percent in the original study. The results are shown in Figure II-3.

Representative Susan Bell

Senator Beverly Bustin

Robert Clark, Health Cost Review Board

Edgar Curtis, Union Mutual

Martha Freeman, Legislative Assistant

Karen Foster, Blue Cross/Blue Shield

Madonna Fullerton, Department of Education and Cultural Services

Beverly Gilcreast, State Planning Office

Arnold Gross, Maine AFL/CIO

Andy Loman, Maine Association of Substance Abuse Programs

Dick Loomer, National Council on Alcoholism in Maine

James Montell, Department of Public Safety

Jamie Morrill, Department of Mental Health and Retardation

James Orser, Union Mutual

Senator Tom Perkins

Rob Pfeiffer, Family Violence Center

Tom Reardon, State Police

Gerald Sampson, Department of Corrections

Miles Tremper, Department of Human Services

Linda Wilcox, Department of Human Services

Susan Wygal, Department of Mental Health and Mental Retardation

David Ells, Private Consultant

Figure II-2: Twenty-two advisors in Maine helped compile our estimate of costs associated with alcohol abuse.

Cost Category	Million Dollars	Percent
Lost Production	398.7	57
Health Care	113.3	16
Motor Vehicle	35.3	5
Crime	28.5	4
Fire	1.6	1
Social Responses	115.4	17
TOTAL	692.8	100

Figure II-3: Six areas of costs from alcohol abuse totaled almost $700 million annually in Maine in 1980.

II-7. Allocation of Potential Savings

All the individuals contributing to our cost survey generally agree with the resulting estimate. However, most people find the number is too large and its impact too ambiguous for it to be immediately meaningful. It cannot be related readily to policy alternatives available to individuals, firms, social service groups, or state agencies. The estimate combines many different categories of cost, and it does not distinguish clearly just who would profit directly from reductions in alcohol abuse. In this section we will recast the total to show the general nature of the savings that could come from more successful alcohol programs.

Two facts make it impossible to allocate these potential savings precisely. The costs belong to quite different categories, and the locus of the ultimate saving is often unclear. Elimination of some cost categories would produce immediate gains in wealth. For example, if expenditures on alcohol were reduced, there would be an immediate and direct rise in the wealth of consumers. Elimination of other cost categories would not lead immediately to reduced expenditures. For example, if the time of school personnel spent in disciplining alcohol abusers

could be lowered, there would not be an immediate reduction in school budgets. The personnel would still draw their salaries; they would merely allocate their time to other important needs within the school system. This shift would be very desirable, but it would not produce immediate financial savings.

All of the alcohol costs we tabulated are ultimately borne by individuals, primarily those living within Maine. However, an extensive period may lapse before the savings are visible. Also the agencies that spend the money we have summed up generally would transfer any savings from reduced alcohol abuse to other agencies or individuals in the state. As examples, the expenditures we tabulated within the household sector have a fairly direct bearing on personal wealth. The costs of excess or inefficient personnel in companies is reflected in higher product prices. Were alcoholism by corporate employees to be reduced, consumers would benefit from lower prices and stock holders would receive higher dividends. Of course inflated public budgets are translated directly into higher personal and corporate tax burdens.

Nevertheless, it is possible translate our calculations into estimates of the financial savings that would be available to different groups in Maine, if alcohol abuse could be reduced.

The total figure, $692.8 million, may usefully be divided into six categories.

Corporate expenditures on non-productive personnel and reduced income from the sale of inferior products total about $219.8 million annually. If alcohol abuse were eliminated, the cost of companies' salaries and wages would be reduced quickly and dramatically. The savings would be in the form of lower payrolls or of increased output from the same staff. Numerous firms have experienced these savings when they have implemented vigorous programs to reduce alcohol abuse by their employees.

Public expenditures on non-productive state employees amount to approximately $39.3 million every year. It seems likely that reduced alcohol abuse by public employees would not lead to lower budgets; the savings would be manifest though better and more comprehensive services.

Reductions in personal equity in homes, expenditures on alcoholic drinks, and increased payments for household services cost Maine citizens around $153.1 million each year. The deterioration in homes eventually shows up through increased maintenance expenses or lower sales prices. In either case, the result is directly felt by homeowners. The money spent on alcohol would also, of course, be available for other purposes if alcohol abuse were eliminated. The impact of lost production in the home is less clear. In part alcohol abusers must pay others to perform services that they have neglected. In part the loss takes the form of lower quality of life. If alcohol abuse could be eliminated, much of this $150 million annually would be added to the discretionary wealth of Maine citizens.

Annual state expenditures for school and correctional system personnel and facilities that could better be used to provide services unrelated to alcohol abuse are estimated to be $133.9 million. Total success by alcohol programs would probably not reduce social service costs by this amount. Instead the people and facilities now occupied by alcohol abusers would be free to perform other valuable services to state citizens.

Losses to individuals, firms, and public agencies from property damage sums to $8.9 million per year. Much of this loss is insured, but elimination of alcohol abuse would lead to lower insurance premiums or higher insurance company dividends, both tangible gains. However, there is some possibility that the reductions would be distributed across policyholders in many states, so the savings would not accrue solely in Maine.

Expenses within the medical system for personnel, equipment, and facilities that could better serve other health needs within the state

amounts to about $127.1 million annually. Some of these expenditures would be diverted to other pressing health needs, but some of them would be saved. The result would be significant savings to individuals within the state.

II-8. General Notes on Our Calculations

1. All costs are in million 1980 dollars. We used 1980 data whenever they were available. When we could only obtain figures for some year other than 1980, the consumer price index was used to adjust the available numbers to their equivalent 1980 values. All costs are rounded to the nearest $100,000 for computational convenience. In fact the accuracy inherent in our data and assumptions does not warrant such precision, so all our results should be understood to contain no more than two significant figures. For example, 113.3 is not significantly different from 110.

2. Generally we used an equation in the form:

COST OF ALCOHOL ABUSE FROM AN ACTIVITY	=	TOTAL ANNUAL COST OF THE ACTIVITY	X	FRACTION OF THE ACTIVITY ATTRIBUTABLE TO ALCOHOL ABUSE

However, a different approach was used to estimate the costs of lost production.

3. All 36 of the written source materials cited in the text are listed at the end of the report. When no written source is mentioned, our figures were drawn from the educated estimates of our advisory committee.

4. Each principal component of our cost calculations is arrayed in a table with several rows (horizontal lines) and columns (vertical lines). The rows are numbered - 1,2,3 etc. The columns are lettered - A,B,C, etc. Thus each cell, or square, in the table has a unique identifier, for example the upper left hand cell is A1. These identifiers

are used in the text to explain the source off all numbers or assumptions used in each table.

5. A "?" was placed in a cell when we chose not to attempt an estimate for the cost of alcohol abuse associated with that particular activity. Our decision was not based on any estimate of the cell's relative importance. Indeed some of the activities left only with a question mark are undoubtedly very costly in Maine. A "?" means only that the group had not even an informed opinion about the numerical values of the factors that would be involved in estimating the cost.

Our calculations are summarized in six figures, one for each of the principal cost components - lost production, health care, motor vehicle accidents, crime, fire, and social responses. Following each figure we provide extensive notes explaining our assumptions and calculations. This description serves to indicate the source of our estimate; it also provides the starting point for those who will later work to refine and update our analysis.

II-9. Estimate of Lost Production

Figure II-4: Seven components of production lost from private organizations, the public sector, and households due to alcohol abuse in Maine totaled $398.7 million in 1980.

A	B Private Organization	C Public Sector	D House-hold	Totals
1. Cost of time lost by labor force	106	28	43.8	177.8
2. Cost of compensatory labor	42.5	11.3	?	53.8
3. Cost of poor quality workmanship	71.3	?	?	71.3
4. Loss in house equity	--	--	11.8	11.8
5. Opportunity cost	?	?	97.5	97.5
6. Cost of poor management	?	?	?	
7. Human damage	?	?	?	
TOTAL	219.8	39.3	153.1	412.2
Less Double Counting[1]				- 13.5
				398.7

[1] Production loss from motor vehicle accidents, crime, and fire. See Figures II-6, 7, and 8 for details.

A1:

It is commonly assumed that about 10 percent of all employees abuse alcohol (Alcohol and Health 1981, p. 41 and EAP 1974, p. 16). It is also generally agreed that 25 percent of the productive efforts of these employees are wasted because of their alcohol consumption (EAP 1974, p. 34) and Pratt and Whitney 1976). "Lost Production" is an estimate of the many ways employers are forced to pay for this loss in productivity. The costs tallied in row 1 of Figure II-4 are the salaries wasted on

employees during their periods of low productivity. The equation used here is:

$$ML = E \times AS \times FA \times PLA$$

where:

ML	is	monetary loss ($ per year)
E	is	number employed (employees)
AS	is	average salary ($/year/employee)
FA	is	fraction affected (assumed to be 0.1)
PLA	is	productivity loss of those affected (assumed to be 0.25)

B1:

E	=	357,000 (1981 figures, DOL 1982a, Table 25 and DOL 1982c, p. 9)
AS	=	11,900 (DOL 1982b, p. 7)

C1:

E	=	98,000 (DOL 1982a, Table 25 and DOL 1982c, p. 9)
AS	=	11,500 (DOL 1982b, p. 7) Federal employees are assumed to earn as much as state employees.

D1:

People not only produce valuable goods and services within firms and public agencies, they also create useful output within their homes. Because most of this product does not move through established markets, it has traditionally been ignored. But it is important. When alcohol abuse lowers household production, either those in the home must spend extra money to replace the lost output, or they have a lower level of consumption and welfare. Our advisory group chose to estimate the loss in the following way:

E	=	250,000 half time or 125,000 full time worker equivalents. This would mean that of the one million residents in the state, roughly ¼ spend an average 20 hours a week working in the home to provide services such as child care, cooking, and maintenance. This includes the unemployed, those not seeking employment, the young, the elderly, and people working after their regular jobs are completed each day.
AS	=	$3.5/hour x 40 hours/week x 50 weeks/year = $7000/year. Since most household production is not sold in any competitive market, we use the minimum wage of $3.50 per hour as a conservative estimate of lost value.
FA	=	0.1 (Alcohol and Health 1981, p. 41)
PLA	=	0.5 We assumed the productivity loss of home-based abusers is 50 percent, because the home environment lacks the work discipline of a firm.

A2:

This item is the cost of hiring extra workers to compensate for the reduced productivity of alcohol abusers, the cost of higher turnover, and the cost of dealing with alcohol abusers. Examples are the salaries of health personnel, safety and training staff, extra personnel administrators to deal with grievances, EAP staff, and quality control personnel. The formula we used is:

$$ML = E \times AS \times CE$$

where ML, E, and AS have the same meaning as above and CE is the compensatory effort estimated at 1 percent of the total work force.

B2:

357,000 x 11,900 x .01 = 42,483,000 ($/year)

C2:

98,000 x 11,500 x .01 = 11,270,000 ($/year)

D2:

We did not estimate costs of compensatory efforts in the household.

A3:

One effect of reduced productivity is the production of inferior goods. As a result, additional quality control procedures and staff are needed, or products are discarded or sold at a discount. The formula we used is:

$$ML = VP \times FAIP$$

where

VP	is	the value of products ($/year)
FAIP	is	the fraction lost through inferior production, estimated at 1 percent.

B3:

The total cost omits services; we included only manufactured output, though compensatory labor is also required in the service sector.

VP = $7,134 million (DOL 1982d, Appendix D)

C3:

No data are available.

D3:

No estimate has been attempted for households.

A4:

Houses and dwellings derive some of their value from the constant maintenance work done by their inhabitants. Part of the economic impact of alcohol abusers comes from the deterioration of their dwellings over and above "normal wear and tear." Our group had some question about this component of costs, but is is a relatively minor constituent of the total.

$$ML = HU \times AVHU \times FA \times FAV \times AVL$$

where

HU	is	housing units (Census 1980, Table2)
AVHU	is	average value of housing (Census 1980, Table2)
FA	is	fraction of alcohol abusers (.1)
FAV	is	fraction of abusers affecting the value of their dwelling without compensation by others in the household. We guessed this might be 20 percent.
AVL	is	additional value lost from the house each year (5 percent).

D4:

$$350{,}000 \times \$33{,}800 \times 0.1 \times 0.2 \times 0.05 = \$11{,}830{,}000$$

A5:

This is the opportunity cost; it represents the value consumers might have realized if the money spent on alcohol had been spent instead on productive goods and services. We approximate this simply by calculating the expenditures by alcohol abusers on the liquor they consume. Each year $64.4 million is spent on liquor (Financial Report 1981, p. 86). We estimate that 50 percent of those expenditures are from alcohol abusers:

$$64.4 \times 0.5 = 32.3$$

In addition, 25.8 million gallons of beer, 1.8 million gallons of table wine, and 0.09 million gallons of sparkling wine were sold in that year (PC 1982a). We estimated the average price per gallon of beer, table wine, and sparkling wine at $4.50, $7.50, and $10 respectively. Thus the total expenditure for beer and wine per year is $130.5 million. We assumed that half of those expenditures are by abusers, $65.3 million. Thus the total opportunity cost of alcohol purchases (in $ million) is:

$$\$32.2 + \$65.3 = \$97.5$$

A6:

Members of our advisory group offered anecdotal evidence of enormous losses suffered by organizations in which a few senior managers' effectiveness was impaired by alcohol abuse. Faulty judgement can lead to serious personnel problems, loss of market share, and even bankruptcy. We considered these costs to be important, but we found them impossible to estimate with any confidence.

A7:

Much physical and psychic trauma is caused by those under the influence of heavy drinking. We consider these costs to be very important, but they are impossible to estimate with any confidence.

II-10. Estimate of Health Care Expenditures

Figure II-5: Fourteen categories of health care expenditures related to alcohol abuse in Maine totaled $113.3 million in 1980.

A	B	C	D
	Total Expenditure	Percent Attributable to Alcohol Abuse	Cost of Alcohol Abuse
1. Hospitals	422.2	15	63.3
2. Nursing Homes	115.6	10	11.6
3. Physicians	169.9	15	25.5
4. Drugs & Sundries	88.5	15	13.3
5. Underwriting Gain		2-3	.1
6. Mental Health & Mental Retardation			
6.1 State Mental Hospital System	5	50	2.5
6.2 Group Homes	3	30	1
6.3 AMHI Adolescent Unit	.6	50	.3
6.4 Community Mental Health Centers	15	15	2.3
6.5 Inpatient Psychiatric Care	7	30	[2.1]
6.6 Pineland [1]	12	10	1.2
6.7 State Hospitals	20	30	6
6.8 Special Projects		?	?
TOTAL			127.1
Less Double Counting [2]			-13.8
			113.3

[1] Center for the severly retarded.

[2] Health care expenditures from motor vehicle accidents and crime. See Figure II-6, 7, and 8 for details.

All costs other than mental health and mental retardation have been inflated by 13.5 percent from the original 1979 figures to arrive at the

1980 costs. No adjustments have been made to account for any other change from 1979 to 1980. Cost data are from HCEM (1982).

The costs of dentists, other professionals, eyeglasses, prepayment, and administration, government public health services, and all other health services have been excluded.

All estimates relating to mental health and mental retardation were supplied through personal communication by the Planning and Review Division of the Department of Mental Health and Mental Retardation.

C1:

The task of assigning a proportion of health care cost to alcohol abusers is very difficult in the absence of conclusive evidence of causative links between alcohol abusing behavior and health cost. Thus, we have consistently used estimates from the lower end of the range of percentages commonly in use. The 15 percent estimate in the case of hospital expenditures derives from data gathered at the Mary Hitchcock Memorial Hospital, Hanover, N.H. That study found that 1 percent of the costs were attributed directly to treatment of alcohol-related problems; 14 percent were for problems that stemmed indirectly from alcohol abuse.

D:

Column 3 = Column 2 x 0.01 x Column 1

C6.1:

50 percent of the patients come from alcohol abusing families, and 20 percent are alcohol abusers themselves. The percentage of the total cost attributable to alcohol abuse is therefore 50 to 70 percent.

D6.5:

Hospital-based psychiatry expenditures are already counted in D1.

A6.8:

Special projects vary in content and duration. Their general cost cannot be accurately estimated. Many health-related special projects in

Maine are related to effects of alcohol abuse, such as the Cumberland County sexual abuse project, but some are not. Their general cost cannot be accurately estimated.

II-11. Estimate of Motor Vehicle Accident Costs

Figure II-6: Four categories of cost associated with motor vehicle accidents caused by alcohol abuse in Maine totaled $35.3 million in 1980.

A	B	C	D
	Total Cost	% Caused by Abuse	Alcohol Abuse Cost
1. Lost Production	21.4	50	10.7
2. Property Damage	13.0	50	6.5
3. Health Care	25.5	50	12.8
4. Criminal Justice	5.3	100	5.3
TOTAL			35.3

As far as possible we have assigned motor vehicle accident costs to the incidents causing them. Thus medical expenses resulting from a car accident are accounted for in this section rather than in the health care sector. To do this, we had to use some rather arbitrary cost estimates. We judged this to be warranted, since it permits costs to be assigned to their proper causes. This is important, because society's responses to drunken driving will be quite different from its responses to health care costs caused by chronic alcohol abuse. This is true even though almost all of both types of cost are incurred in the same location, namely the health care sector.

A1:

Lost production is calculated with the following equation:

$$ML = (PV(AS) \times FT \times AER) + (PI \times PA \times AS \times AER)$$

where

ML	is	money lost ($ million/year)
PV(AS)	is	the present value of annual salaries ($ million)
FT	is	number of fatalities
AER	is	average employment rate
PI	is	number of persons injured
PA	is	percent affected, the average percent of the work force missing from work because of injuries
AS	is	annual salary of the average worker ($/year)

The net present value is:

$$PV(AS) = AS \frac{(1 + i)^n - 1}{i(1+i)^n}$$

where

AS	is	annual salary in constant dollars ($/year)
i	is	the discount rate
n	is	the number of years the salary would have been earned

We use

$$PV(AS) = 11{,}000 \times \frac{(1+.1)^{30} - 1}{.1(1 + .1)^{30}} = 103{,}696$$

We assume the salary is lost for 30 years, since the majority of fatalities involve people 30 years or younger (Vital Statistics 1980, Table 12), and average retirement age is 60 years or over. Our discount rate is quite high, 10 percent; thus it tends to minimize the present value of lost future earnings. A second conservative assumption is that there would be no increase in the real earnings of those killed today.

$$ML = (103{,}696 \times 217 \times 0.9) + (12{,}000 \times 0.01 \times 11{,}000 \times 0.9)$$
$$= 20.2 + 1.2 = \$21.4 \text{ million}$$

B1:

Post mortem data for fatal accidents show a minimum 50 percent incidence of excessive levels of alcohol in the body at the time of the accident. The use of the 50 percent figure for other accidents is an extrapolation.

A2:

ML = DPA x NAC

where

DPA	is	damage per accident ($/accident)
NAC	is	number of accidents
ML	is	500 x 26,000 = $13 million

The number of accidents, types of accidents, and fatalities were obtained through personal communication from the Department of Public Safety (PC 1982b).

A3:

About 1/3 of all accidents result in a personal injury to the 1.5 persons involved, on average, in each accident. We estimate medical expenditure at $2000/injury. Thus:

8,500 x 1.5 x $2000 = $25.5 million

A4:

Criminal justice costs related to those operating under the influence of alcohol were obtained through personal communication (PC 1982b).

Law Enforcement:

10,000 OUI arrests at 3 hours/arrest of officer time at $15/hour:

10,000 x 3 x $15 = $450,000

mileage at $.20/mile for the 20 miles involved in a typical arrest:

10,000 x $0.2 x 20 = $40,000

The total is $490,000

Testing:

85 percent of those arrested are tested

35 percent of those tested take the blood test at $45/test ($5 equipment, $20 analysis, and $20 physician fee):

10,000 x 0.85 x 0.35 x $45 = $133,875

35 percent of those tested take the breath test at $25/test:

10,000 x 0.85 x 0.35 x $25 = $74,375

30 percent of those tested take the intoxylyser test at $.25/test:

10,000 x 0.85 x 0.3 x $.25 = $637

The total is $208,887

Court:

90 percent of those arrested come to court at $150/trial:

10,000 x 0.9 x $150 = $1,350,000

of those, about 2000 go before a jury at an additional $1500/trial:

2000 x $1500 = $3,000,000

of those 15 may be exceptionally expensive, involving an additional $15,000/trial:

15 x 15,000 = $225,000

The total is $4,575,000

Incarceration, probation, and parole expenses are also significant, but no estimate for them is included in this analysis.

C4:

The total criminal justice expenses total $5.3 million. All of this is attributable to alcohol abuse, since the calculations only dealt with alcohol-related criminal justice expenses.

II-12. Estimate of Criminal Offense Costs

Figure II-7: Four categories of cost from criminal offenses caused by alcohol abuse in Maine totaled $28.5 million in 1980.

	A Total Cost	B % Caused by Abuse	C Alcohol Abuse Cost
1. Lost Production	2.7	67	1.8
2. Property Damage	17.7	10	1.8
3. Health Care	3.	30	1.
4. Criminal Justice	23.9	100	23.9
TOTAL			28.5

A1:

Lost production results when violent crimes - murder, rape, robbery, and aggravated assault - remove their victims from the workplace. The least ambiguous area of lost production resulting from any of these crimes is when the victim is murdered. We have not included in the calculations production lost while the victim recovers sufficiently to begin working again. We have used an approach here similar to that employed in estimating lost production from motor vehicle fatalities, see Figure II-6, Note A1.

$$ML = PV(AS) \times NMD \times AER$$

where

PV(AS)	is	the present value of future earnings lost by those who are murdered
NMD	is	the number murdered
AER	is	the average employment rate

Vital Statistics (1980, Table 12) shows the average age of those killed to be around 40 years; therefore, an income stream of about 20 years is lost:

93,600 x 32 x 0.9 = $2,695,000

Since lost production from other crimes is left out of our estimate, the true cost is considerably higher.

B1:

Berry et. al. (1977, p.154)

A2:

Crime (1981, p. 49) deflated to 1980

B2:

Berry et. al. (1977, p. 164) does not develop an estimate for this category. We chose to use a very conservative figure of 10 percent.

A3:

In 1980 there were 32 murders, 145 rapes, and 1,618 aggravated assaults reported to the police (Crime 1981, p. 14). This is a total of 1,795 crimes where, by definition, severe personal harm was done. We guessed the average medical cost may be $2000 per incident:

1,795 x $2000 = $3,590,000

B3:

Berry et. al. (1977, p. 154)

A4:

Law Enforcement ($ million)

State Policy	12.6	(Budget 1982, p. 516)
Sheriffs	3.8	(CFS 1977-1980)
Municipal Police	18.0	(1200 officers (Crime 1981, p. 71) x estimated cost of one officer.
TOTAL	34.4	

To estimate the cost of one officer, we divided the county expenditures on sheriffs by the total number of sheriffs.

Courts ($ million)

State Judicial Expenditure	9.6	(Budget 1982, p. 356)
Court Judicial Expenditure	3.0	(CFS 1977-1980)
TOTAL	12.6	

Incarceration ($ million)

Maine State Prison	4.9	(Budget 1982, p. 428)
Maine Youth Center	4.0	(Budget 1982, p. 432)
Correctional Center	3.4	(Budget 1982, p. 414)
Probation & Parole	1.5	(Budget 1982, p. 430)
Correctional Services	0.8	(Budget 1982, p. 408)
County Support of Prisoners	3.3	(CFS 1977-1980)
TOTAL	17.9	

	Cost	% from Alcohol	Cost of Abuse
Law Enforcement	34.4	30	10.4
Courts	12.6	50	6.3
Incarceration	17.9	70	12.5
			29.2
Less double counting from motor vehicles			- 5.3
			23.9

B4:

We use the figure 100 percent, since the original cost figure was derived only from those activities directly associated with alcohol abuse.

II-13. Estimate of Fire Costs

Figure II-8: Four categories of cost from fire damage caused by alcohol abuse in Maine totaled $1.6 million in 1980.

	A Total Cost	B % Caused by Abuse	C Alcohol Abuse Cost
1. Lost Production	2.0	50	1.0
2. Property Damage	8.9	7	.6
3. Health Care	?		
4. Social Responses	?		
TOTAL			1.6

A1:

Lost production from fires is calculated similarly to the motor vehicle lost production (Figure II-6, Note A1). Vital Statistics (1980, Table 12) shows that 26 people died of "fire and flames" with a mean age of about 45 years. Thus an income stream of 15 years was lost on average for each:

$$\$86,000 \times 26 \times 0.9 = \$2,026,000$$

B1:

Berry et. al. (1977, p. 135)

A2:

PC (1982c)

B2:

Berry et. al. (1977, p. 135)

II-14. Estimate of Expenditures for Social Responses

Figure II-9: Four categories of cost for social responses to problems caused by alcohol abuse in Maine totaled $119.1 million in 1980.

A	B Total Cost	C Percent Attributable to Alcohol Abuse	D Cost of Alcohol Abuse
1. Public Schools	396.0	19	76.7
2. Public Assistance	92.3	30	27.7
3. Family Violence Shelters	0.4	70	0.3
4. Alcohol Activities	10.7	100	10.7
		TOTAL	115.4

The consequences of alcohol abuse are dealt with in Maine's social support systems both through intentional programs and through programs that unintentionally address problems engendered by alcohol. For example, alcohol treatment programs exist for the purpose of treating alcohol abusers. Schools and jails, on the other hand, do not specifically exist to deal with alcohol abusers; they do so by default.

Where programs unintentionally address problems related to alcohol, it is very difficult to determine the alcohol related portions of their total budget. Nevertheless, we have worked to develop crude estimates of the costs involved. However, because of the uncertainties, we have consistently used the more conservative of the estimates commonly in use for any of the factors used in our calculations.

B1:

All figures and estimates in the public school section come through personal communication from the Division of Alcohol and Drug Education Services, Department of Education and Cultural Services.

A. Administrative

- Discipline: Vice Principals and administrators handling disciplinary issues spend 75 percent of their time on problems related to alcohol abuse.
- Suspensions: 75 percent are related to alcohol abuse
- Expulsions: 90 percent are related to alcohol abuse
- Vandalism: 90 percent is related to alcohol abuse, an average of $1800 per school system per year
- Administrative Costs: Superintendents spend 3-4 administrative hours each week dealing with alcohol-related issues

Salaries	=	$12,300,000
Time Involved	=	0.75
		$ 9,200,000

B. Attendance and Health

- School Nurses: At least 50 percent of the child abuse cases nurses deal with involve an alcoholic parent
- School Physicians: At least 50 percent of the time spent by school doctors is on medical problems in some way related to an alcoholic parent

Total Cost	=	$2,300,000
Time Involved	=	0.5
		$1,200,000

C. Instruction

- Classroom Impact: There are significant costs in time, energy, and productivity for teachers who are dealing with disruptive behavior caused by students who are abusing alcohol and by those are affected by the problem in a family member. Their disruption affects the physical and educational well being of all children in the schools.

Salaries + Other Costs	=	$227,900,000
Time Involved	=	0.25
		$ 56,900,000

D. Maintenance

- Maintenance of plant and equipment (includes vandalism by youths under the influence or reacting to home stress

Total Costs	=	$11,600,000
Percent	=	0.025
		$ 300,000

E. Consultants

- Guidance Counselors and School Psychologists: These consultants spend 50 percent of their time with students dealing with issues of alcohol abuse (either by the student or by a member of the student's family); for another 20 - 25 percent of their time alcohol abuse is an indirect issue in their work with students

Total Costs	=	$4,200,000
Time Involved	=	0.5
		$2,100,000

F. Lost Productivity

- Lost Productivity: There are 23,000 teachers, counselors, principals, and superintendents. Ten percent of them have a drinking problem. Alcohol abuse also affects the productivity of the support staff such as bus drivers, cafeteria workers, secretaries, and custodians.

Average Annual Salary	=	$12,400	
Lost Percentage		0.25	
		$3,100	
Ten percent have problems		310	average loss per worker
Total Cost	=	$7,100,000	

This cost is already implicitly included in Table II-4, C1.

G. Lost Subsidies

- Lost Subsidies: The drop outs caused by problems related to alcohol abuse cost the school system an annual subsidy from the

state of $3,400,000. This appears as a cost to the schools, but it is merely a transfer within the state boundaries.

H. Special Education

- Special Education: During the 1980-81 school year there were 7,811 children in grades K-12 who were diagnosed as learning disabled. A significant number of those children (estimated at 60 percent) are experiencing learning disabilities as a direct result of alcoholism within their families. The extra cost for each of these children is $1,500/year.

  Cost of learning disabilities:

  7,811 x 0.6 x $1,500 = $7,000,000

I. Totals ($ million)

Administrative	$ 9.2	
Attendance & Health	1.2	
Instruction	56.9	
Maintenance	.3	
Consultants	2.1	
Lost Productivity	(7.1)	Not tallied here
Lost Subsidies	(3.4)	Not tallied here
Special Education	7.0	
TOTAL	76.7	

B2:

Public Assistance Includes

Child Welfare	2.6	(Budget 1982, p.325)
Social Services	13.0	(Budget 1982, p.326)
Welfare Administration	1.8	(Budget 1982, p.337)
AFDC	61.8	(Budget 1982, p.339)
Food Stamps	3.1	(Budget 1982, p.341)
General Assistance	1.1	(Budget 1982, p.343)
Supplementary Security Income	8.9	(Budget 1982, p.345)
TOTAL	92.3	

B3:

This is the budget figure for five family violence shelters in Maine (PC 1982e). The figure is, however, a poor estimate of the budget that would be required to offer adequate shelters, since 23.5 percent of all assaults reported to the police were identified as domestic violence assaults (Crime 1981, p. 31)

B4:

This category, alcohol activities, includes the cost of all intentional, dedicated state programs initiated to deal with alcohol abuse. They include, but are not limited to:

Treatment	7.144
Education	.837
Prevention	.989
Research	.180
Coordination	1.522
TOTAL	10.67

By including the entire amount, $10.7 million, in the state cost estimate, we neglect a small amount of double counting. For example, some of the funds listed under the category, treatment, were allocated to St. Mary's residential treatment program. That program's budget is also included, implicitly, in the estimate of total hospital expenditures in Figure II-5. Similarly, some of the state's support for the AMHI Adolescent Unit would appear twice in our figures. However, the amounts involved are very small.

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STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter III:

A SURVEY OF PROGRAMS RELATED TO ALCOHOL ABUSE IN THE STATE OF MAINE

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A SURVEY OF PROGRAMS DEALING WITH
ALCOHOL ABUSE IN THE STATE OF MAINE

Table of Contents

A SURVEY OF PROGRAMS DEALING WITH ALCOHOL ABUSE IN THE STATE OF MAINE

III-1. Abstract

Because there was no comprehensive and detailed survey of Maine's alcohol services, we conducted a survey of 168 state programs. We received 134 responses; they are summarized in this chapter. The survey was designed to provide information on the mix of services, the funding sources, the staffing patterns, client characteristics, and evaluation methods associated with the organizations. We also determined the level of confidence respondents had in their answers.

At least $10.7 million is spent annually on direct alcohol services. These services strongly emphasize treatment, 67% of the total. Prevention and education activities receive 17% of the funds, and coordinating activities account for 14%. Research activities represent only 2% of the total.

The state of Maine is the leading source of financial support for these programs, 38% of the total. The Federal government is a close second, 36%. Fees and health insurance reimbursements contribute only 6% and 8% respectively. Private, county, municipal, and other sources make up the difference, 14%.

Staffing patterns strongly emphasize direct service and the use of volunteer effort. Paid staff are concentrated in the formal service programs and state agencies. Volunteers are the primary support of school programs, advocacy groups, regional councils, and professional groups.

Overall, there is a disturbingly low level of confidence in data gathered by programs on the characteristics of their clients. Information on many important attributes of clients is not collected at all. As a consequence, it is impossible to eliminate doubling counting in the data. Forty percent of the programs in our survey conduct no follow-up studies on their clients after their release.

III-2. List of Figures

List of Figures (cont.)

Chapter III:

A SURVEY OF PROGRAMS DEALING WITH ALCOHOL ABUSE IN THE STATE OF MAINE

III-3. Introduction and Purpose

Any guidelines developed to alter investment of public funds in Maine's alcohol programs must be based on a clear impression of current activities. There have been a number of alcohol service directories compiled by different organizations within the state, for example:

- Alcohol and Drug Abuse Services in the State of Maine (OADAP/DHS)
- Where to Go for Help: Alcohol and Drug Abuse Services (ERCADA)

However, these were created for purposes quite different than those of the Joint Committee, and they omitted activities and data essential to us in our study. Thus we developed a comprehensive list of 168 programs involved in alcohol abuse prevention, education, research, and treatment. This chapter describes our survey of these efforts and summarizes their principal features.

Our survey had four chief goals:

- compile a set of descriptive data that could be used to illustrate the magnitude and the scope of alcohol services in Maine;
- understand how each program's staff used information to manage and evaluate their own efforts;

- discover the level of confidence in the existing information systems; and

- present the collected data in a way that provides a useful model for future planning efforts by state agencies.

Descriptions of the individual agencies and activities included in our survey are provided in Chapter VI. In this chapter we describe the seven different types of organizations included in our study. We summarize program expenses, funding sources, staffing patterns, and client characteristics for the state and for each of the five regions within Maine. We discuss the way data are collected and analyzed by the agencies, and we outline our survey method. The results in this chapter are an important foundation for the recommendations that have emerged from our work.

III-4. Surveyed Groups

Because the consequences of alcohol abuse pervade all sectors of society, public and private response to alcohol-related problems is widespread. There is virtually no institution in Maine, employing staff, that has not responded in some way to alcohol abuse. Government agencies, industries, schools, families, volunteers, and professional societies all respond in a variety of ways to alcohol abusers and alcoholics. Often the investments or policies involved are not recognized, explicitly as alcohol-related. Instead, they are viewed as responses to absenteeism, or criminality, or mental illness and retardation, or careless work habits, or other symptoms of excessive alcohol consumption. Nevertheless, in practice they are part of the state's alcohol response system. We recognize the importance of all these activities in reducing the ultimate cost of alcohol abuse. However, to help the Select Committee fulfill its charter, we have focused our attention only on the activities that are explicitly addressed to alcohol abuse.

Even within the formal alcohol services system there exists a wide range of groups, each with different approaches and roles. In our survey we differentiated among seven types:

- state agencies
- school-based teams
- service providers
- regional volunteer groups
- employee assistance programs
- advocacy groups
- professional associations

A complete list of the programs in these groups and a description of their individual efforts is given in Chapter VI.

State Agencies

State agencies in Maine exercise a combination of planning, management, evaluation, and service responsibilities. There are activities in most state agencies that have some useful influence on alcohol problems. We surveyed all four of the agencies (with their component programs) that have some formal responsibility to address alcohol-related problems in Maine.

School-based Teams

At the time of our survey, approximately 30 school-based teams had participated in the training programs conducted by the Division of Alcohol and Drug Education Services of DECS. Each group is composed of school and community members committed to reducing alcohol-related problems within their school's population of students and employees. The teams are comprised principally of volunteers; generally they have a very small budget. These programs have been described separately in a short summary that is included in the state summary. Their budgets and volunteers are included in the state summary; however, they did not, in general, provide information that could be used to describe the populations with which they work. Our survey obtained information on 23 of these efforts.

Service Providers

Seventy-six service providers responded to our survey. Included in this category is a diverse group of programs whose primary purpose is to provide some type of treatment, education, or prevention services. These programs are generally staffed professionally, and they have significant budgets, even though their efforts are often supplemented

with volunteers. This group includes counseling agencies, hospitals, free-standing clinics, and a variety of other organizations. The survey generally included only those service providers that have alcohol services as a specific, formal component of their program. We did include in the survey a number of agencies without formal alcohol programs. In many cases, however, these agencies were unable to provide us with specific information on their alcohol activities and clients with alcohol problems. These included, among many, several community mental health centers, most group homes for children, and some hospitals. There are indications that these programs encounter a large number of alcohol-related problems while dealing with their in their caseloads. Effective coordination of alcohol service activities with these programs can broaden the availability of services without an increase in the expenditure of additional funds.

Regional Volunteer Groups

The five regional volunteer groups have a specially defined role in Maine. Called regional councils, these groups are responsible for communicating the needs of their region to state government and for providing input useful in the coordination of services within their region. In addition, each of the councils has taken on serious, additional responsibilities that involve education and prevention efforts. Each council has a paid executive director or coordinator, and all five receive some financial support from the state. They are also supported by extensive volunteer efforts.

Employee Assistance Programs

Our survey included 13 employee assistance programs (EAPs). This type of program is developing in the state as a private sector response to alcoholism, alcohol abuse, and other employee problems. The active EAPs in Maine are supported by individual firms. Management for each program comes either from each company's staff or from outside consultants under contract to each firm. In some cases, treatment for alcohol abuse is covered by the firm's health insurance plan.

Advocacy Groups

In Maine we identified two statewide advocacy groups. They are based primarily on volunteer effort. While they are not formally affiliated with any other program, these groups do seek to publicize the needs associated with alcoholism and alcohol abuse.

Professional Associations

Four organizations currently exist in Maine to represent professionals in various parts of the alcohol service field. These organizations promote the exchange of service techniques, facilitate communication among their members, and provide them with a unified voice in the discussion of state-level policy questions.

III-5. State Summary

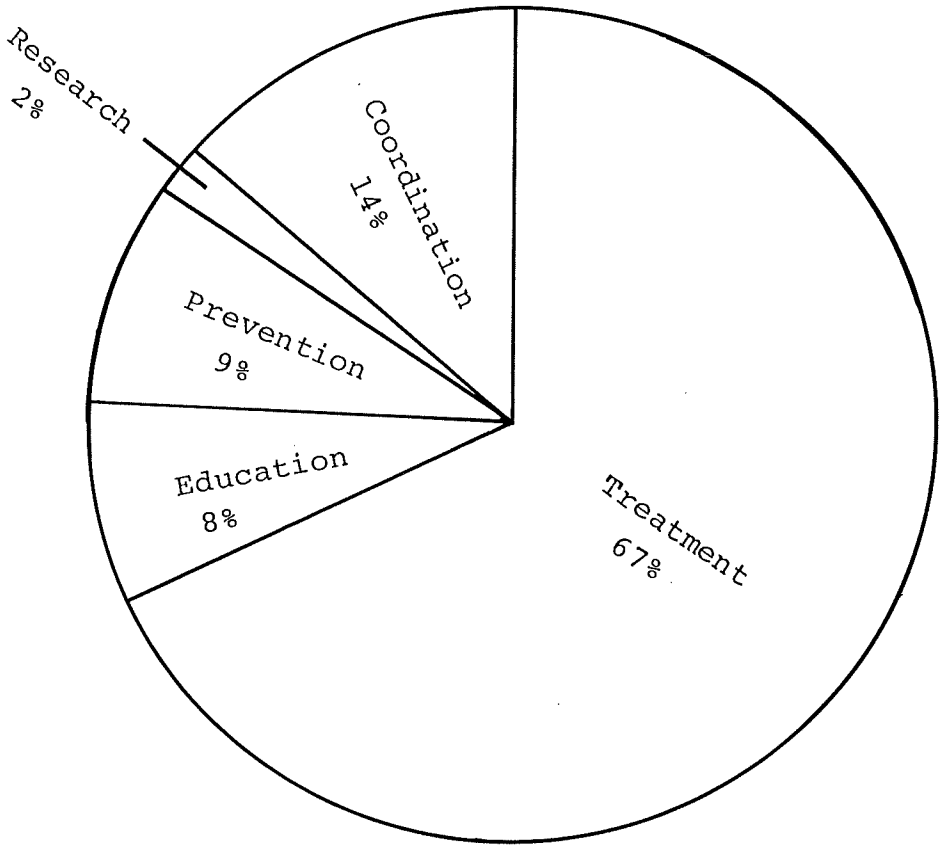
Alcohol services in Maine could be characterized in several different ways. In this statewide summary we concentrate on the features that are most relevant to discussions of Premium Bill allocations: expenditures and budget sources, staffing patterns including volunteer efforts, client characteristics, procedures for data collection and management, program evaluation methods, and staff qualifications.

Expenditures and Budget Sources

The agencies we surveyed reported total expenditures of approximately 10.7 million dollars on various alcohol services in Maine in 1982; Figure III-1 illustrates their distribution. Treatment accounted for two-thirds of total costs, 67%. Education and prevention combined received only 17% of the allocations. Research was a miniscule 2%, and interprogram coordination accounted for the remainder, 14%. Coordination includes interagency coordination, grant management planning and other related activities.

The heavy emphasis on treatment is offset partially by the proportionately greater reliance of prevention and education service providers on volunteer effort. The discussion of staffing patterns will illustrate this point later.

Figure III-1: Expenditures for alcohol services in Maine, by category (1982 $).



State agencies and service providers accounted for 98% of the expenditures reported. State agencies contract out approximately two-thirds of their combined budget; most of the rest is allocated to contract management and coordination. Only 15% of their budget goes to direct services in treatment, education, prevention, and research.

Service providers emphasized treatment most heavily with about 82% of their expenditures related to treatment services; the remainder went to education, prevention, research, and coordination.

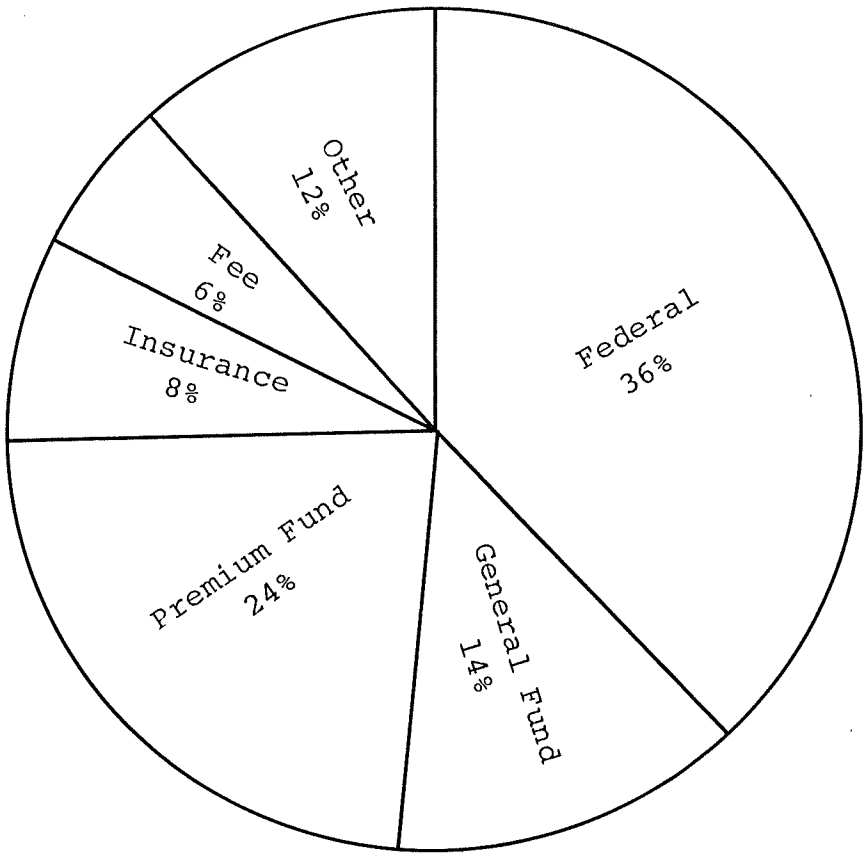
Other program types spent only 2% of the funds officially allocated to alcohol abuse and addiction. Their efforts were predominantly oriented toward prevention and education activities.

The alcohol service system in Maine is heavily dependent on state and federal sources of funds. Figure III-2 illustrates this point. Direct federal contracts and reimbursements along with the state-administered federal block grants accounted for 36% of the total budget. A large portion of the federal dollars, roughly 40%, were budgeted to the Veterans' Administration program at Togus. The state contributed 38% of the total budget from general revenues and from the Premium Fund. All other sources of funding, including reimbursements, constituted only 26% of the total state budget for alcohol services. Since there was a heavy emphasis on treatment activities, we are surprised at the relatively minor role of health insurance reimbursement; it comprised only 8% of the total budget.

Staffing Patterns

The alcohol programs of Maine involve over 430 paid employees and at least 1500 full-time equivalent volunteers. The number of individuals involved is actually much greater, but most of them work only part time. The paid staff members work primarily for service-oriented programs and for the state agencies. The remaining program types have less than 10 full-time equivalent paid employees on alcohol activities.

Figure III-2: Sources of income for alcohol services in Maine, (1982 $)



The majority of the employees spend their time in providing the services offered by their agency; this activity takes 70% of the paid staff time. Another 25% of the paid staff time is divided almost equally between managerial and administrative or support activities. This distribution is shown in Figure III-3. The fraction of administrative effort expended by the state agencies' personnel is higher than the state average, because they have a much greater responsibility for contract management and coordination activities.

We obtained information on the professional qualifications of the paid direct service staff in the service programs. Our questionnaire was not designed to obtain precise and detailed information on this characteristic. Thus the results of the survey, summarized in Figure III-4, should be interpreted cautiously.

The largest professional group consists of registered substance abuse counselors; they comprise 15% of the direct service staff. Social workers and nurses each comprise 9% of the staff. Almost 60% of the direct service staff has no reported professional qualifications. This feature of the service programs definitely warrants further investigation, though it is partially explained by three observations.

First, a large number of recovering alcoholics work in this field. Much of their qualification for the job derives from their personal experiences, not from formal education. Second, many of these staff members are working to become registered as substance abuse counselors. Many of the programs we contacted reported that they provide training to prepare their staff for the registration examination. Third, though they are heavily oriented toward treatment, many of the service programs provide other services that have traditionally not involved staff with the professional qualifications covered by our survey.

Figure III-3: Staffing patterns for alcohol service programs in Maine.

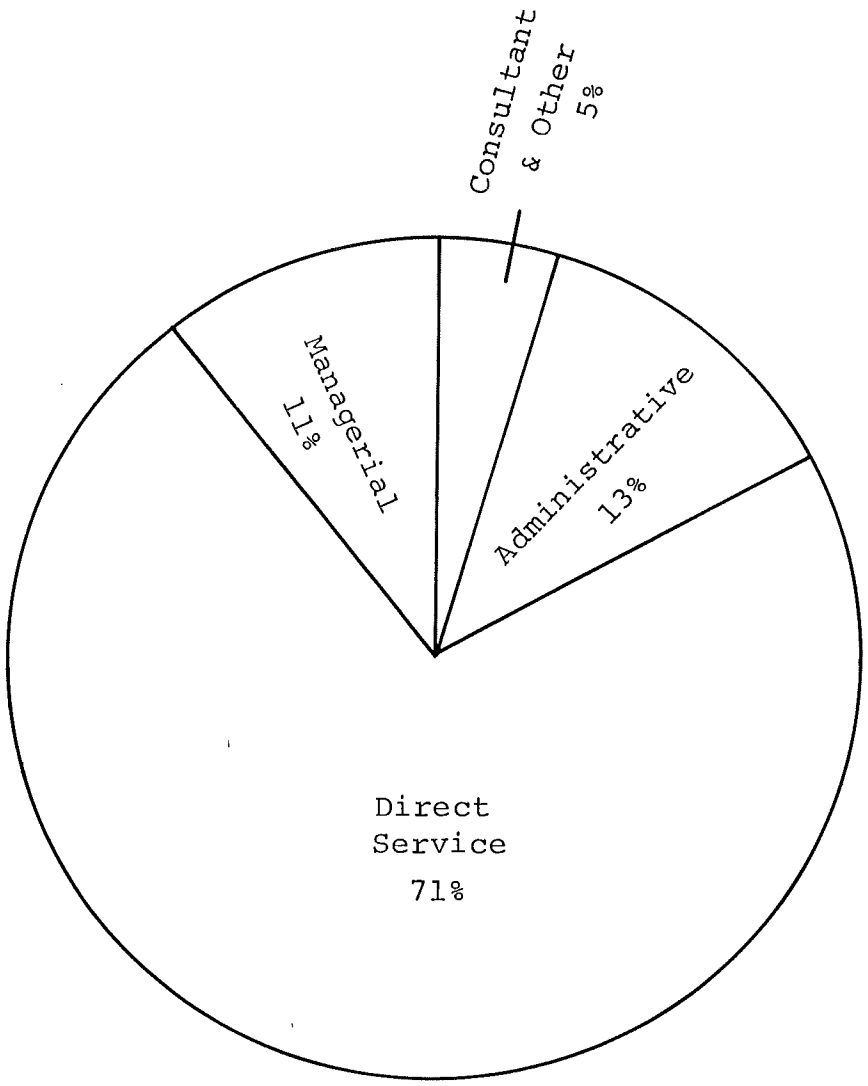


Figure III-4: Professional qualifications of direct service staff.

TYPE	PERCENT OF DIRECT SERVICE STAFF
Registered Substance Abuse Counselor	15
Social Worker	9
Nurse (LPN or RN)	9
MD or Psychologist	4
Other	4
None	59
TOTAL	100

Volunteer effort is distributed somewhat more evenly among the program types than is the paid staff effort. Our survey indicates that school-based programs have the largest single volunteer group, even though our sample omits several school efforts that did not report. Service providers are supported by a similar sized body of volunteers. Together these two groups employ 77% of the reported non-paid staff. Other programs that are heavily supported by volunteer effort include the regional councils and the advocacy groups, such as the National Council on Alcoholism - Maine.

Client Characteristics

The clients reported in our survey include both alcohol abusers and those affected by others, generally family members, who consume excessive alcohol. We have compared the characteristics of these clients in our survey with the general population of the state. Before interpreting our results, the reader should keep three caveats in mind. First, our survey does not eliminate possible duplication in the count of clients. Current data do not make it possible to eliminate the multiple "clients" that would be generated when one individual uses the services of more than one program--a fairly common occurrence. Second, it was not always possible to determine whether a given client was utilizing

treatment services or education and prevention services within a given agency. Finally, it appears that some programs reported on characteristics of their total client group, not just of those with alcohol-related problems. This may have inflated client populations in Regions Four and Five especially.

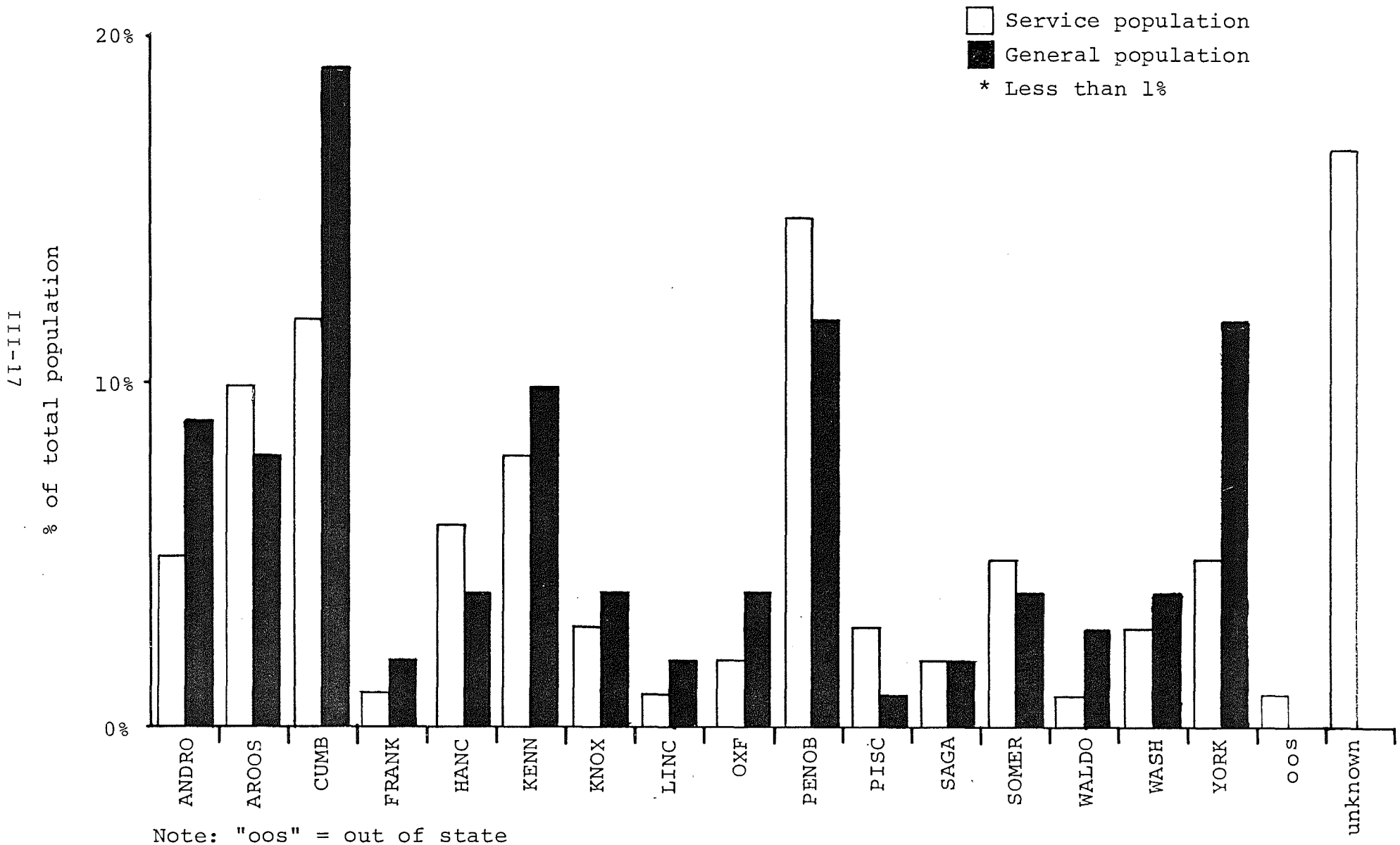
We did make two adjustments to minimize the effects of these three problems. School-based programs are described separately in our analysis, and the programs conducted in county jails are excluded entirely. Both of these programs could offer data only on their total populations; neither of them could provide information on the subgroups of students or inmates, respectively, that had been involved in their alcohol-related programs

Residence. The distribution of client residence, shown in Figure III-5, is similar to the distribution of the general population within the state, when allowance is made for the uncertainties introduced by the large fraction of clients with unknown residence. However, it may be that the more populous areas of the state including Cumberland and York Counties are somewhat underrepresented in the client population. Very few out-of-state residents receive services in Maine.

Family Income. The survey data on family income, summarized in Figure III-6, show the client population to have lower income levels than the general population. However, many of the patients were assigned to the unknown income category; and most of these can be traced to programs that do not use services traditionally used by low income clients. Thus we believe that the "unknown" category partially offsets the heavy representation of low-income individuals in the survey.

Sex. Conventional wisdom suggests that alcohol abuse has much lower incidence among females. Thus we were surprised at their high representation in our survey. Almost four out of every ten clients in Maine's alcohol programs are women. This includes the clients for treatment, education, and prevention services.

Figure III-5: Alcohol Service Consumers: County of Residence Compared with General Population



Note: "oos" = out of state

Figure III-6: Alcohol Service Consumers: Socioeconomic Characteristics Compared with General Population

A. Service Population
B. General Population

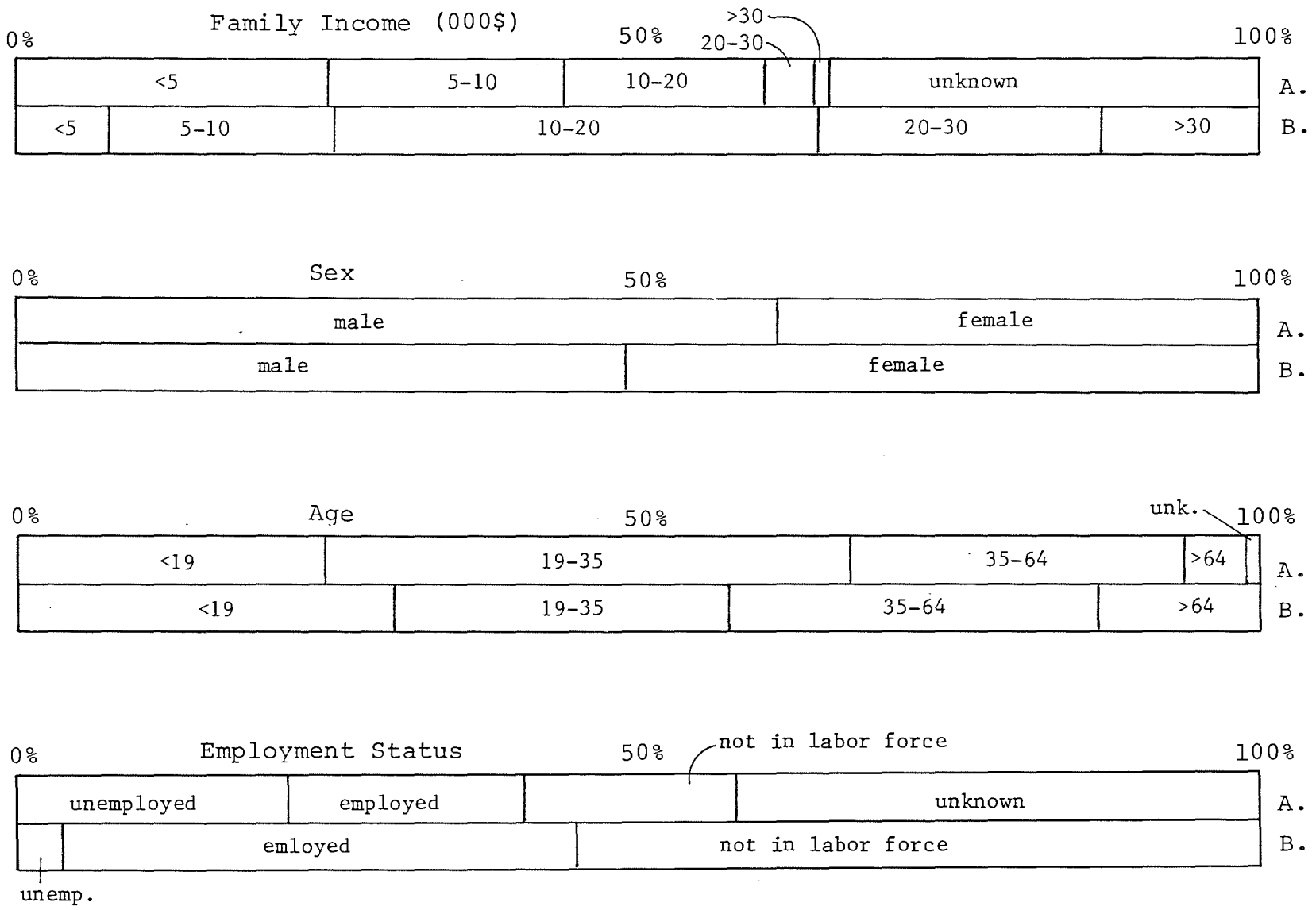
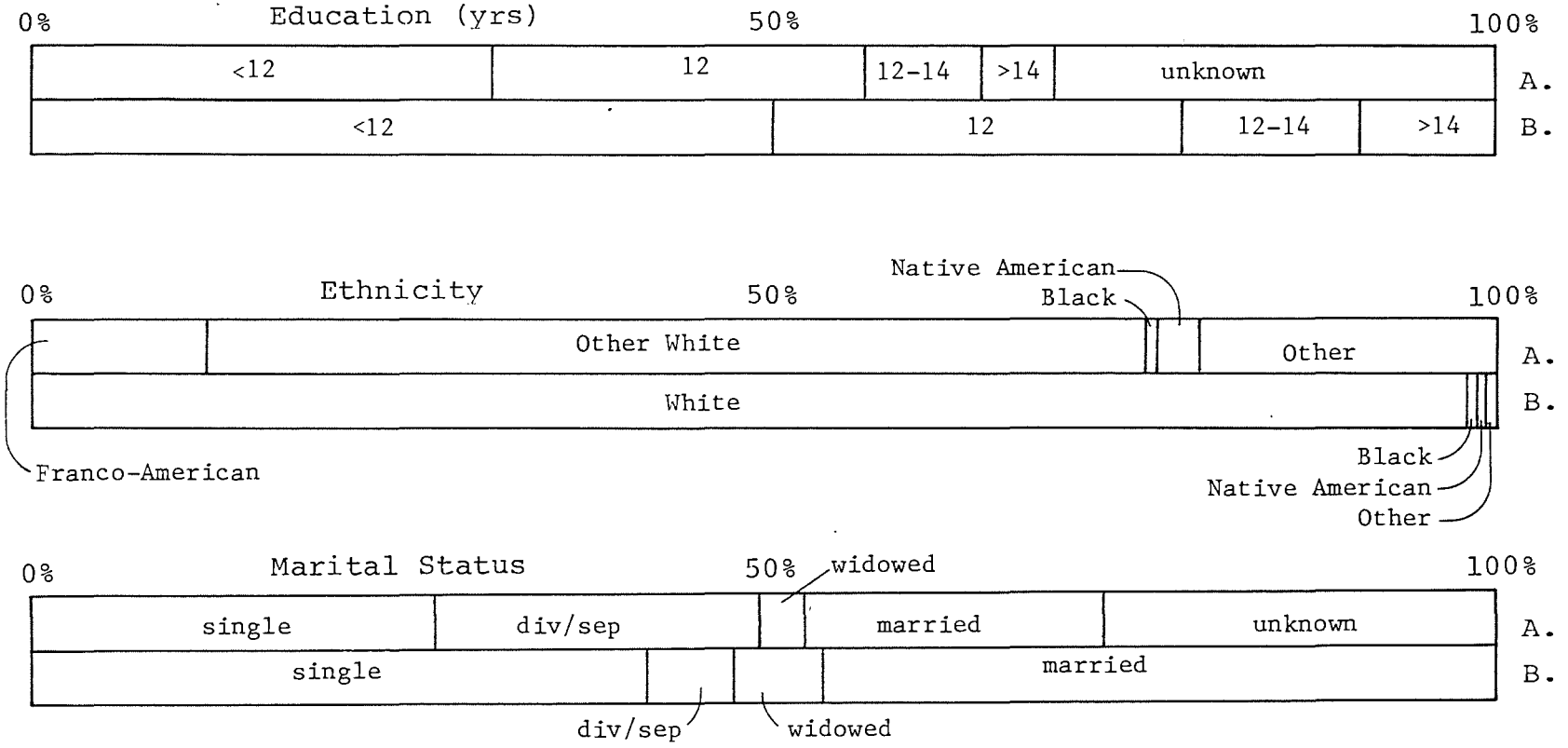


Figure III-6: (continued)

A. Service Population
B. General Population



Age. There are minor age differences between the client group and the general population. Clients are more likely to be 19-35 years old and less likely to be over 64 or under 19 than the average citizen of Maine.

Employment Status. Clients appear less likely to be employed than those in the general population. Confidence in this finding is low, since over 40% of the client population falls into the "unknown" category on this dimension.

Educational Levels. The distribution of the client population among education categories appears similar to that for the general population. Again the large fraction of those assigned to the "unknown" category makes it impossible to offer firm conclusions on this attribute.

Marital Status. Despite the relatively large fraction of clients whose marital status is unknown, it is clear that the client population has proportionately fewer married individuals and a greater number of divorced and/or separated individuals than are found in the general population. Removing the larger fraction of young children in the general population would reduce the apparent discrepancy in the "single" category.

Ethnic Background. The large "other and unknown" component and the lack of information regarding Franco-Americans in the general population make some comparisons impossible. However, it is clear that there are proportionately more blacks and Native Americans in the client population than in the general populace of Maine.

Relationship to Alcohol. We differentiated among five different categories of alcohol use for clients--early stage abuse, late stage abuse, social user, non user, unknown. Early stage abusers are the largest group, 38.2% of the total. Figure III-7 summarizes the results of the survey. Note that the first five categories are mutually

exclusive, they total 100%, while the affected category overlaps with all of the first five.

Figure III-7: Relationship to alcohol of the clients for alcohol services.

RELATIONSHIP	PERCENT OF CLIENT POPULATION
Early Stage Abuse	38.2
Late Stage Abuse	24.5
Social User	7.3
Non User	4.2
Unknown	25.8
TOTAL	100.0
Person Affected by Another's Use*	13.3

* Note: This category overlaps with those listed above.

Evaluation and Information Management

Virtually all programs conduct some type of evaluation effort. The survey sought to uncover the major components of these evaluations. We placed special emphasis on the data that might be available to evaluators outside the program in question. Staff judgment and community feedback are, by far, the major components of evaluation efforts. Admission and discharge files, which are broadly interpreted to include any recorded pre- and post-service evaluations of clients, are third in importance. Follow-up efforts rank a distant fourth. Forty percent of the service-providing groups do not conduct follow-up studies of those they served. The use of state or federal studies in evaluation efforts is minimal. Many school-based programs reported no evaluation efforts; those that did report such efforts very strongly emphasized community feedback and professional staff judgments.

The apparently low to moderate emphasis on formalized records in the evaluation process is very surprising in light of the reported effort expended to collect information. The survey asked the question, "What fraction of your staff's time is spent completing reporting forms sent to funding agencies?" The combined total for state agencies and the service provider group is 89 person years, 84% of which is for professional staff time and 16% for support staff. Assuming very modest salaries, this amount of time represents over $1 million of effort.

Information management is accomplished primarily with manual systems. We did find several computerized systems that provided extensive evaluation of staff management and financial services. However, despite the apparently massive effort spent collecting and reporting information, only 20% of the state agencies and service providers have computerized their information systems.

Summary of School-based Programs

School based programs are summarized here separately because they constitute a large bloc of activities that share many similarities among themselves and because, as a group, they are very different from the other program types, particularly the service programs.

Based on the survey responses, it is evident that relatively little money, roughly $60,000, is budgeted to alcohol services beyond the $350,000 that supports the Division of Alcohol and Drug Education Services in the Department of Education. These figures may understate the actual level of activity. One respondent usefully pointed out that the school districts do bear a substantial amount of indirect costs attributable to school staff salary and expenses during training sessions.

At the time of the survey, 30 school/community teams had been trained by the Division. Roughly 440 volunteers support the programs responding to the questionnaire. The Division estimates that a combined total of 1,000 volunteers supports the school-based programs. Programs typically had 10-35 active volunteers. There are very few paid staff in

these programs (total of 2-3 reported). The school programs emphasize education and prevention activities. There is some treatment activity (counseling, assessment and referral).

Very few programs provided thorough descriptive information on their target populations. Most programs indicated that the entire school population and students' parents are the target population, but only a few programs provided data on the numbers of persons reached through specific efforts (e.g. chemical-free graduation parties, special curricula, evaluations, referrals, etc.).

Evaluation of school-based activities is based almost exclusively on professional staff judgment and community feedback. Virtually no follow-up effort is undertaken.

The regional distribution of the school-based teams in the survey is as follows:

Regions		No. of Teams
1	-	6
2	-	10
3	-	6
4	-	6
5	-	2
		30

III-6. Regional Summaries

In most respects, data from the five regions of the state reveal budget, staffing, and client patterns similar to those described above for the state as a whole. However, there are some significant departures from the average, and those will be identified here. As a backdrop to the discussion of the regions, Figure III-8 presents data on the number and the percent of clients with residences in each of the regions.

Figure III-8: Regional location of residences for clients of alcohol services.

REGION	NUMBER OF CLIENTS	PERCENT
1	8842	24.3
2	2855	7.8
3	4592	12.6
4	9976	27.4
5	3724	10.3
Out of State	329	0.9
Unknown	6086	16.7
TOTAL	36,404	100.0

Note: These data do not eliminate double counting.

For the regional analysis, we used data only on the service provider group. Agencies offering state-wide services were excluded from the regional tallies, since their inclusion would have biased the results for Region Three where many state-wide services are based. School-based programs were also omitted in the regional analysis, primarily because they provided little information on the clients for their programs. The state-wide services excluded from the regional analysis have a greater emphasis on coordination, education, prevention, and research activities than do the regional programs. Figures III-9 through III-28 present summaries of the survey results for each region. They are presented in Section III-9.

Region One

Region One is comprised of six counties:

- Cumberland,
- Knox,
- Lincoln,
- Sagadahoc,
- Waldo,
- York.

Programs in this region had the lowest emphasis on prevention and education. These activities combined to represent only 7% of total

regional expenditures. This compares with 17% at the state level and 12-16% in the other regions. Region One was somewhat less dependent on state and federal dollars than the state as a whole.

Several counties within Region One contribute less to the client population than they do to the general population of Maine. York County stands out particularly in this regard. Eight percent of the client population comes from outside the region. Compared with the state figures, the client population in Region One is:

- older,
- more heavily male,
- more likely to be unemployed or out of the work force,
- poorer,
- less educated, and
- more likely to be single or divorced.

Many of these differences can be traced to the existence of two shelter and detoxification facilities in this region. Several other programs, including the Salvation Army facility and programs servicing the state's prison population, also account for these differences. The statistics mask the existence of several programs serving women and youth almost exclusively. In addition, out-patient services and prevention/education programs are more representative of the state patterns.

Region Two

Region Two is comprised of three counties:

-Androscoggin
-Franklin
-Oxford

No research effort was reported in Region Two. The region has a low reliance on federal dollars and a heavier reliance on health insurance reimbursement than the state average. This reflects the residential treatment program at St. Mary's Hospital in Lewiston.

In comparison with the distribution of the general population, Oxford County is under represented in the client population. Twenty percent of the client population comes from outside the region. As in Region One, the client population is:

- older,
- more likely to be male, and
- more likely to be single or divorced.

The higher representation of older men stems primarily from the caseloads at the Fellowship House, St. Mary's rehabilitation program, and Tri-County Mental Health Services. The latter two also account, in part, for the relatively higher education and employment levels.

Region Three

Region Three is comprised of two counties:

-Kennebec
-Somerset

The region's activities rely somewhat more on federal dollars and depend less on state dollars than the other regions. Insurance reimbursements constitute a substantial source of revenue.

The distribution of client population indicates that Kennebec County is under represented in comparison with the general population. Twenty-six percent of the client population comes from outside the region. Compared with the average Maine citizen, the client population is:

- more likely to be female,
- more likely to be employed, and
- likely to have a higher family income.

Most of the differences in Region Three are attributable to the New Directions program in Augusta, which is strongly oriented towards women. The Crisis and Counseling program also has a high proportion of women in its case load.

Region Four

Region Four is comprised of four counties:

- Hancock
- Penobscot
- Piscataguis
- Washington

This region relies only lightly on federal dollars and very heavily on state funds. In comparison with the distribution of the general population, Penobscot and Washington counties are under represented in the client population. This could be due in part to the large fraction of clients with unknown residency in the region. Five percent of the client population comes from outside the region. In comparison with the state level figures, the client population is:

- a greater proportion female, and
- somewhat younger.

These differences stem directly from the large reported caseload at Community Health and Counseling Services in Bangor. The other programs in the region reflect state patterns more closely.

Region Five

Region Five is comprised of Aroostook county. This region has greater emphasis on treatment and prevention than any of the other four. It is somewhat less dependent on state funds than the state level average. The region also appears to be somewhat more successful in raising private, county, municipal, and other miscellaneous funds.

Only 2% of the client population comes from outside the region. In comparison with state-level figures, the client population is:

- more often female,
- younger,
- less likely to be in the labor force,
- less well educated,
- more likely to be single, and
- likely to have a higher family income.

These differences stem primarily from a large education program at Aroostook Mental Health Center.

III-7. Survey Method

We started to develop our survey by compiling a list of 150 organizations and individuals. We obtained the names from earlier catalogues and through discussions with many individuals in Maine. We circulated this list to numerous groups, including the Second Friday Management Group and several regional councils. With their help we deleted entries that were obsolete, and we corrected many omissions. The final list included 168 organizations and groups; it is provided in Chapter VI. Initially this list included a sampling of substance abuse counselors. These were later dropped from the survey, as it became apparent that the majority of the people in this group were affiliated with some other organization covered in the survey.

We then designed a seven page questionnaire. It requested information on a program's budget, program emphasis, staffing patterns, client characteristics, and procedures used in evaluation and in data management. We designed the format to allow for a wide range of responses, and we built several cross checks into the questionnaire. These improve its reliability and help to eliminate double counting in agencies' descriptions of their budgets. A copy of the questionnaire is included as Section III-9 of this chapter.

We received excellent assistance from several individuals on our list. They pretested the questionnaire to help us eliminate questions that were ambiguous or difficult to answer. The Interdepartmental Planning Committee also reviewed the form and suggested several useful changes. This pretesting helped us reword the questionnaire to clarify its intent and to include several additional items that provide better coverage of agencies that depend on volunteer effort or that are not involved in treatment.

We mounted an intensive follow-up effort by telephone two weeks after the final questionnaire was mailed out. At first we contacted all non-respondents to determine their reasons for failing to respond. We provided clarification and assistance, if it was needed. The information we obtained from these discussions permitted us to send out several additional questionnaires. Later we called respondents and sought to clarify their responses to the questionnaire. All the responses that passed through the second step were entered into a computerized data base for subsequent tabulation and analysis.

We sent out 168 questionnaires. About 80% of these, 134, were returned, and 100 were entered into the data base. The alphabetized index in Chapter VI indicates the type of response we received from each program. We used the responses to develop the individual program descriptions provided in Chapter VI.

Non-respondents generally tended to be small programs or programs not directly involved in the provision of alcohol services. Programs that apparently have gone out of business were eliminated from the mailing list. Several regional EAP programs, including those conducted by the U.S. military, the U.S. Postal Service and New England Telephone, could not provide data specific to Maine, although general descriptive information was supplied to us by each of them. With a few exceptions the overall response from industrial EAP programs was weak. Responses were not received in time for tabulation from either the Alcohol Institute of Eastern Maine Medical Center or from York County Counseling Services.

III-8. Findings

The results of a survey of 168 agencies and programs have been tabulated and summarized in the preceding sections. The major findings of this effort are listed here.

General

One of the most striking results from our survey was evidence of the deficiencies in information currently available to describe and report on services delivered to the general, at-risk, and abusing populations. This lack seriously reduces the ability of the state to evaluate its efforts and to assess unmet needs. The problems with data take three forms:

- inability to measure the characteristics of clients in the most expensive component of the system of treatment, as required by 22 MRSA c.1601; §7106 (OADAP enabling legislation);
- inability to characterize adequately the indeterminant but large group of alcoholics and alcohol abusers in other components of state services, including mental health and retardation, corrections, children's services and others; and
- a low level of confidence on the part of service providers in the reliability of the information they do collect, including the information they do obtain on income, other socio-economic characteristics, and their clients' relationship to alcohol.

Expenditures

Expenditures for alcohol services in Maine are weighted toward treatment activities, they constitute two-thirds of all funds spent. Funded prevention and education activities are concentrated in statewide agencies, both public and private, while regionally-based activities tend to emphasize treatment.

Very little research is underway in Maine on either the causes of alcoholism or on the evaluation of existing services. What research is conducted is not broadly disseminated to benefit other programs.

Funding Sources

Reliance on Federal funding, both direct and through the block

grants, remains high (36%) despite the introduction of new funding through the state Premium Law Fund. This has potentially dangerous implications for the future stability of alcohol services in Maine, given the widespread expectations of cuts in federal funding and the need to implement the new tax indexation scheme.

The role of health insurance and fees as sources of funding is surprisingly small, only 8% and 6% respectively of total revenues. This is particularly notable in light of the heavy emphasis on treatment activities.

Staffing

The equivalent of 430 full-time staff and at least 1,500 volunteers work in alcohol programs in Maine. Most of the paid staff work with service providers and state agencies. While a large group of volunteers support the activity of service providers, the majority of volunteer effort is in the school-based programs, regional councils and advocacy groups.

In the service provider group, which employs 90% of the paid staff, 60% of the direct service staff has no reported professional accreditation.

Client Characteristics

Cumberland and York counties contributes less (more than 5% less in both cases) to the client population than they do to the general population of Maine.

In treatment, education and prevention programs, women represent 40% of the client population. This fraction falls to 30-35% in treatment programs and increases to 50% in prevention/education programs.

The elderly (greater than 64 years) are a smaller fraction of the client population than they are of the general population.

Evaluation and Information Management

A large effort is reportedly expended, 89 person years, to collect information regarding clients in the alcohol service system. This time is conservatively estimated to cost over one million dollars annually.

Yet, many programs are unable to report completely on socio-economic characteristics of the clients or target groups. Large unknowns exist with the following characteristics:

-income,
-employment status,
-education,
-marital status, and
-ethnic background.

Most use of information in alcohol services relies on manual storage and management systems.

While virtually all programs conduct some kind of evaluation effort, fully 40% do not conduct any follow-up studies on their clients or target populations. Consequently, more than ten thousand clients pass through the service system each year without the programs making any effort to follow up on their subsequent condition or attitudes.

III-9. Regional Figures

Figure III-9: Expenditures for alcohol services in Region 1, by category (1982 $).

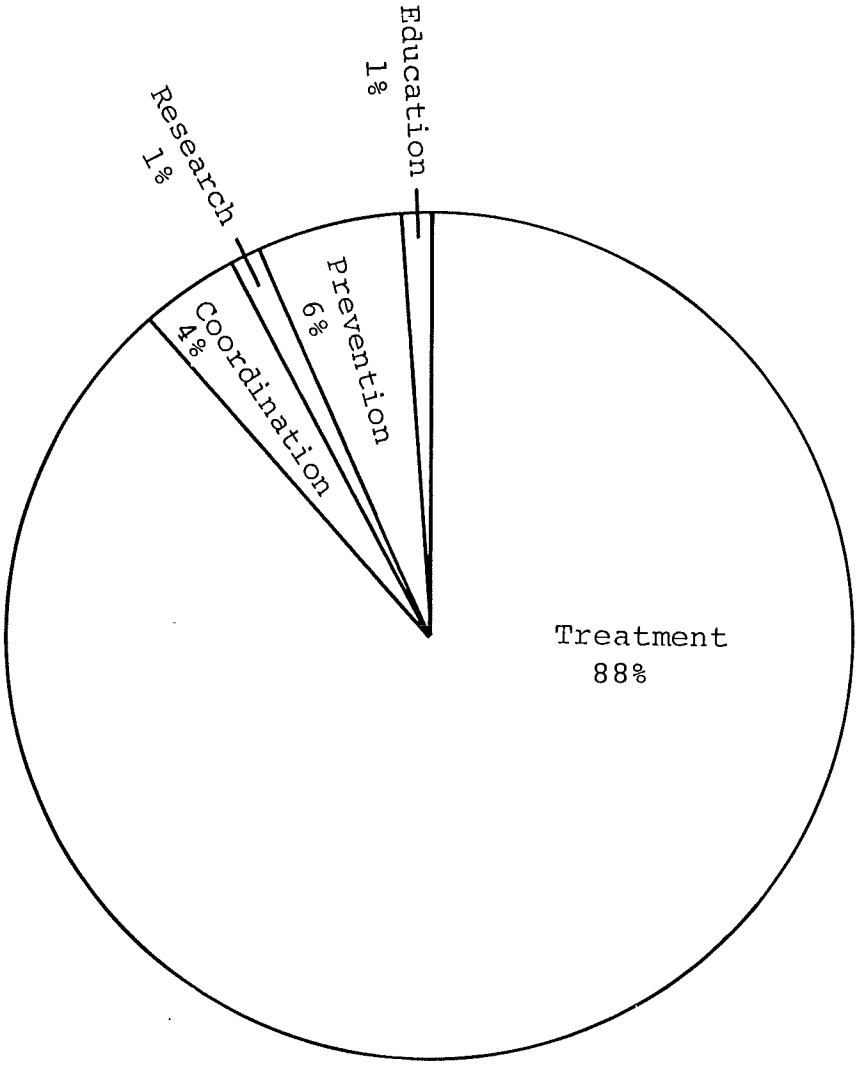
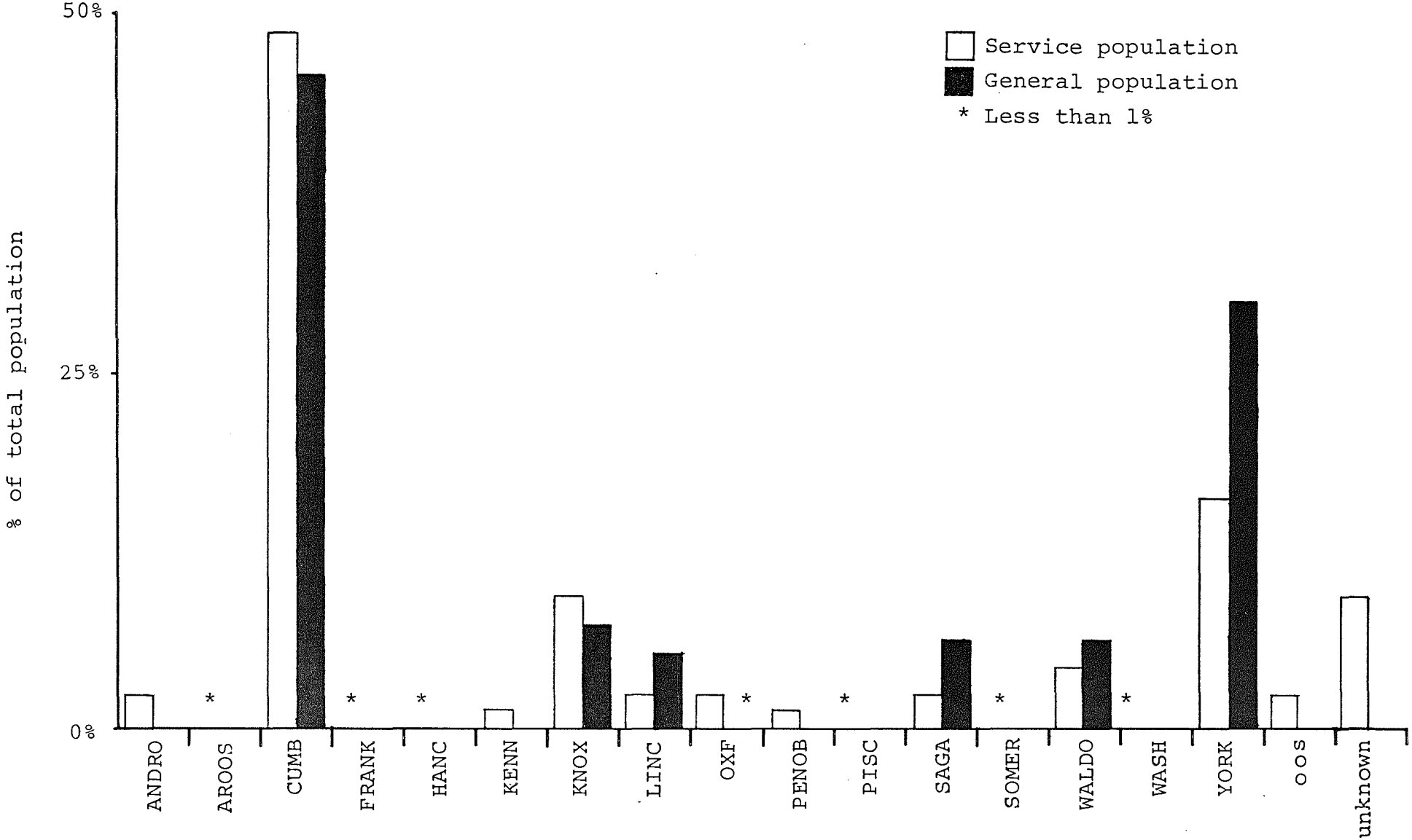


Figure III-10: Sources of income for alcohol services in Region 1 (1982 $)

Figure III-11: Alcohol Service Consumers: County Residence Compared with General Population in Region 1



Note: "oos" = out of state

Figure III-12: Alcohol Service Consumers: Socioeconomic Characteristics Compared with General Population in Region 1

A. Service Population
B. General Population

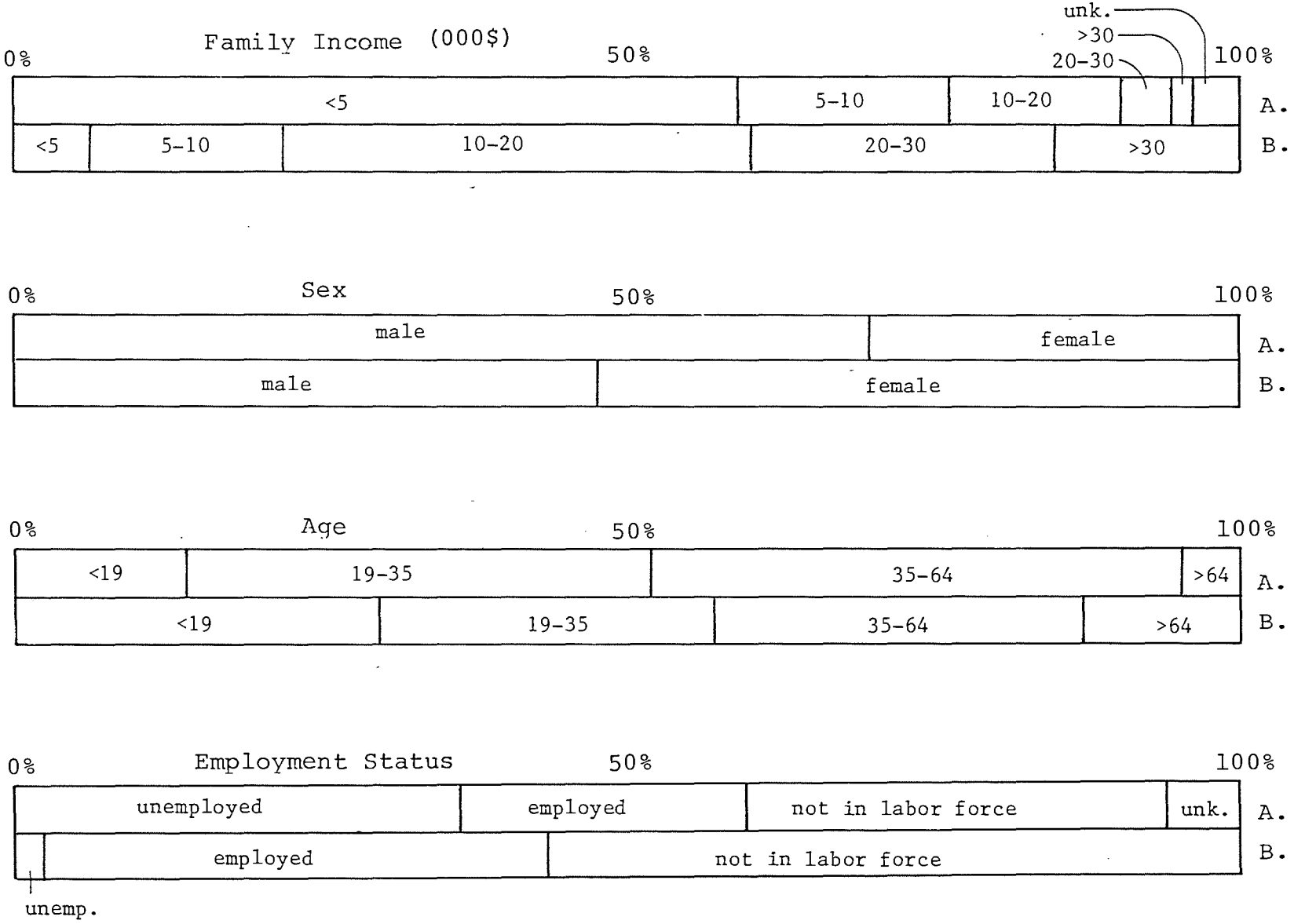


Figure III-12: (continued)

A. Service Population
B. General Population

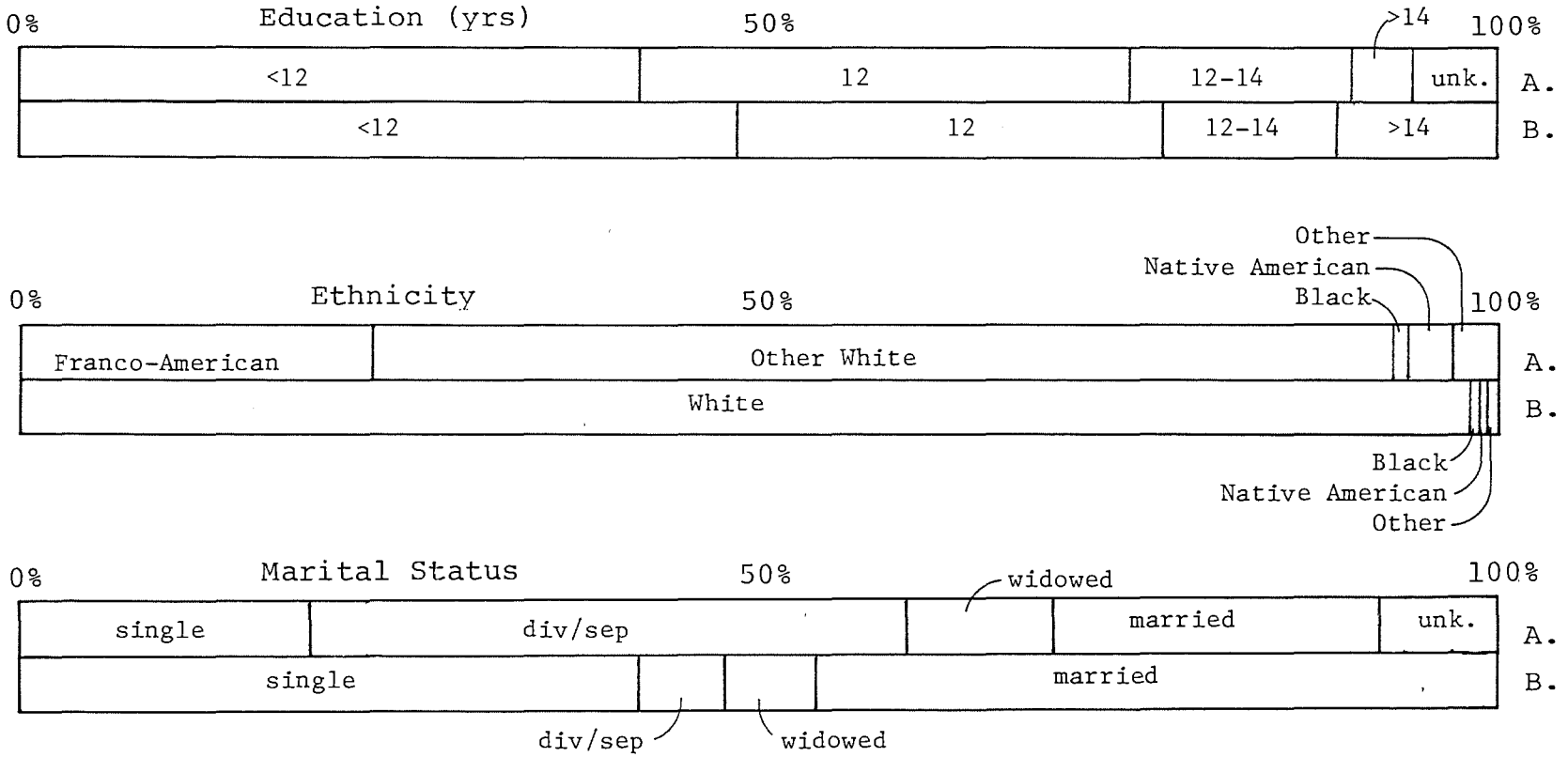


Figure III-13: Expenditures for alcohol services in Region 2, by category (1982 $).

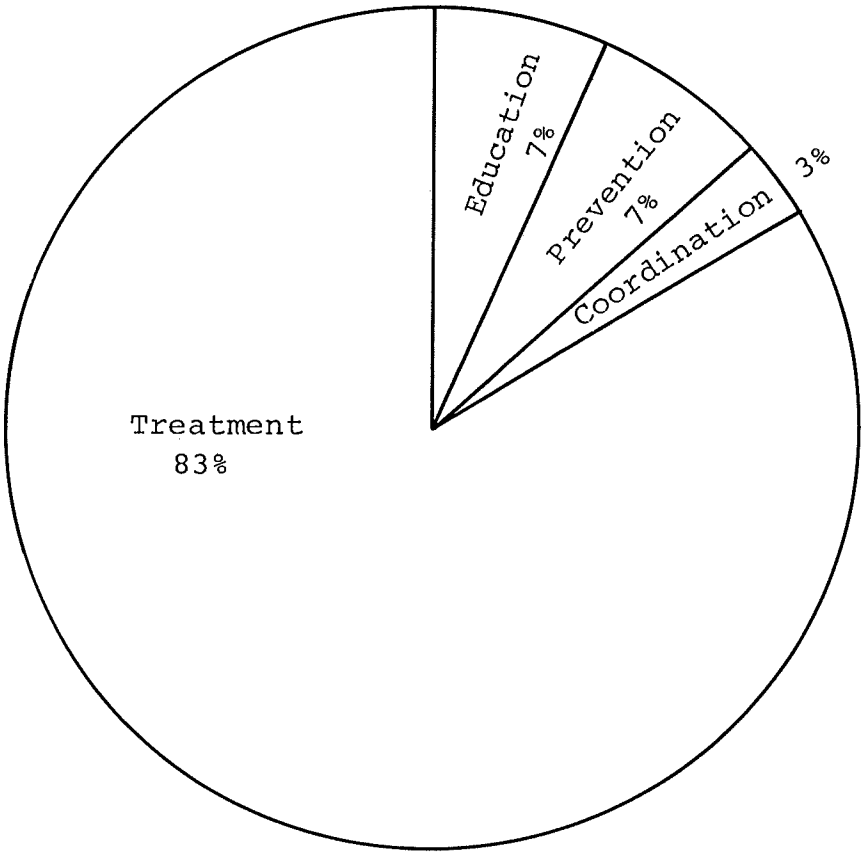


Figure III-14: Sources of income for alcohol services in Region 2 (1982 $).

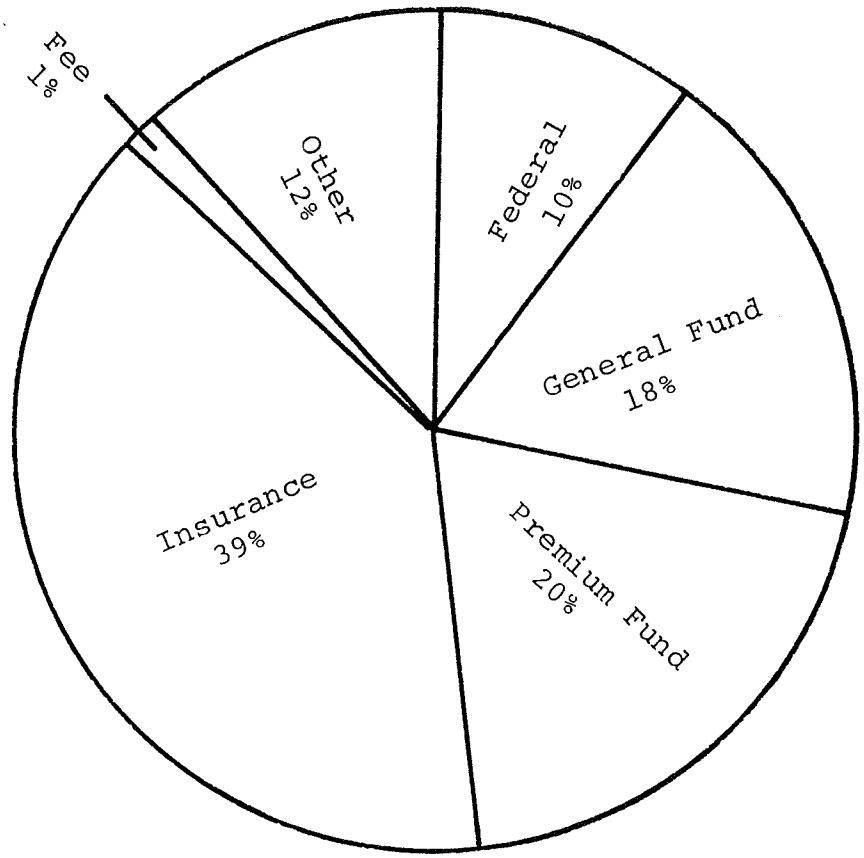
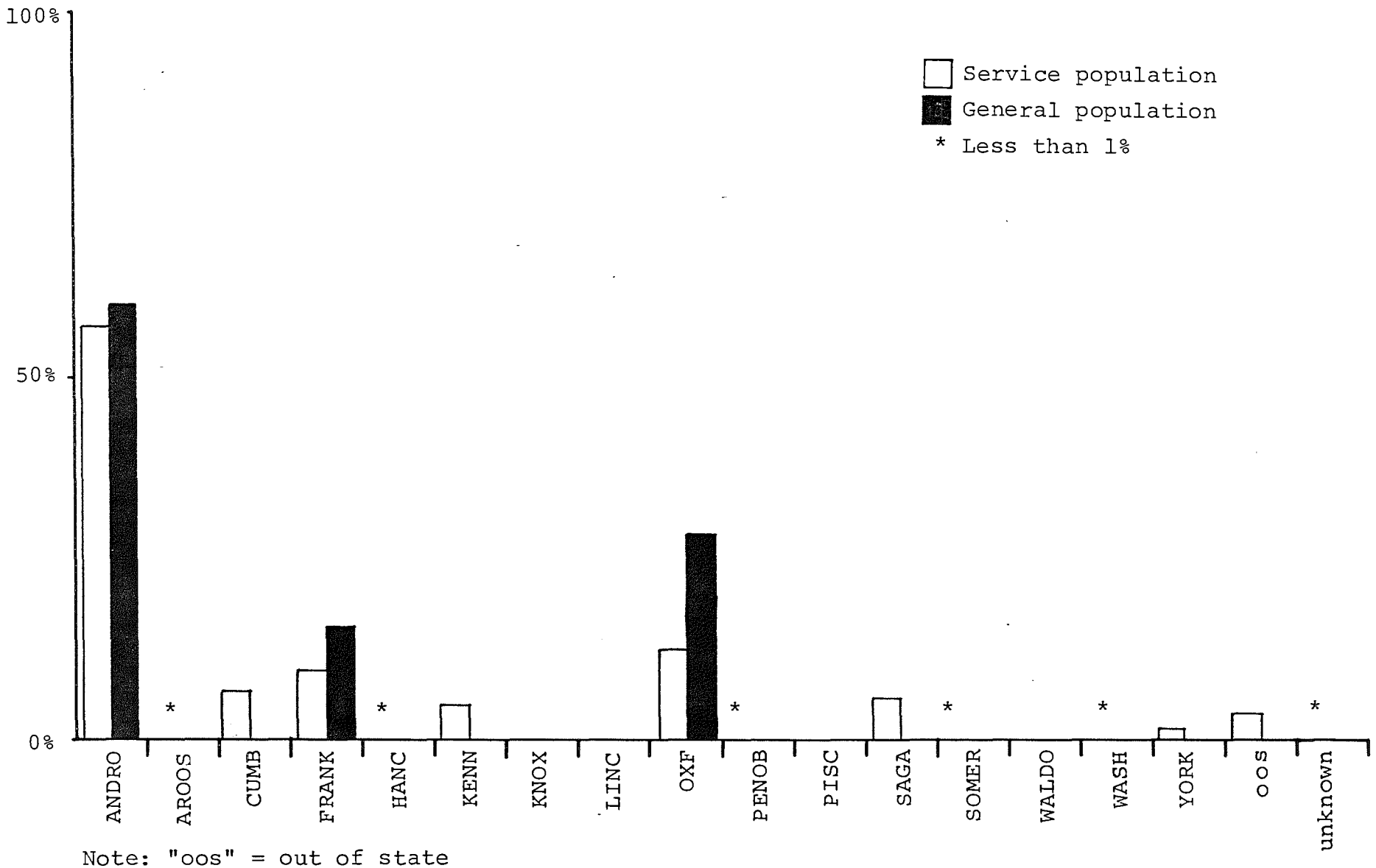


Figure III-15: Alcohol Service Consumers: County Residence Compared with General Population in Region 2



Note: "oos" = out of state

Figure III-16: Alcohol Service Consumers: Socioeconomic Characteristics Compared with General Population in Region 2

A. Service Population
B. General Population

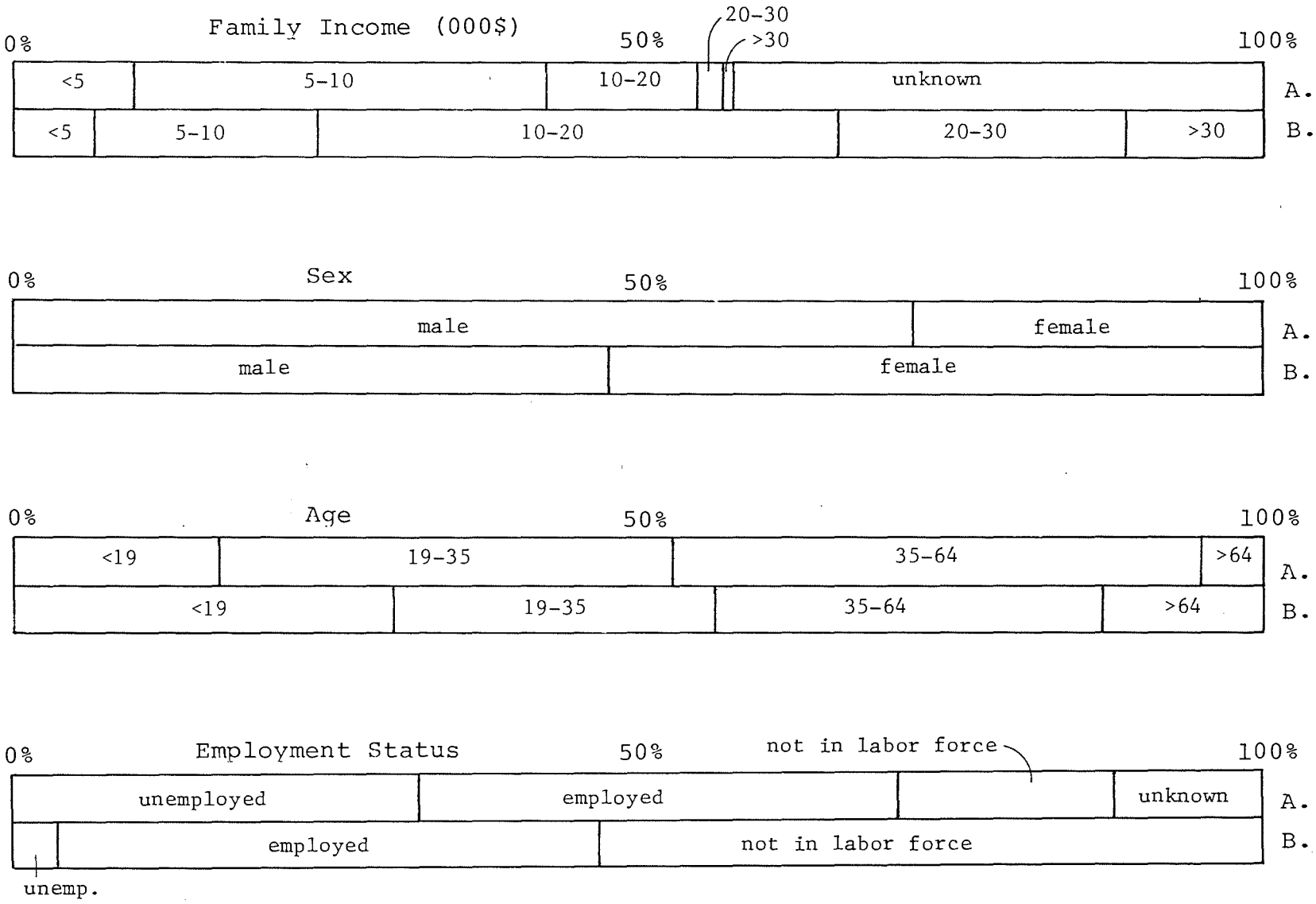


Figure III-16: (continued)

A. Service Population
B. General Population

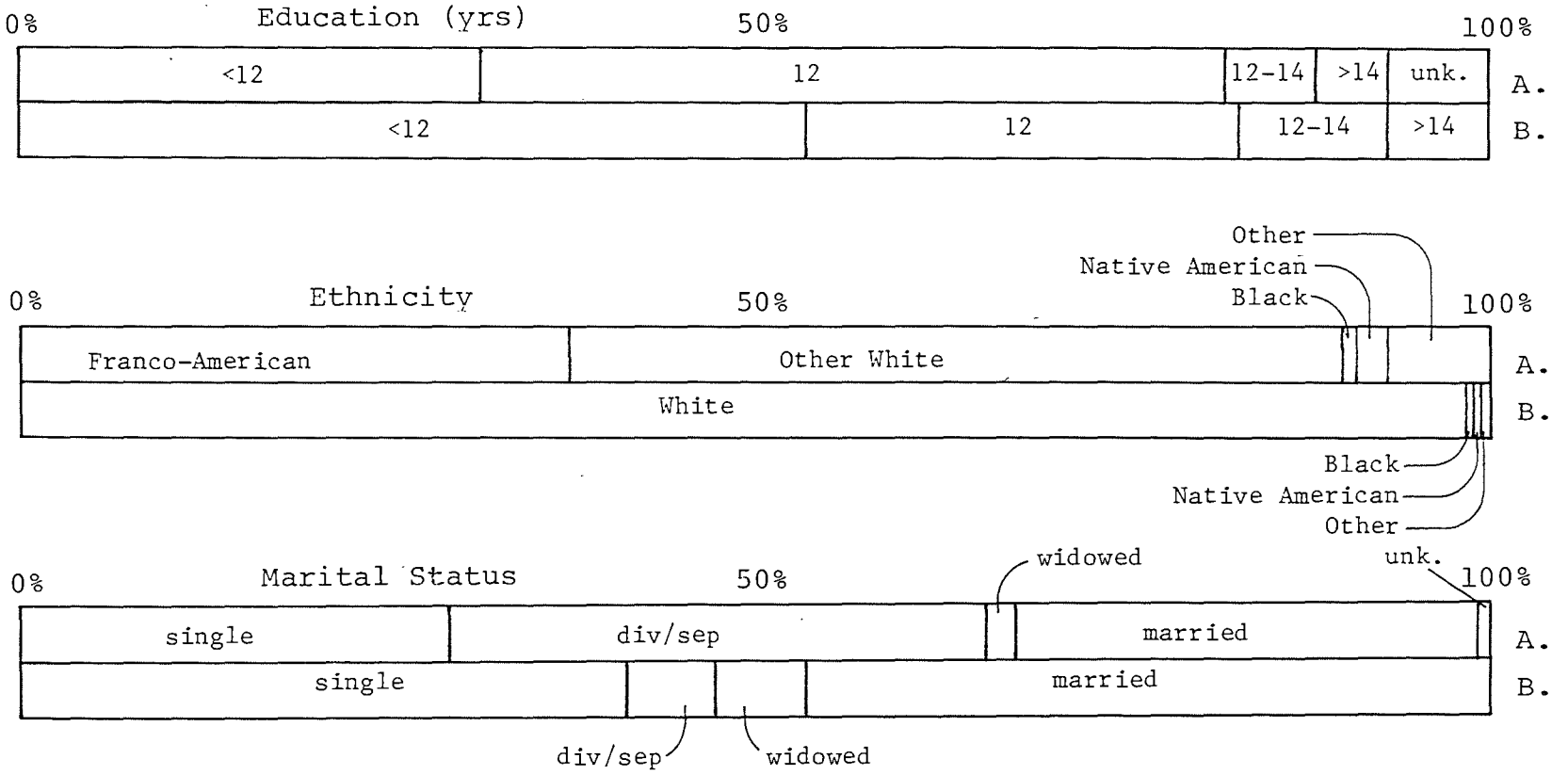


Figure III-17: Expenditures for alcohol services in Region 3, by category (1982 $)

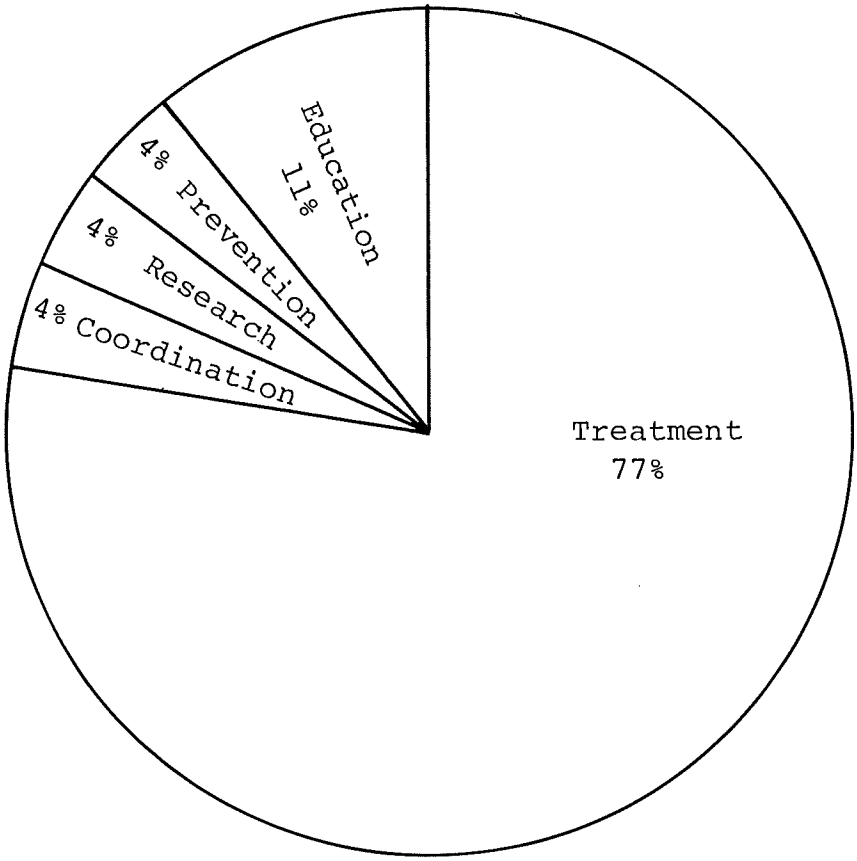


Figure III-18: Sources of income for alcohol services in Region 3 (1982 $)

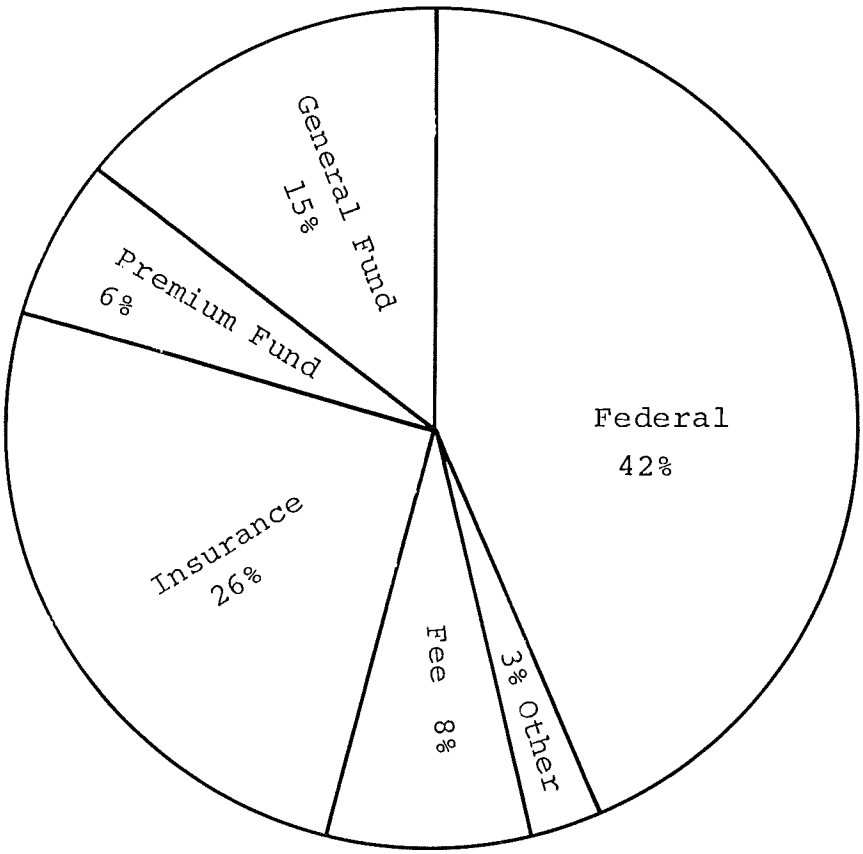
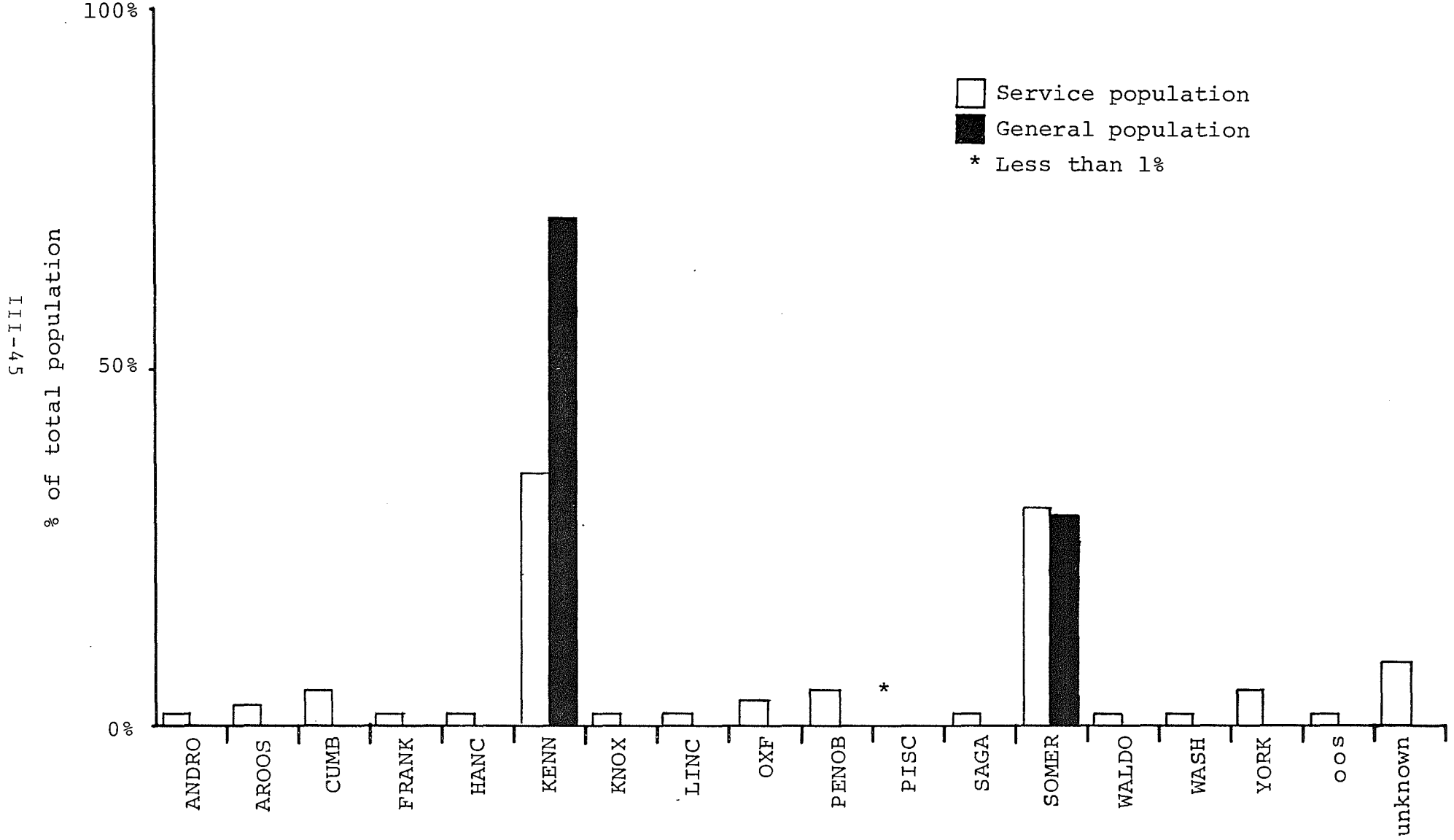


Figure III-19: Alcohol Service Consumers: County Residence Compared with General Population in Region 3



Note: "oos" = out of state

Figure III-20: Alcohol Service Consumers: Socioeconomic Characteristics Compared with General Population in Region 3

A. Service Population
B. General Population

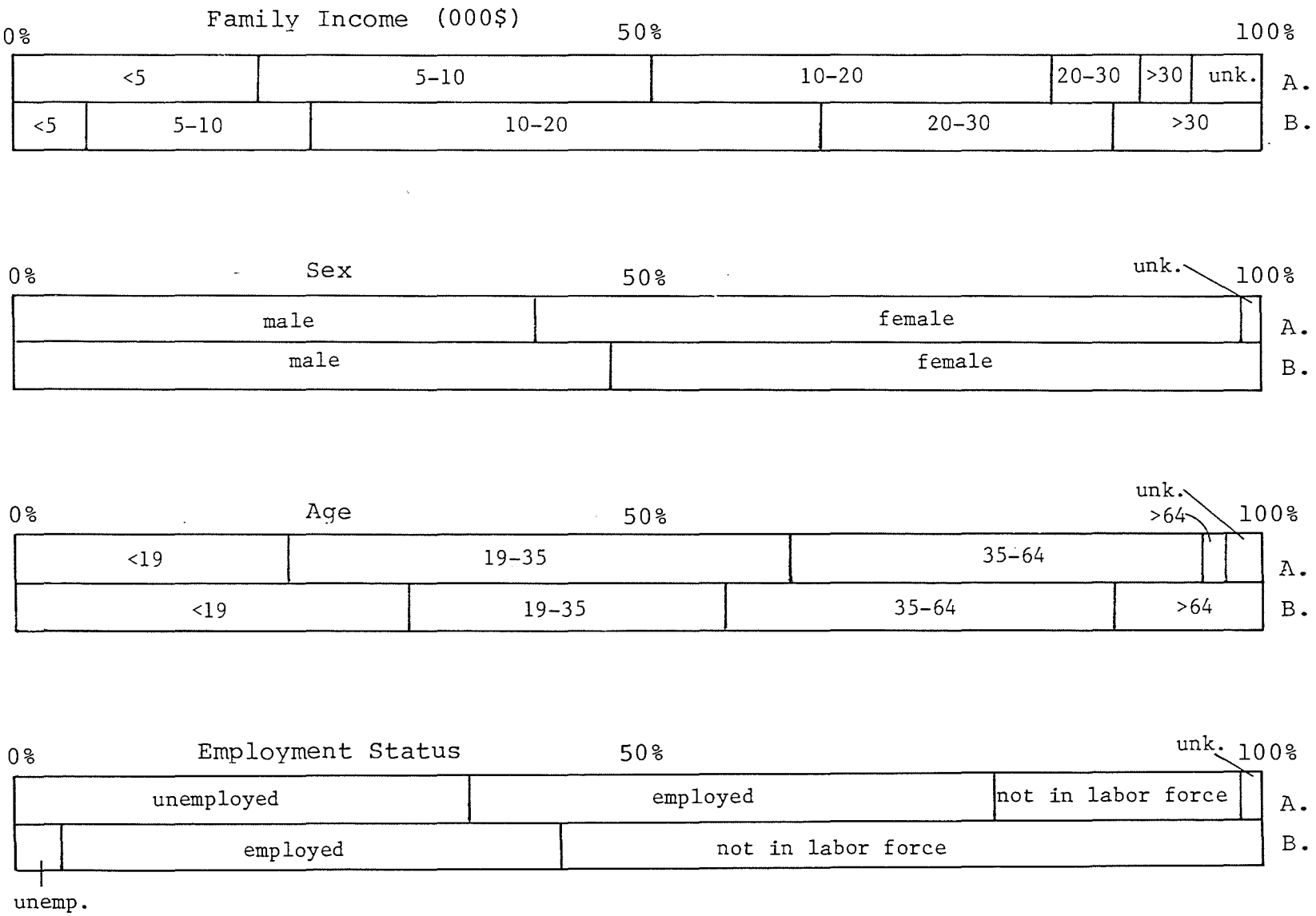


Figure III-20: (continued)

A. Service Population
B. General Population

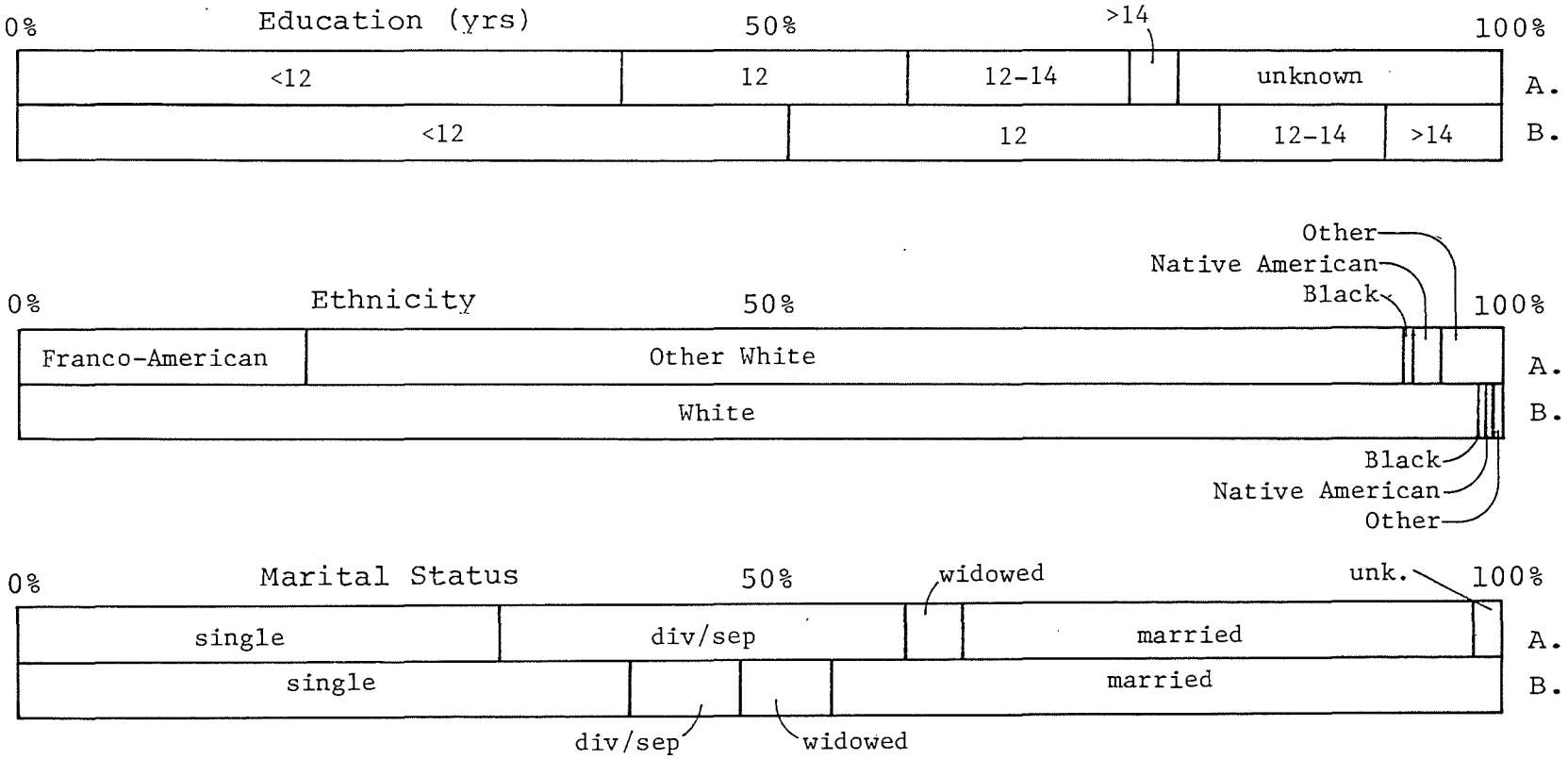


Figure III-21: Expenditures for alcohol services in Region 4, by category (1982 $)

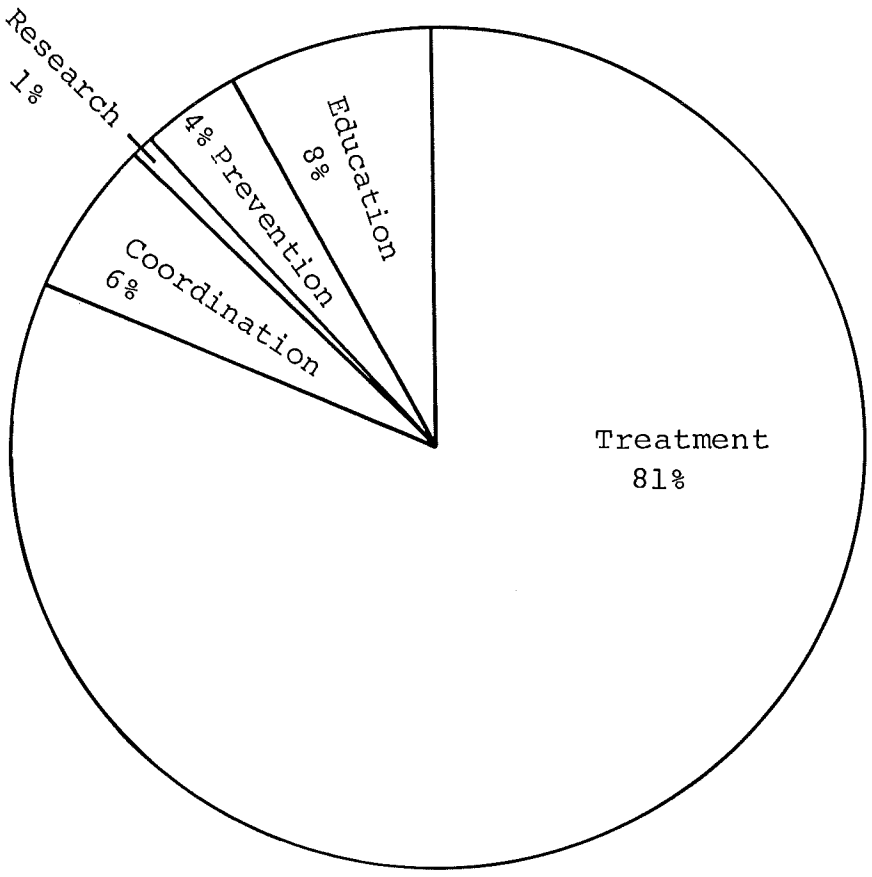


Figure III-22: Sources of income for alcohol services in Region 4 (1982 $).

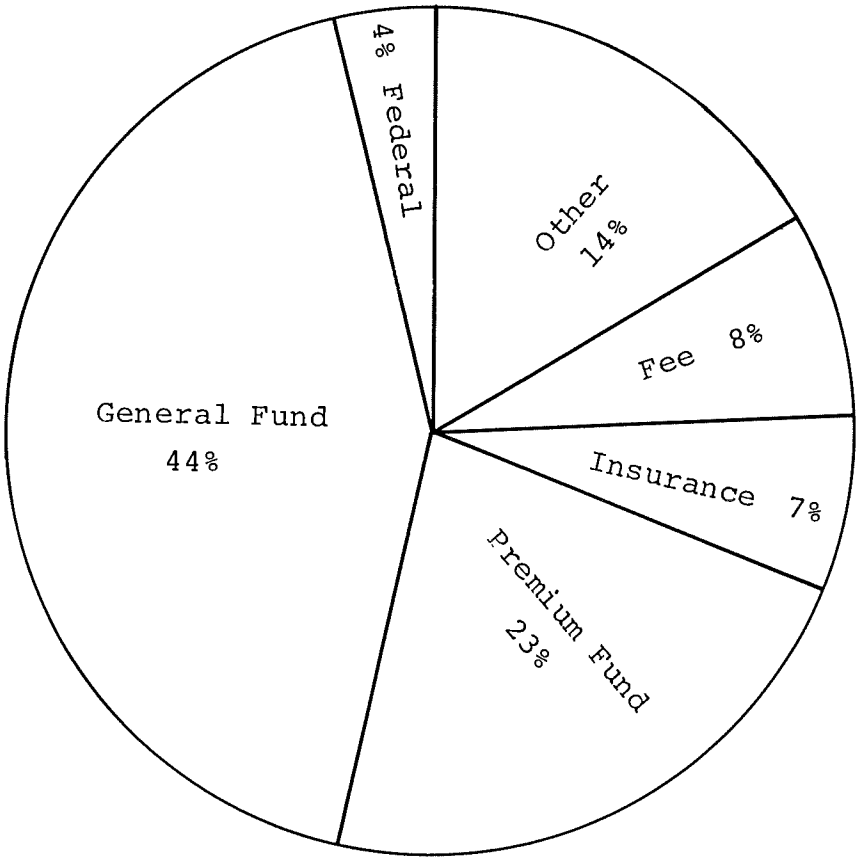
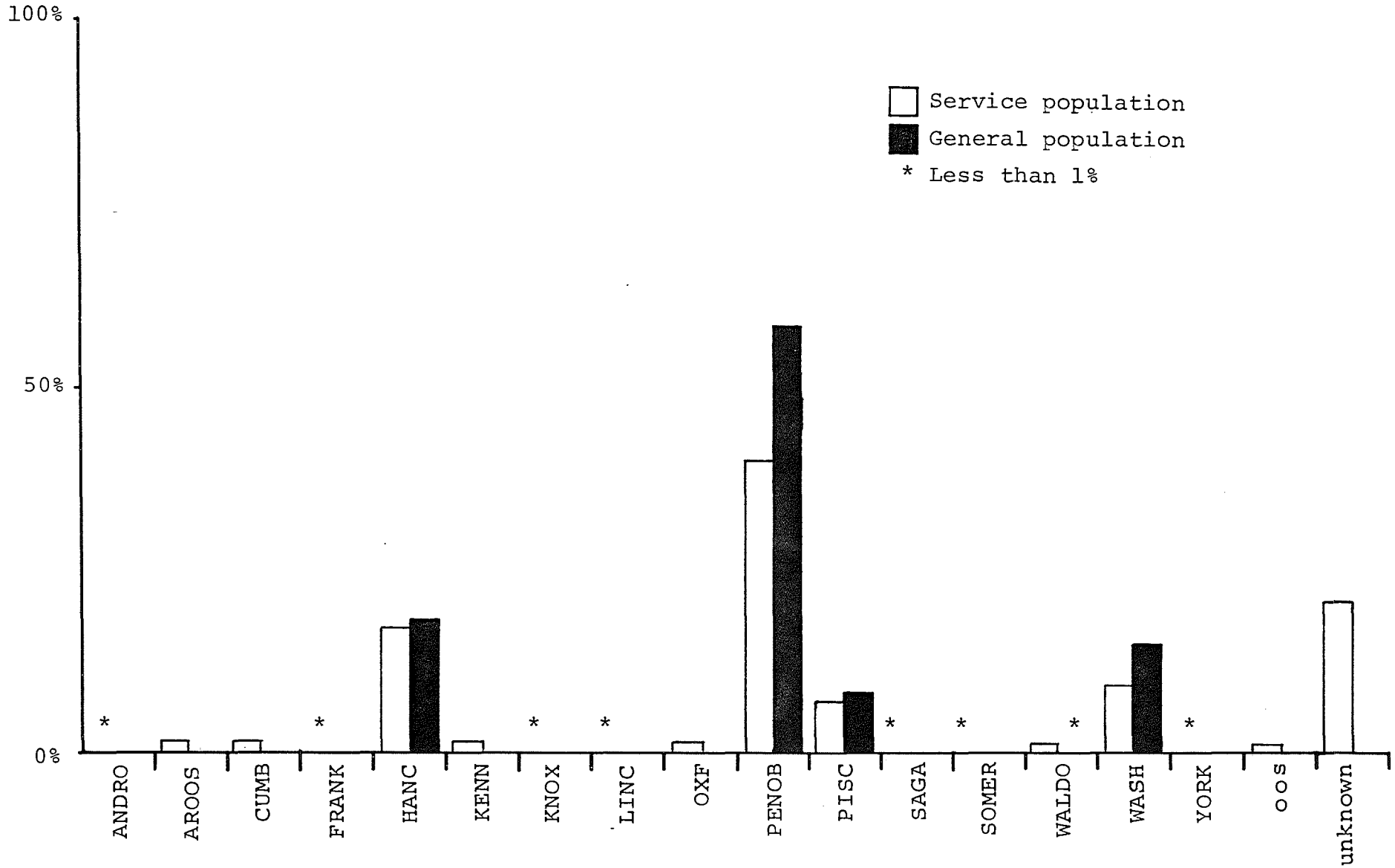


Figure III-23: Alcohol Service Consumers: County Residence Compared with General Population in Region 4



Note: "oos" = out of state

Figure III-24: Alcohol Service Consumers: Socioeconomic Characteristics Compared with General Population in Region 4

A. Service Population
B. General Population

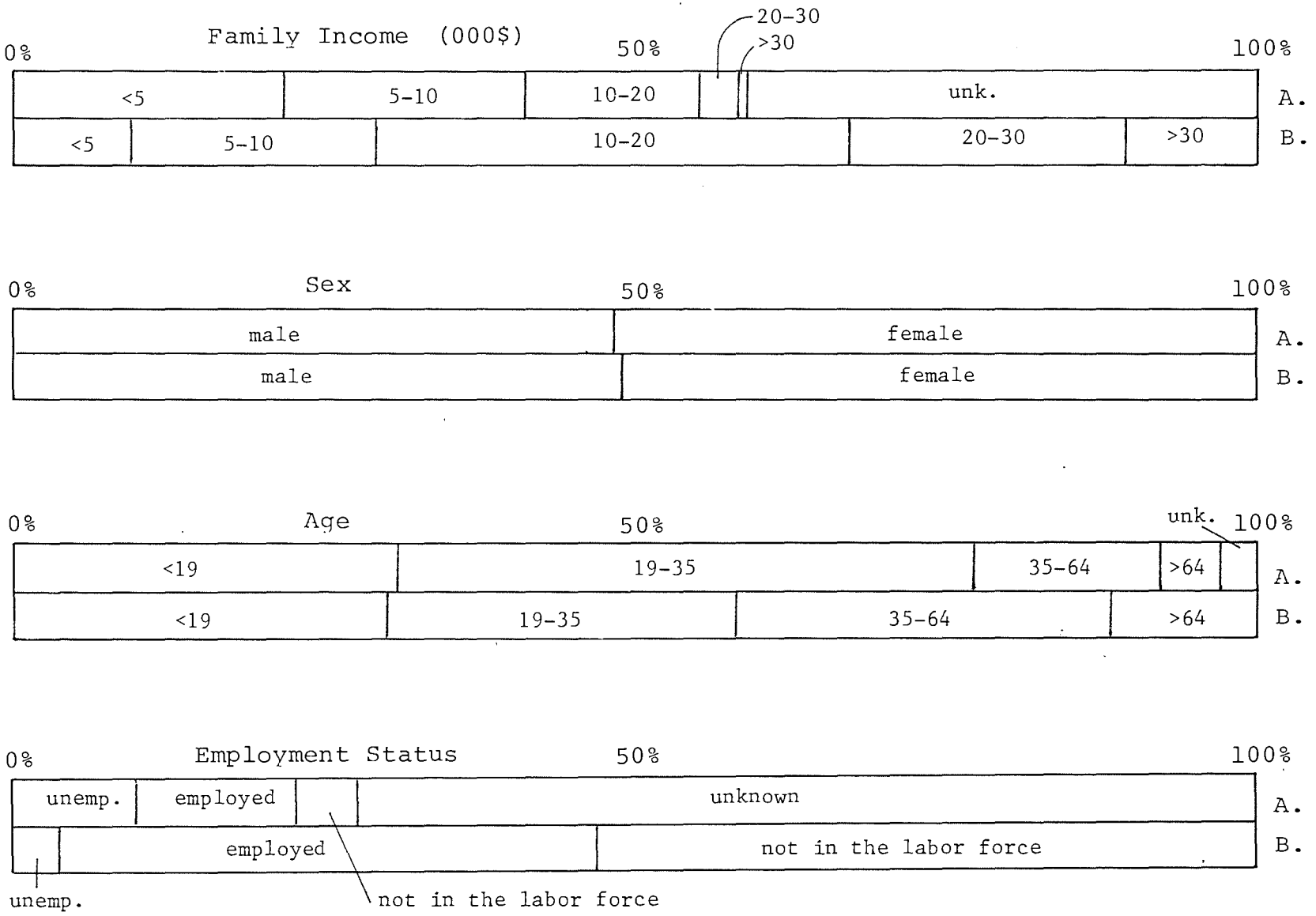


Figure III-24: (continued)

A. Service Population
B. General Population

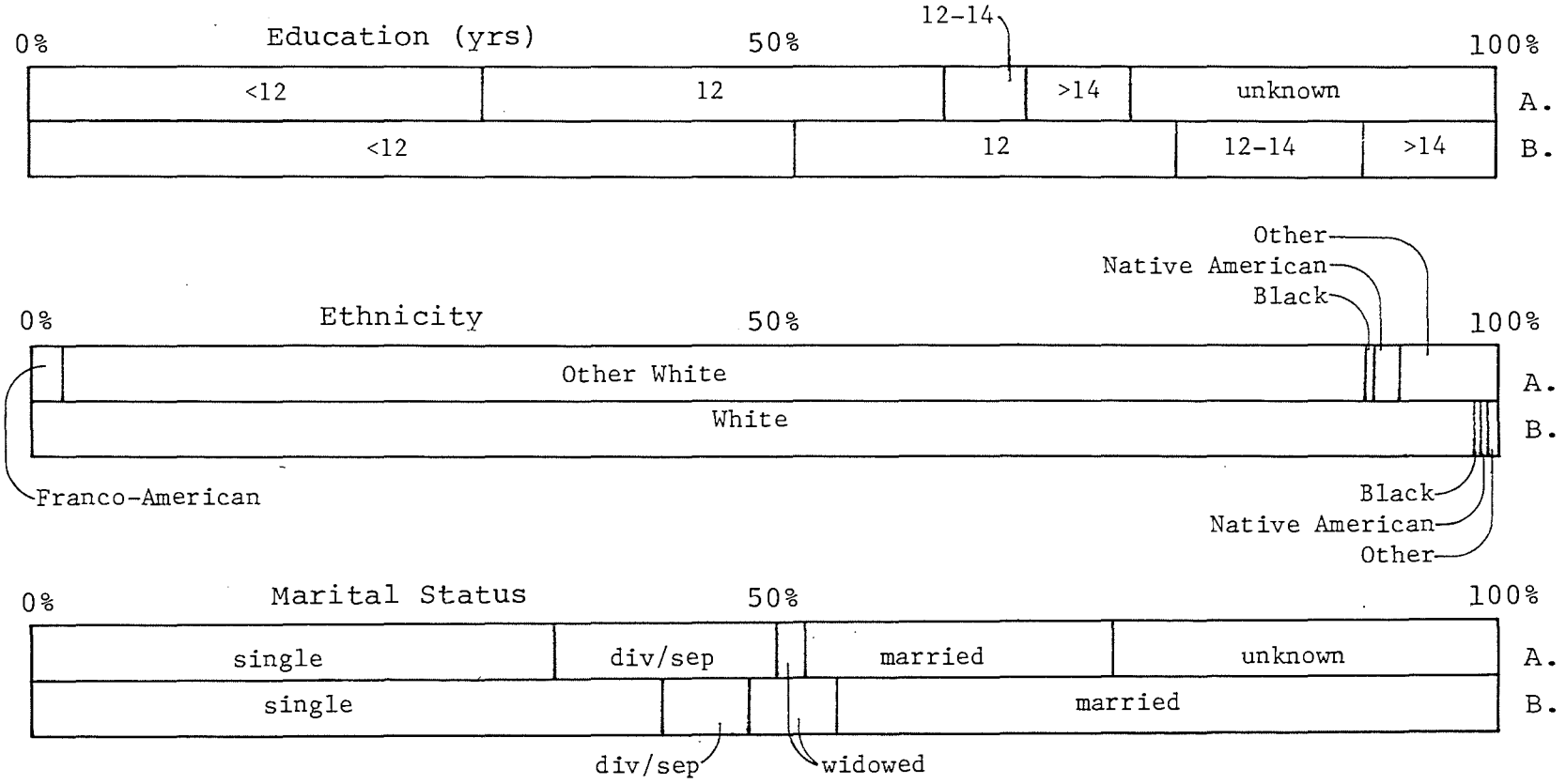


Figure III-25: Expenditures for alcohol services in Region 5, by category (1982 $).

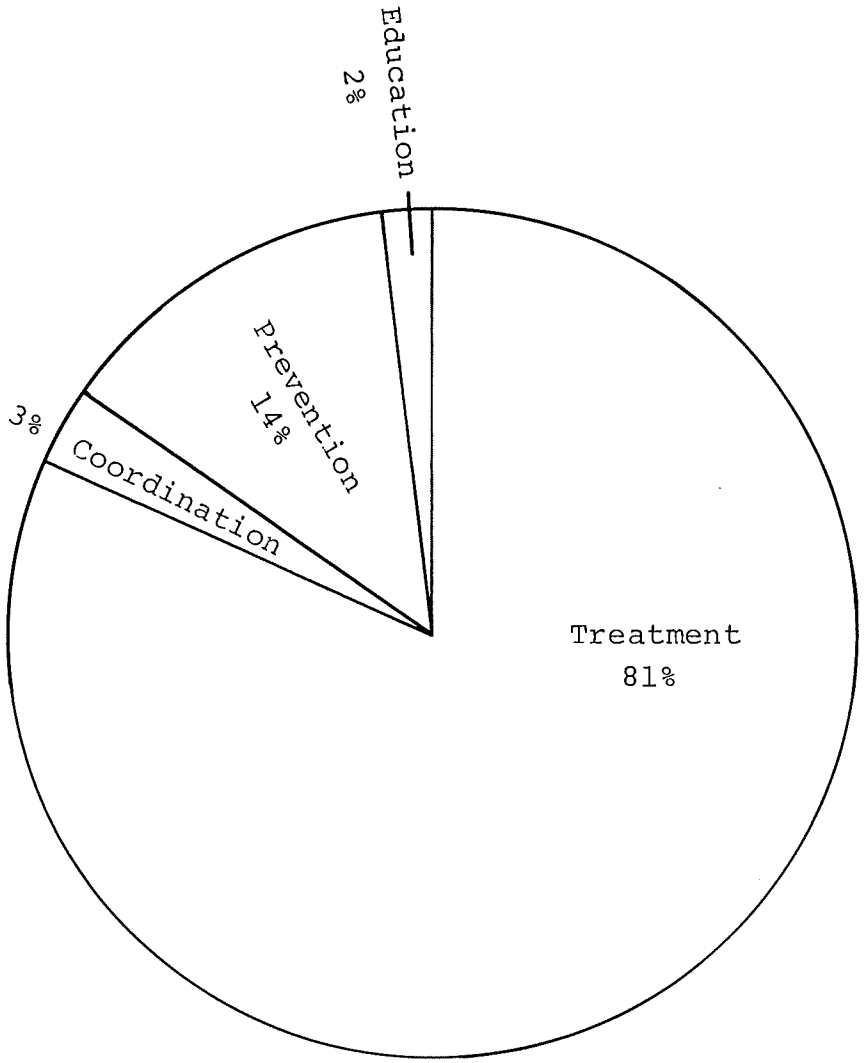


Figure III-26: Sources of income for alcohol services in Region 5 (1982 $).

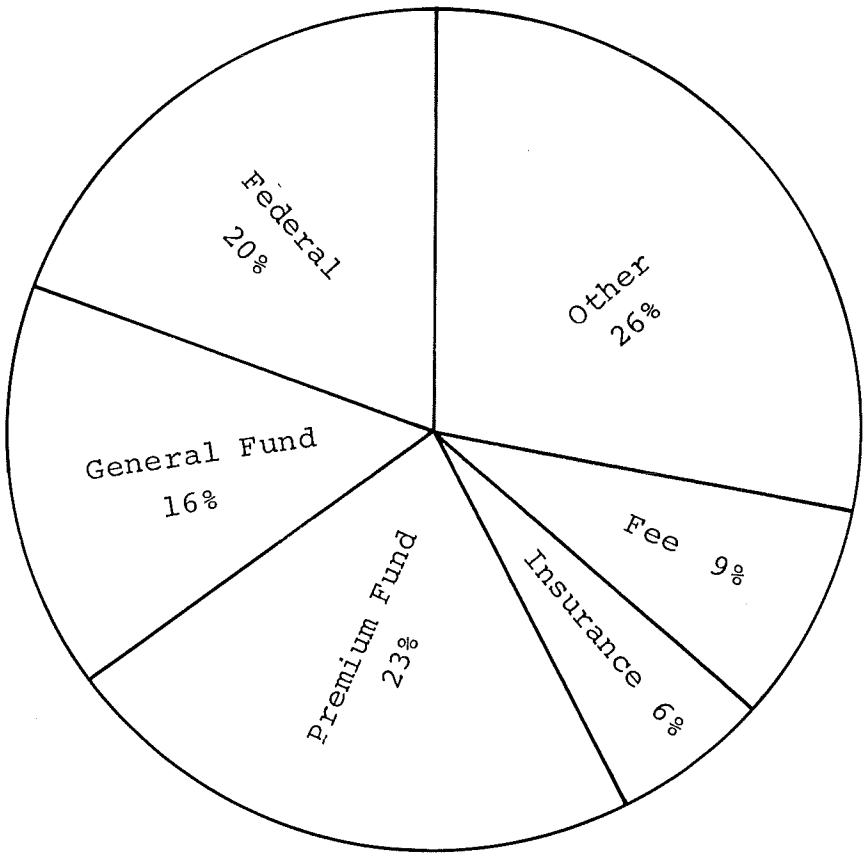
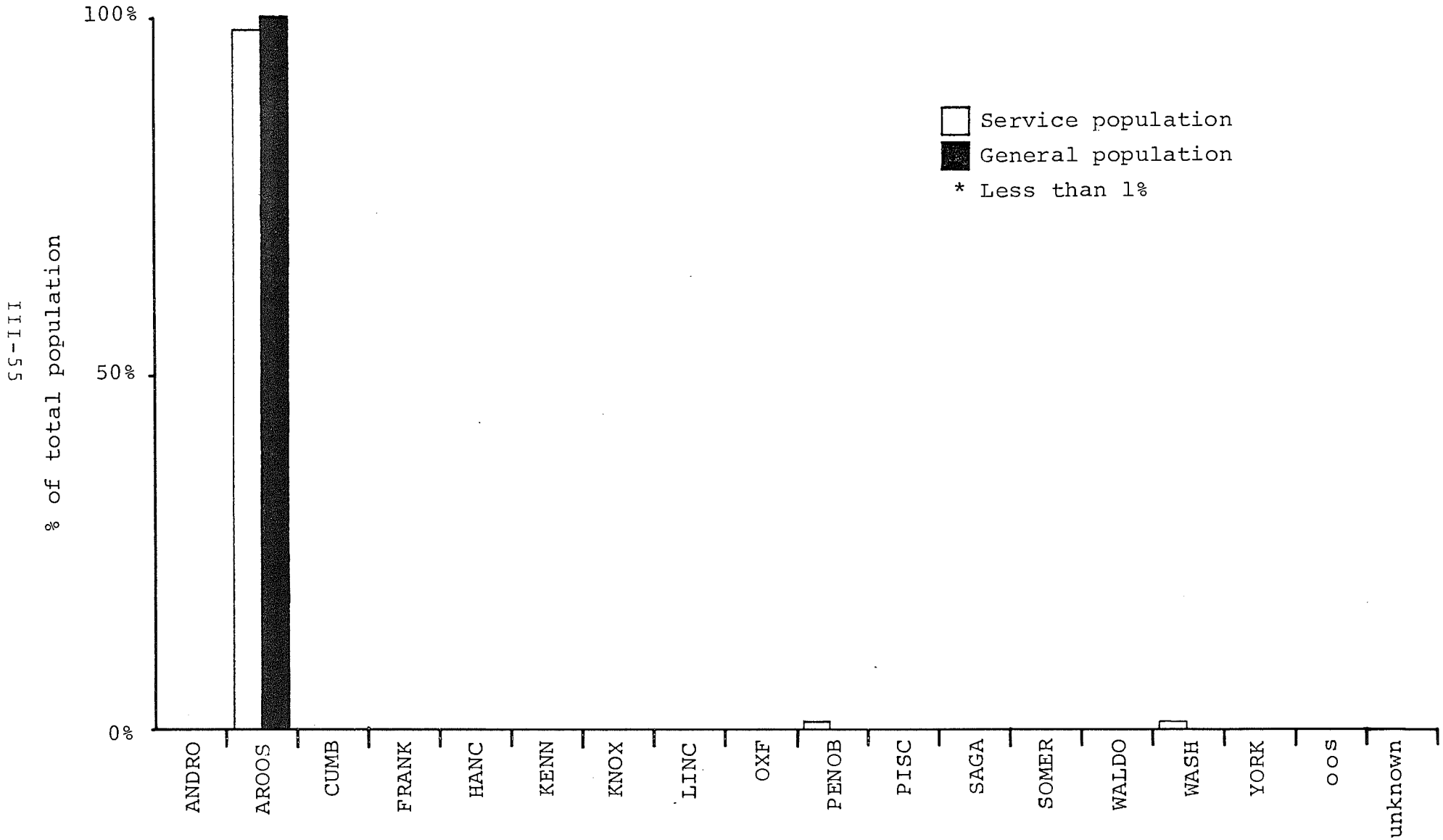


Figure III-27: Alcohol Service Consumers: County Residence Compared with General Population in Region 5



Note: "oos" = out of state

Figure III-28: Alcohol Service Consumers: Socioeconomic Characteristics Compared with General Population in Region 5

A. Service Population
B. General Population

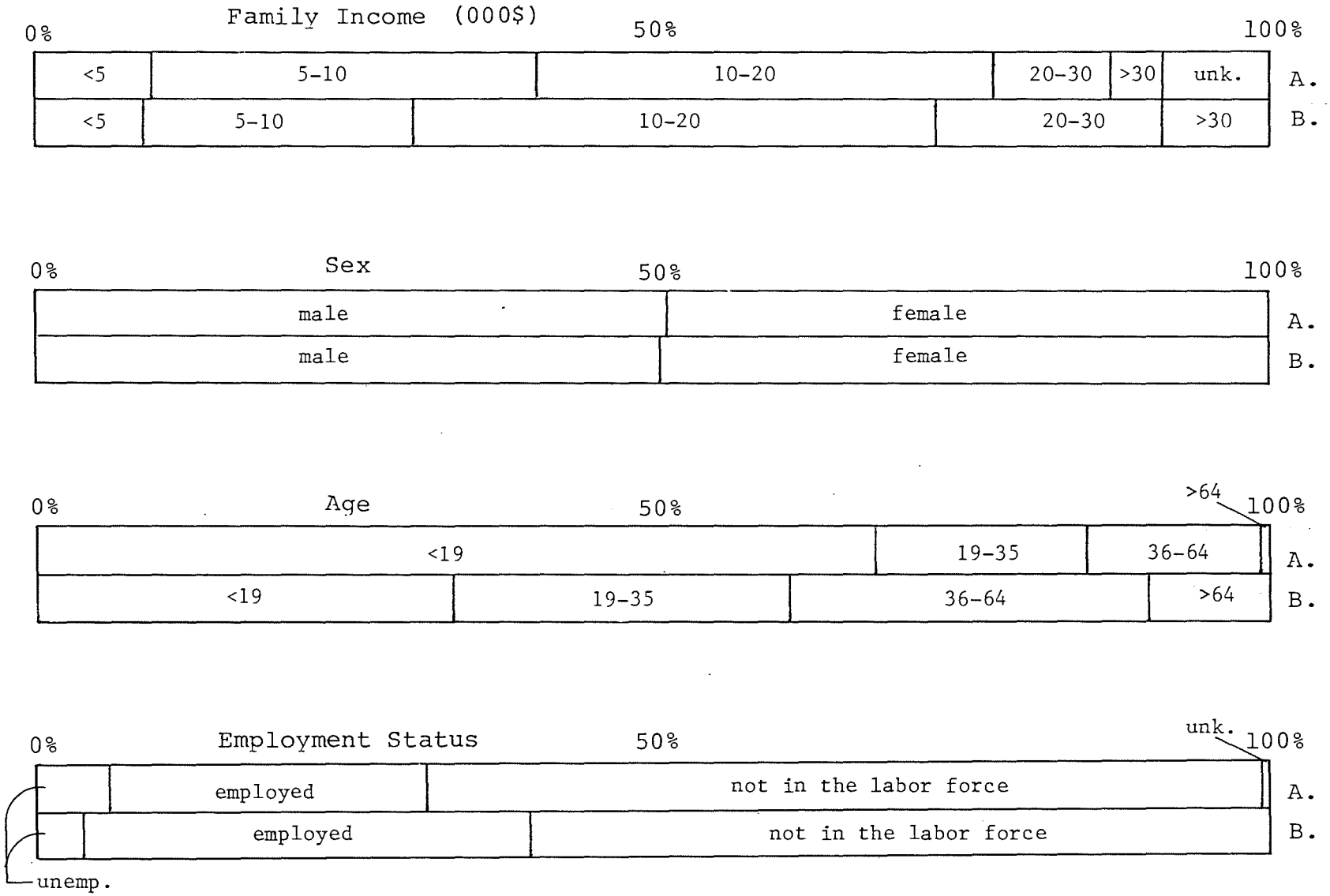
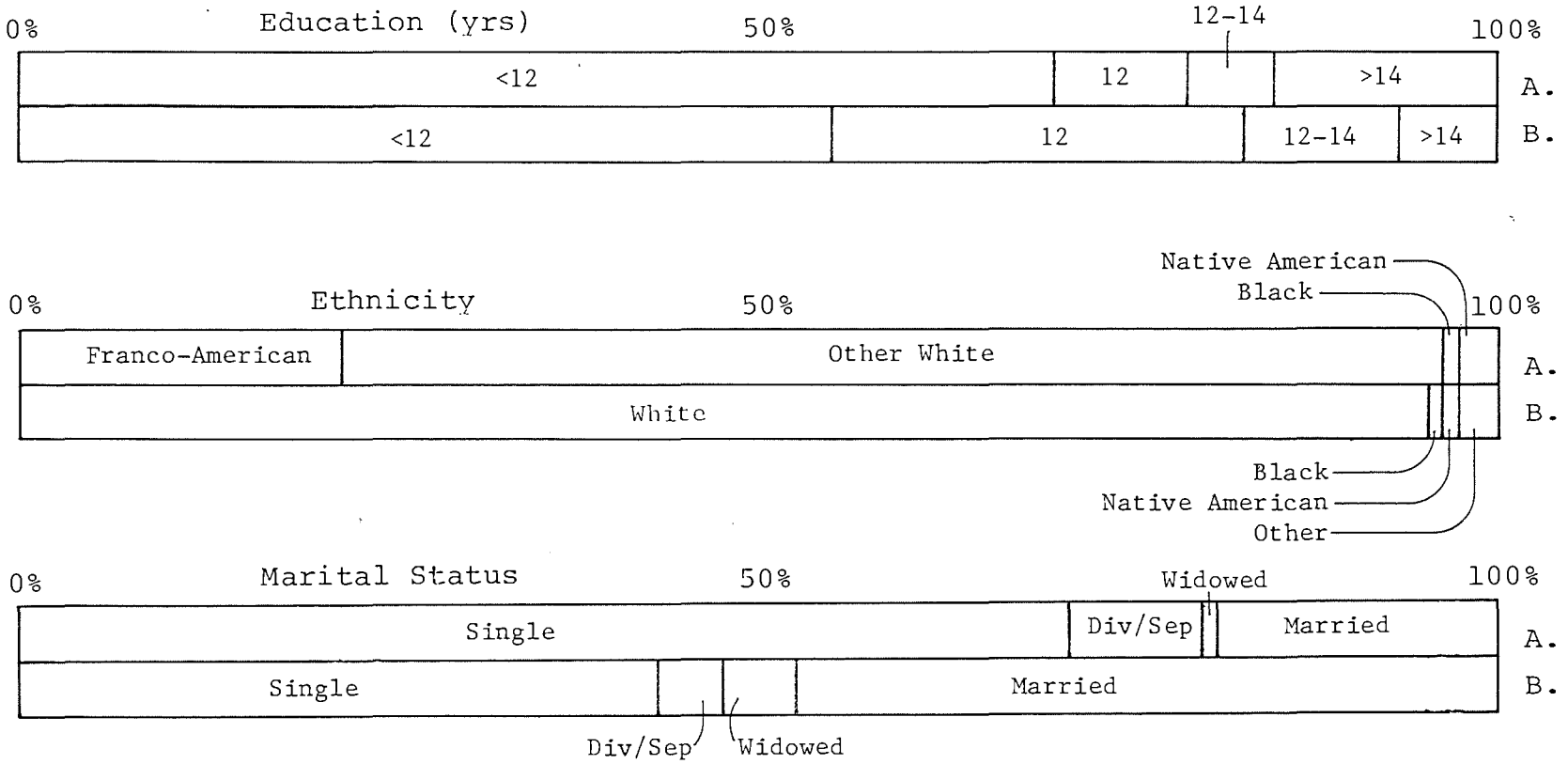


Figure III-28: (continued)

A. Service Population
B. General Population



III-10. Survey Questionnaire

State of Maine
Senate Chamber
Augusta, Maine 04333

September 21, 1982

Dear Sir or Madam:

The problems caused by alcoholism and alcohol abuse persist in the State of Maine despite the extensive efforts of many dedicated professionals and concerned individuals such as yourself. As you are undoubtedly aware, the Legislature initiated a new effort to reduce the cost and human suffering caused by alcohol abuse when it enacted in 1981 AN ACT Promoting Alcoholism Prevention, Education, Treatment and Research. The Act placed a new premium on the sale of liquor in Maine to generate revenues specifically dedicated to funding activities aimed at the problems of alcoholism and alcohol abuse.

The Joint Select Committee on Alcoholism Services of the Legislature has the responsibility to allocate the premium funds so as to insure the support of programs for alcoholism prevention, education, treatment and research. For assistance in this effort, the Committee has retained Foundation Associates, a group specializing in questions of social policy, to conduct a study of the costs of alcoholism and alcohol abuse in Maine, to survey the existing range of alcohol-related programs and services, and to recommend to the Committee a set of policies to guide the most effective use of the premium funds.

The enclosed questionnaire is part of this cooperative effort. It is designed to collect information on the full range of alcohol-related activities in Maine. While some of its questions may not be relevant to your particular efforts, your help in the conduct of this study would be greatly appreciated.

The information collected with the questionnaire will be used by Foundation Associates only to describe the services provided in the State. The survey is not designed as a program-specific evaluation effort, nor will it be used in that manner.

If you have any questions, or need help completing the questionnaire, please contact Foundation Associates at 622-0899. On behalf of the Committee we thank you in advance for your valuable assistance.

Sincerely,

Thomas R. Perkins

Thomas R. Perkins
Senate Chairman
Joint Select Committee on
Alcoholism Services

Neil Rolde

Neil Rolde
House Chairman
Joint Select Committee on
Alcoholism Services

enclosure
elk

Questionnaire Instructions

Thank you very much for taking the time to fill out this questionnaire for us. Our review and pretest of the questionnaire indicates that it takes about 30 minutes to complete. When you have finished, please return the questionnaire in the enclosed, self addressed envelope. If you have lost the envelope, our address is:

Foundation Associates
124 State St.
Augusta, Maine 04330

The information collected with this questionnaire will be used to provide the Select Committee on Alcohol Services with a general description of the State's activities in the field of alcoholism and alcohol abuse. The information will not be used to evaluate individual programs or agencies.

A few general instructions will be of use:

- We understand that, in many instances, the information requested may not be readily available or very reliable. We expect you to rely primarily on professional judgement and experience; do not spend substantial amounts of time summarizing case records or other internal documents.

- In order that we are able to evaluate the quality and reliability of the information you provide we ask you to rate the information on a scale of one (1) to four (4). This scale is defined as follows:

  1 - Reliability Unknown; a guess with no method of substantiation.

  2 - Low reliability; draws on staff experience but no written records exist on this item.

  3 - Fair reliability; draws on staff experience and a written record with partial coverage of this item.

  4 - Good reliability; draws on staff experience and a complete, summarized record system for this item.

  Down the right-hand side of each page in the questionnaire you will see a number of boxes in a column headed with the title, "IQ". Please write the rating for a question in the box immediately next to it.

- The focus of our study is on alcohol related activities only. We have however asked a few specific questions to get a feel for the scope of your more general activities. Please be aware of this distinction.

Instructions - 2.

- In Section II - Staffing Patterns - please use full time equivalents when adding up the total staff figures or when apportioning staff effort among various categories.

- In Section III - Client Characteristics - you have been asked to provide a profile of your client or contact population. This may mean a general description of the target population in an education program or a profile of clients in a treatment program. You may undertake several activities, each with very different client characteristics. If you believe this is the case, please copy Section III and fill out a separate sheet for each service type.

- Please feel free to comment at length if this would be helpful for you. The last sheet of the questionnaire can be used for this purpose. Attach additional material if you feel it would be valuable in describing your services and capabilities.

If you have any problems filling out the questionnaire or questions regarding our study, please call us at 622-0899. Your response will be a very important contribution to the Select Committee's understanding of the situation in Maine and to the Committee's subsequent decisions.

Thank you again for your assistance.

Foundation Associates

NOTE: PLEASE READ THROUGH THE QUESTIONNAIRE BEFORE ANSWERING ANY OF THE QUESTIONS.

Premium Project Survey of Alcohol Services and Activities
prepared by
Foundation Associates
124 State St.
Augusta, Maine 04330

Name & Address of Agency or Program: _____

_____

_____

_____

TEL: _____ _____

Name of person completing this questionnaire: _____

Your position: _____

PLEASE READ ALL INSTRUCTIONS CAREFULLY!

* *

I. ALCOHOL PROGRAM ACTIVITIES AND RELATED COSTS IQ

1. Please estimate to the nearest thousand dollar figure, the total amount of your 1982 budget for alcohol programs and activities. $_____ ☐

1a. What percent of your combined alcohol and drug abuse budget does the above figure (#1) represent? _____% ☐

1b. What percent of your total budget does the above figure (#1) represent? _____% ☐

2. The following questions will give us a sense of how your alcohol-related budget (question #1) is allocated among various activities.

-First, estimate what percent of the alcohol-related budget is spent in the six, general categories of treatment, education, prevention, research, coordination and contracted services. The percentages given for the six, general categories should total to 100%.

-Second, estimate what percent of each general category's budget is spent on the associated service/activity components. Each grouping of service/activity components should total to 100%.

General Category		Service/Activity Type	
A. TREATMENT	_____%	a. Public Institutions	_____%
		b. Outpatient	_____
		c. Detoxification	_____
		d. Shelter	_____
		e. Halfway House	_____
		f. Residential Rehabilitation	_____
		g. Home-based(Alternative Living)	_____
		h. Self-help (AA model)	_____
		i. Other (please describe)	
		_____	_____
		_____	_____
		_____	_____
			100% ☐

General Category		Service/Activity Type		IQ
B. EDUCATION	____%	a. Inservice (staff) education & training	____%	
NOTE: Education activities are operationally defined as those targeted to a general population with no specifically identified at-risk groups although these groups may be reached.		b. Community Education	____	
		c. Consultation & Technical Assistance	____	
		d. Resource & Information Services	____	
		e. Other Training	____	
		f. Other (please describe)		
		_____	____	
		_____	____	
		_____	____	
			100%	☐
C. PREVENTION	____%	a. Primary Prevention	____%	
NOTE: Prevention activities are operationally defined as those targeted specifically to identified at-risk groups or individuals.		b. Early Intervention	____	
		c. Employee/Student Assistance Program	____	
		d. Health Promotion	____	
		e. Other (please describe)		
		_____	____	
		_____	____	
		_____	____	
			100%	☐
D. RESEARCH	____%	Briefly Describe:		
		_____	____%	
		_____	____	
		_____	____	
			100%	☐
E. COORDINATION	____%	a. Grant management	____%	
		b. Planning	____	
		c. Interagency coordination	____	
		d. Other (please describe)		
		_____	____	
		_____	____	
		_____	____	
			100%	☐

F. CONTRACTED SERVICES ____% If you contract with another agency for services, please indicate the name of the program/agency holding the contract(s) and the estimated percent these services represent of your alcohol budget. Attach additional sheets if necessary.

Agency	%
_____	____
_____	____
_____	____
_____	____
_____	____
	100% ☐

IQ

4. Please estimate what approximate percent of your total budget for alcohol-related activities (question #1) comes from the following sources:

A.	Direct Federal Contract	_____%
B.	State-administered Federal Block Grant	_____
C.	State General Fund	_____
D.	State Premium Fund	_____
E.	County/Municipal	_____
F.	Third-party Reimbursement	_____
G.	Other Private	_____
H.	Fees	_____
I.	Other (please describe)	
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
		100%

☐

IQ

II. STAFFING PATTERNS (Please use full time equivalents throughout)

1. How many people do you employ in your alcohol and drug abuse program? _____ ☐

2. How many of these people are employed for alcohol services/ activities? _____ ☐

3. How many volunteers provide support for your alcohol activities? _____ ☐

4. Please indicate the approximate percentage of alcohol activity staff employed in the following categories:

Position/Title	Employee	Volunteer
A. Managerial	_____%	_____%
B. Direct Service	_____	_____
C. Administrative/Support	_____	_____
D. Consultants	_____	_____
E. Other (please describe)		
_____	_____	_____
_____	_____	_____
_____	_____	_____
	100%	100%

☐

5. Please indicate what fraction of your direct service, alcohol activity staff is registered, licensed, or certified by a state, federal, or professional organization? (categories need not be mutually exclusive)

license, registration, or certification category (please describe)	% of direct service staff
_____	_____
_____	_____
_____	_____

6. Is your program licensed or certified by the state?

Yes ____ No ____

6a. If yes, please describe: _____

_____

_____

III. CLIENT CHARACTERISTICS Activity/Service Type: _____ IQ

1. We are trying to develop a sense of the general socioeconomic and demographic characteristics of your client or contact population. Drawing on your professional experience, please estimate, in percent notation, these parameters on the scales below.

PLEASE NOTE: If you provide services to groups with substantially different characteristics, please copy this sheet and fill out a separate client characteristics section for each service or activity for provide.

a. County of Residence (%) ☐

___Androscoggin	___Knox	___Somerset
___Aroostook	___Lincoln	___Waldo
___Cumberland	___Oxford	___Washington
___Franklin	___Penobscot	___York
___Hancock	___Piscataquis	___Out of State
___Kennebec	___Sagadahoc	___Unknown

b. Family Income (%) ☐

_____ less 5,000/yr. _____ 5,000-10,000/yr. _____ 10,000-20,000/yr.

_____ 20,000-30,000/yr. _____ 30,000 +/yr.

c. Sex (%) _____ male _____ female ☐

d. Age (%) _____ under 19 _____ 19-35 _____ 36-64 _____ over 64 ☐

e. Employment Status (%) _____ unemployed _____ employed _____ not in the work force ☐

f. Education Level (%) _____ less than 12 _____ 12 _____ 12-14 _____ 14+ ☐

g. Ethnic Background (%) ☐

_____ FrancoAmerican _____ Other White _____ Black _____ American Indian _____ Other

h. Marital Status _____ single _____ divorced/separated _____ widowed _____ married ☐

i. % of clients covered by health insurance for services you provide. _____% ☐

2. Estimate the average number of clients served per year _____ ☐

3. Estimate the average length of involvement per client _____ ☐

4. The following terms describe an individual's possible relationship to alcohol. Please estimate the portion of your contact population meeting each description recognizing that there maybe overlap or duplication among the categories. ☐

	(%)
Alcohol Abusers early stage	_____
late stage	_____
Social Users	_____
Non-Users	_____
Individuals affected by another's alcohol abuse	_____

IV. EVALUATION PROCEDURES

1. What are the primary sources of information you use in evaluating your program? (please indicate the order of importance)

_____ admission and discharge files
_____ community feedback
_____ professional staff judgment
_____ state or federal surveys and/or studies
_____ follow-up surveys of former clients
_____ other (describe briefly) _____
_____
_____

2. How do you use the information you collect to evaluate your program? _____
_____
_____
_____
_____
_____

3. How do you manage and process the information you collect?

Manual ____
Computerized ____

4. Would you please enclose blank copies of the forms you commonly employ for your own internal program evaluations and for any outside agencies. NOTE: Please do not include MIS Quarterly Report Forms, CODAP Forms, or OADAP grant progress report forms.

5. Do you periodically contact clients or patients who have left your program? (please check the appropriate entries)

30 days _____
90 days _____
other _____
no follow-up _____

6. How would you improve your evaluation process if time and funding permitted? _____
_____
_____
_____

7. What fraction of your staff's time is spent in completing the reporting forms sent to funding agencies (federal, state, insurance, etc.):

IQ ☐

Professional staff _____%
Support staff _____%

8. If you had more money to spend on activities to reduce the incidence of alcohol abuse in Maine, how could you best utilize this money?

_____

_____

_____

_____

_____

* *

Thank you very much for the time you have spent on this questionnaire. If you need more space for comment, please feel free to attach additional sheets. If you have any questions, please call Tim Glidden or Valerie Savage at

*** 622-o899 ***

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter IV:

ASSESSMENT OF PLANNING, EVALUATION, AND DATA MANAGEMENT FOR ALCOHOL SERVICES IN MAINE

Tim Glidden
Dennis Meadows
Valerie Savage

FOUNDATION ASSOCIATES
Box 89, Daniels Road
Plainfield, NH 03781
(603) 675-2230

December 1982

This work was supported by a contract from the Maine Legislature's Joint Select Committee on Alcoholism Services under Appropriation 4050.1

ASSESSMENT OF PLANNING, EVALUATION, AND
DATA MANAGEMENT FOR ALCOHOL SERVICES IN MAINE

Table of Contents

ASSESSMENT OF PLANNING, EVALUATION, AND DATA MANAGEMENT FOR ALCOHOL SERVICES IN MAINE

IV-1. Abstract

Three acts by the Maine Legislature have established goals for the state agencies that are working to reduce alcohol abuse. In this chapter we:

- assess the goals for planning, evaluation, and data management that have been expressed in the law by the Legislature,
- summarize our survey of 134 alcohol service agencies in Maine to determine the degree that service agencies have met the Legislature's goals,
- describe some effective alcohol and drug abuse planning efforts in other states,
- identify deficiencies in the current alcohol service data system, and
- suggest changes in the form and procedures of state agencies that would enhance the effectiveness of programs with state support.

We propose a simple, idealized model of the process that should be used to assess needs, allocate funds, and measure performance of alcohol programs. Then we review the legislative mandate and current state activities involving the needs assessment, the definition of goals and performance indicators, and the evaluation of performance. In response to our observations we make five recommendations to the Legislature:

- make institutional changes,
- establish data standards,
- implement a four-year planning cycle,
- fund planning research, and
- set a schedule for implementation.

IV-2. List of Figures

Chapter IV:

ASSESSMENT OF PLANNING, EVALUATION, AND DATA MANAGEMENT FOR ALCOHOL SERVICES IN MAINE

IV-3. Introduction and Purpose

Three acts by the Maine Legislature have established goals for the state agencies that are working to reduce alcohol abuse:

- the 1973 enabling legislation for OADAP and the State Advisory Council, 22 MRSA c. 1601,
- the 1981 alcohol premium act, 28 MRSA c. 12, and
- the 1982 authorization bill for alcohol programs in fiscal year 1983.

All of these have prescribed goals for a coordination and planning process that includes all publicly-supported alcohol services. In response to the Legislature's latest mandate, the Departments of Education and Cultural Services (DECS), Corrections (DC), Human Services (DHS), and Mental Health and Mental Retardation (DMHMR) established in 1982 the Interdepartmental Planning Committee on Alcoholism Services (IDPC). This group prepared the draft plan for fiscal year 1984 now being considered by the Joint Select Committee. We have reviewed this document in detail. It is a significant improvement over its predecessor, but it still lacks many features required to satisfy the intent of the legislature.

Some of the plan's deficiencies result from problems built into the structure of the planning process. For example, legislation establishing

the alcohol premium stripped OADAP of several important powers without clearly delegating them to any other agency involved in budget decisions.

Other difficulties stem from inadequacies in the state's system for acquiring and interpreting data both on alcohol abuse and on alcohol services in Maine. The extent of the problem may be illustrated by comparing The IDPC plan with its counterparts in other states. For example in "Colorado State Plan for Alcohol and Drug Abuse, FY 1982," 107 pages are devoted to a detailed statistical treatment of alcohol abuse and its related problems in Colorado. The corresponding section in Maine's plan occupies little more than one page, and it does not contain a single piece of information specific to Maine. It offers only a brief summary of data about general problems of alcohol abuse in the United States.

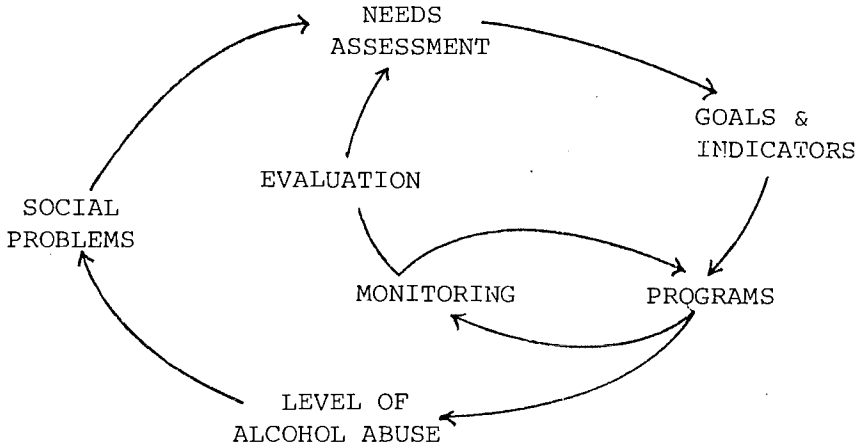
These problems will significantly reduce the effectiveness of efforts to reduce alcohol abuse across the state. Thus much of our effort during the Premium Project involved study of the procedures for data acquisition and management that are currently employed by those offering alcohol services in Maine. During the course of the project we:

- assessed the goals for planning, evaluation, and data management that have been expressed in the law by the Legislature,
- surveyed the alcohol service system to determine the degree that service agencies have met the Legislature's goals,
- studied some effective alcohol and drug abuse planning efforts in other states,
- identified deficiencies in the current alcohol service data system, and
- determined what changes in the form and procedures of state agencies would enhance the effectiveness of programs with state support.

We employed many sources in our project. Our research involved a mail and telephone survey of 168 alcohol-related programs in the state. We studied OADAP's extensive collection of planning materials from drug and alcohol abuse programs in other states[1], made site visits to 20 alcohol services agencies across Maine, and participated in meetings of the principal coordination agencies in the state (MASAP, The Second Friday Management Group, IDPC, The State Advisory Council, and the Association of Regional Councils). We also met with the director of The National Council on Alcoholism in Maine and with the presidents of ALMACA and OPCAM. In Chapter III we presented the numerical summaries of our survey. Here we interpret those results and combine them with other sources of information to determine what changes should be made in the system.

An ideal process for gathering data, evaluating it, and planning the allocation of future funds would consist of a continuous cycle of activities. Figure IV-1 presents a simple, idealized schematic of this cycle as it could apply to alcohol services.

Figure IV-1: An idealized model for the planning and evaluation cycle by alcohol service agencies.



1. This extremely useful collection was assembled by Linda Wilcox.

The LEVEL OF ALCOHOL ABUSE determines the potential for and incidence of SOCIAL PROBLEMS. By measuring the problems, it is possible to define a NEEDS ASSESSMENT. Some of the needs may be expressed in dollars, as we have done in Chapter II of this report. Others do not have direct monetary equivalents, for example the level of child abuse by alcoholics. With information from the needs assessment including data on priorities and resources, it is possible to determine GOALS and PERFORMANCE INDICATORS for the state's alcohol programs. The goals are then translated into budgets consistent with the state's resources to fund PROGRAMS. These lower the LEVEL OF ALCOHOL ABUSE and reduce SOCIAL PROBLEMS. MONITORING efforts collect data on program performance for use in short term contract management. Performance indicators are also used to compare the magnitude of social problems and the level of abuse with the original goals. This comparison permits EVALUATION, which identifies inefficient efforts and gaps in services. Information from the evaluation will influence future assessments of the state's needs.

When the management system is functioning well, it should be possible it identify the data and the procedures related to each of these steps. Responsibility for each stage should be clearly assigned to one or more agencies in the state-wide system.

We have searched for information on the magnitude and the causes of departures from this ideal planning model in Maine. The problems we found were mainly structural; typically they did not originate with individuals. Throughout our study we met capable people working very hard to reduce the costs of alcohol abuse in the state. We also found many instances of real excellence and innovation in their programs. Without doubt the personnel and the agencies now responding to alcohol problems in Maine can provide very effective programs for education, prevention, and treatment. But they are being hindered by serious deficiencies in the management and coordination of the state's system.

The purpose of this chapter is to review the process through which alcohol services are planned and evaluated in Maine and to suggest changes in the existing process. In the next section we discuss requirements for the state's alcohol information system. The following sections address the components of planning and evaluation, describe current mechanisms for coordination, and lay out our recommendations.

IV-4. Information Systems

Fundamental to the operation of an efficient alcohol system is qualitative and quantitative information that describes the incidence of alcohol abuse, the nature and the magnitude of its related problems, and the impact of different alcohol programs on those problems. The information should provide guidance to the central planning staff, so that its members can understand the problems, design effective policies, recommend alcohol service programs, and evaluate their effects. The information should also provide assistance to those managing individual service agencies, so that they can raise the effectiveness of their efforts. A system to supply these data is clearly called for in 22 MRSA c. 1610 §7106:2 which states:

> Uniform methods of keeping statistical information shall be specified for use by public and private agencies, organizations and individuals. . . . Maintain(ing) 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.

That goal has not been attained. The present information system has evolved principally through the efforts of individual agencies to develop data that will assist in the management of their own affairs. The system mandated by the legislature simply does not exist. Without

it the ability to evaluate and plan for alcohol services is severely limited.

Our surveys and interviews point to several deficiencies in the current system:

- methods used to gather data on alcohol programs and their clients are inconsistent, they differ from one service agency to another, and they vary among state departments. We gathered the forms used for patient records in many different agencies. Most use different formats and request different data. MASAP has been working to standardize its members' data gathering procedures, even though it is hindered by lack of guidance from OADAP on the uses which the state may ultimately have for the information. All four state agencies gather periodic information on client characteristics and program activities, but their summaries differ greatly in content and form.

- few of the data bases are computerized, thus they are cumbersome to use. Only two state agencies use computers, DMHMR and DC. OADAP staff members indicated to us that they find it cumbersome to carry out analyses of the data they receive from treatment programs. Few of the treatment agencies have adopted automated data processing.

- the information that is gathered does not fully serve the needs of state planners. Consequently, much data gathered at great expense within the service agencies is not used by anyone.

- insufficient time is spent assessing program effectiveness, forty percent of the service agencies in our survey reported that they conduct no follow-up surveys whatsoever. We suspect the information is not effectively used in perhaps another twenty percent of the agencies.

- many important characteristics of the clients are not measured, for example our survey revealed low levels of information on such factors as clients' income, educational levels, and relation to alcohol,

- the procedures used today do not eliminate double counting in the patient population - one requirement explicitly stated by the legislature.

We encountered many explanations for current deficiencies. There is legitimate concern over protecting the anonymity of those receiving services. Many professionals in the field also believe that every program (or at least theirs) is sufficiently unique to preclude management based on system-wide norms of performance. There is also fear by some program administrators that the introduction of data collection and subsequent evaluations might illuminate deficiencies in a program, impairing its ability to obtain funding. Lastly, until recently there has been very little incentive to collect information and to evaluate programs. Except for some now defunct federal requirements, none of the funding agencies has implemented rigorous data collection and evaluation systems that are linked to their financial support.

These are significant obstacles, but they have been overcome in other states. For example Oklahoma agencies have implemented a very effective information system that covers treatment programs inside the state. The resulting data are used for fiscal management, outcome evaluation, and system-wide planning. Montana has also developed a data system designed:

- To provide data comparing all programs on a statewide basis using a standardized procedure.
- To assist the state office in assessing the need for additional services and in determining contract levels.
- To assist in the evaluation and management of existing programs.
- To respond to requests for information.[2]

The precise information required by Maine agencies to achieve these goals will depend on the form of planning and evaluation system they ultimately adopt.

2. "Montana Comprehensive Plan for Alcohol and Drug Abuse Prevention, Treatment and Rehabilitation (FY 1982), prepared by: Alcohol and Drug Abuse Division, State Department of Institutions, p. 45.

IV-5. Planning and Evaluation

Existing legislation addresses three elements of the planning and evaluation cycle outlined in Figure IV-1. These are:

- the needs assessment,
- the definition of goals and performance indicators for alcohol services, and
- the evaluation of performance.

Needs Assessment

The 1973 legislation asked for a detailed survey to establish "the extent of of the drug abuse problem, and the needs and priorities for the prevention of drug abuse and drug dependence. . ." This request was repeated in the Alcohol Premium Act, which required that the four departments "jointly prepare and submit a report on alcoholism prevention, education, treatment and research to the legislature," that includes, "specific recommendations regarding allocations from the fund including . . . the specific reasons for their recommendations." OADAP did develop a needs assessment several years ago. It has not been updated, and the current plan does not refer to the earlier document in any explicit fashion. The deficiencies in this area were pointed out in Section IV-3 when comparing the Maine plan with that prepared in Colorado.

The needs assessment is an essential foundation for the planning process. If there is no explicit and current statement of needs, the irresistible tendency is for agencies to specify as objectives merely those goals they are currently capable of pursuing. For example, the state has almost no effective capacity to stimulate development of corporate employee assistance programs. Thus EAPs do not figure prominently in the FY 84 plan. Yet our preliminary assessment of costs, indicates that lost productivity in the corporate sector is the single largest area of impact by alcohol abuse in the state. A competent needs analysis by state agencies would certainly alter their program priorities in this area.

Of course, it is very difficult to identify and measure, even qualitatively, the social problems engendered by excessive alcohol use. Nevertheless it is essential to develop at least a crude needs assessment, and the success of several other states in this area suggests it is possible. Our cost calculations in Chapter II illustrate one way to begin the job. In Figure IV-2 we provide our compilation of the data sources currently available to Maine officials to extend our analysis. Figure IV-3 shows one aspect of the needs assessment developed by Indiana officials. A recent report from Wisconsin illustrates still another approach.[3] In their early efforts it will important for Maine officials to remember that it is less important to be accurate than it is to be comprehensive and to identify needs that lead to objective goals and performance indicators.

Goals and Performance Indicators

The requirement for explicitly defined goals is strongly embedded in the law. The 1973 legislation establishing OADAP requires the development of a state drug abuse strategy including "a comprehensive plan with respect to . . . drug abuse prevention . . . which shall specify the objectives of the strategy " The law also states that the strategy shall be reviewed and revised at least every two years.

An important feature of the FY 1984 plan by IDPC is its extensive set of objectives based on a very general definition of prevention, education, treatment, and research goals. A valuable addition to the plan was a set of "performance indicators" related to each objective. These indicators can become the basis for a useful planning and control system if two significant changes can be made in the approach taken by the IDPC:

- The indicators should not be mere restatements of the activity, nor should they be expressed in terms of spending money or time. They should focus on features of the real system that are to be changed, and they

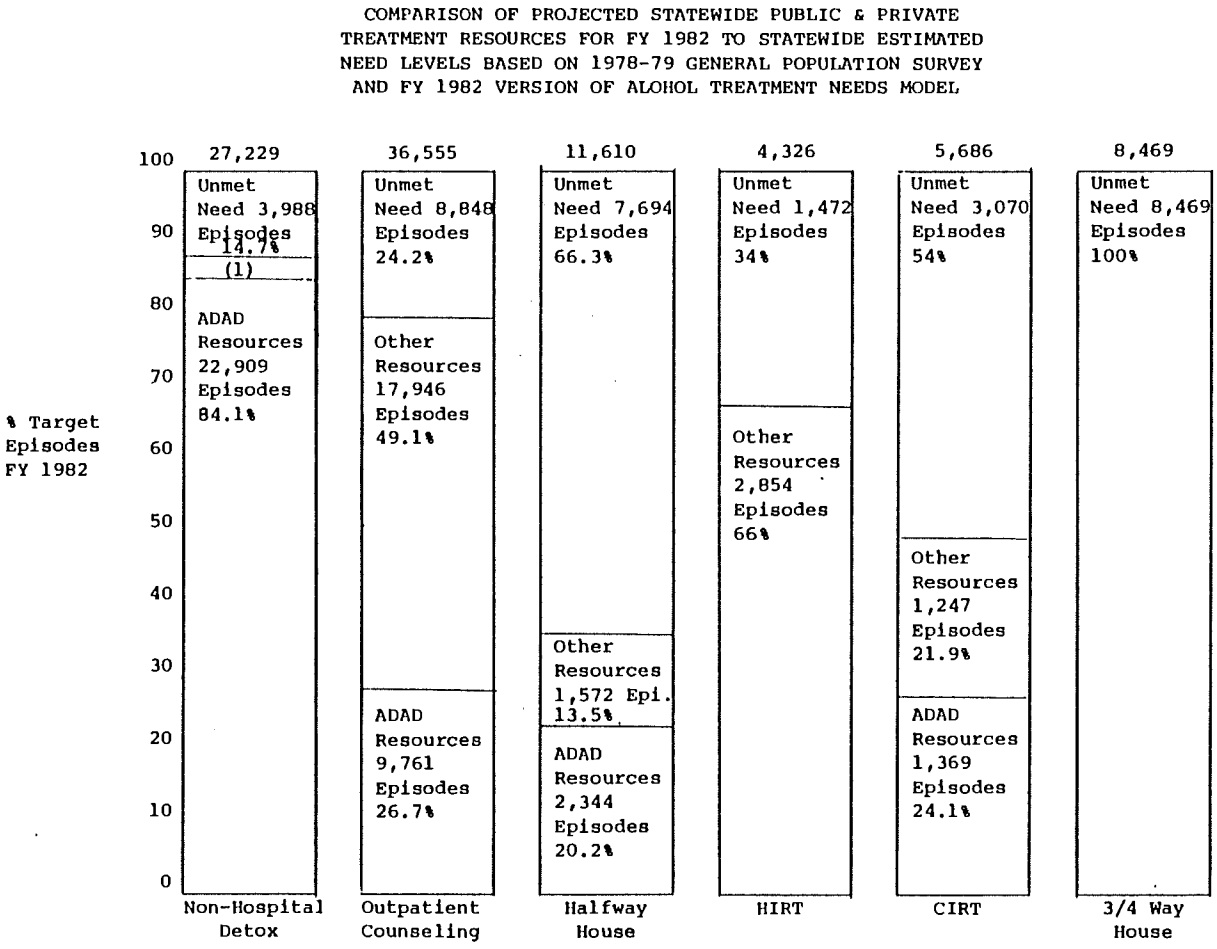
3. "Impact of Alcohol & Other Drug Abuse in Wisconsin: A Profile of Indicators," Department of Health & Social Services, Division of Community Services, Bureau of Alcohol & Other Drug Abuse, Second Annual Report, November 1980.

Figure IV-2: Data sources for estimating the costs of alcohol abuse in Maine.

Indicator	Data Source	Data Location	Reported by
Traffic Fatalities	CAPI* Traffic Report	OADAD Dept. of Public Safety	County Town
Cirrhosis of Liver Death Rates & Other Alcohol-Related Deaths	CAPI Death Certificates	OADAP	County Town Sex Age Marital Status Occupation
Volume-of-Alcohol Sales	Financial Statements Bureau of Alcoholic Beverages	OADAP	State Liquor Stores
Alcohol-Related Crime Rates	Uniform Crime Reports	Dept. of Public Safety	County
Hospital Admissions	Maine Health Information Center	Maine Health Information Center	Hospital County
Alcohol Consumption Rates	1981 OUI Interview Survey	OADAP	County Town Sex Age Marital Status Employment Status

* County Alcohol Problem Indicators, Alcohol Epidemilogic Data System, NIAAA.

Figure IV-3: Illustrative needs assessment conducted by Colorado alcohol planning agencies.



(1) Other Public and Private Resources 332, 1.2%

should be defined so that they could, in theory, be objectively measured by a third party. In Figure IV-4 are a set of objective performance indicators specified in the Colorado plan together with the sources of measurement that can be used later to determine compliance with the plan.

- The planning cycle must include a systematic effort to review each year's accomplishments relative to the performance indicators that were adopted in the previous years' plans. In Figure IV-5 are the results of efforts to determine compliance with past objectives.

Performance Evaluation

Better data on past accomplishments are important, but they must be augmented by the political will and the administrative procedures required to conduct rigorous examinations of each program's effectiveness. Montana uses its data system in this way:

> data is also used to monitor and evaluate treatment programs. The Division examines reasons for discharge from Montana's community treatment programs for the purpose of monitoring completion and non-completion ratios . . . . treatment outcomes and average length of stay in treatment are determined and correlated with reason for discharge. Programs having a high non-completion rate are reviewed by program directors and the state office so that possible problems can be corrected.[4]

The 1973 law recognized the need for evaluation; it called for:

> 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 Government shall be evaluated. (22 MRSA c. 1610 § 7106:2)

Our discussions with department staff and program directors suggest that the only evaluations conducted by OADAP have focused narrowly on the administrative or operational issues that are required for licensing process or for assuring compliance with the terms of a state contract.

4. "Montana Comprehensive Plan for Alcohol and Drug Abuse Prevention, Treatment and Rehabilitation (FY 1982), prepared by: Alcohol and Drug Abuse Division, State Department of Institutions, p. 45.

Figure IV-4: Performance indicators from the FY 82 Colorado State Plan for Alcohol and Drug Abuse Services.

ALCOHOL TREATMENT
PROCESS
EVALUATION OBJECTIVES

MEASUREMENT SOURCE	NON-HOSPITAL DETOXIFICATION	HOSPITAL INTENSIVE RESIDENTIAL TREATMENT	COMMUNITY INTENSIVE RESIDENTIAL TREATMENT	HALFWAY HOUSE	REGULAR OUTPATIENT
Fiscal 1	Maintain 80% utilization of licensed capacity.	Maintain 90% utilization of licensed capacity.	Maintain 90% utilization of licensed capacity.	Maintain 80% utilization of licensed capacity.	N/A
Licensure Monitoring Visits For Outpatients: Fiscal 2	Maintain client-counselor ratio in accordance with licensure & monitoring standards & procedures.	Maintain client-counselor ratio in accordance with licensure & monitoring standards & procedures.	Maintain client-counselor ratio in accordance with licensure & monitoring standards & procedures.	Maintain client-counselor ratio in accordance with licensure & monitoring standards & procedures.	Maintain client-counselor ratio from 30-to-1 (all ind.) to 55-to-1 (all group).
DACODS Monitoring Visits Fiscal 3	Achieve & maintain a clinic average length of stay from 2.5-to-4 days with a maximum of 5 days for voluntary clients and 6 days for involuntary clients.	Achieve & maintain a clinic average length of stay of 45 days with a maximum stay of 90 days for an individual.	Achieve & maintain a clinic average length of stay of 21 days with a maximum stay of 30 days for an individual.	Achieve & maintain a clinic average length of stay of 30 days with a maximum stay of 65 days for an individual.	Achieve & maintain an average contact rate from 12 hours (all ind.) to 24 hours (all group) per client per treatment episode with at least one face-to-face contact per month.
	See current reimbursement policies for limits.				

Figure IV-4 continued.

ALCOHOL TREATMENT
OUTCOME
EVALUATION OBJECTIVES

MEASUREMENT SOURCE	NON-HOSPITAL DETOXIFICATION	HOSPITAL INTENSIVE RESIDENTIAL TREATMENT	COMMUNITY INTENSIVE RESIDENTIAL TREATMENT	HALFWAY HOUSE	REGULAR OUTPATIENT
DACODS 6	N/A	N/A	N/A	N/A	At least 90% (±5%) will not have experienced criminal justice involvement and criminal justice involvement will be reduced by 70% (±5%).
TIME FRAME: ADMISSION-TO-FOLLOW-UP, POST SIX MONTHS					
Follow-Up Study 7	65% (±10%) of referred clients will actually continue treatment.	___ _____ of referred clients will actually continue treatment.	80% (±10%) of referred clients will actually continue treatment.	50% (±10%) of referred clients will actually continue treatment.	N/A
Follow-Up Study Fiscal Reports 8	No more than 40% (±10%) of discharged clients will be readmitted to the same Detox clinic within 6 months.	No more than ___ _____ of discharged clients will be readmitted to any treatment within 6 months.	No more than 30% (±10%) of discharged clients will be readmitted to any treatment within 6 months.	No more than 35% (±10%) of discharged clients will be readmitted to any treatment within 6 months.	No more than 10% (±2%) of discharged clients will be readmitted to any treatment within 6 months.

Figure IV-5: Performance evaluations from the FY 82 Colorado State Plan for Alcohol and Drug Abuse Services.

1980 OUTCOME OBJECTIVES AND ATTAINMENT

TIME FRAME: DISCHARGE ONLY

ITEM	DETOX		OUTPATIENT		HALFWAY HOUSE		CIRT		HIRT	
	OBJ	ATT	OBJ	ATT	OBJ	ATT	OBJ	ATT	OBJ	ATT
Successful Discharges	45%	71%	60%	57%	55%	60%	65%	75%	70%	77%

TIME FRAME: ADMISSION-TO-DISCHARGE CHANGE

ITEM	OUTPATIENT		HALFWAY HOUSE	
	OBJ	ATT	OBJ	ATT
Full & Part-Time Employment	+5%	+2%	+10%	+4%
Prod. Inc. Sources	+5%	+2%	+5%	+4%
Non-Use of Alcohol	+30%	+12%	N/A	N/A
Dysfunctional Alcohol Use	-15%	-4%	N/A	N/A

TIME FRAME: ADMISSION-TO-FOLLOW-UP

ITEM	DETOX		OUTPATIENT		HALFWAY HOUSE		CIRT		HIRT	
	OBJ	ATT	OBJ	ATT	OBJ	ATT	OBJ	ATT	OBJ	ATT
Continue Treatment	50%	73%	N/A	N/A	80%	Not Avail	80%	45% 60%	80%	51% 72%
Readmitted	40%	34%	10%	12%	25%	49%	15%	39%	10%	22%
Full & Part Time Emp.	N/A	N/A	+15%	+7%	+45%	+19%	+10%	+29%	+10%	+11%
Overall Prod.	N/A	N/A	+15%	+10%	+50%	+26%	+15%	+34%	+15%	+11%
Prod. Inc. Sources	N/A	N/A	+15%	+3%	+25%	+16%	+10%	+23%	+10%	+4%
Non-Use of Alc.	N/A	N/A	+40%	+39%	+40%	+34%	+45%	+29%	+50%	+56%
Daily Alc Use	N/A	N/A	-40%	-27%	-40%	-38%	-45%	-40%	-65%	-41%
Drunk Episodes	N/A	N/A	-40%	-46%	-55%	-50%	-75%	-53%	-90%	-56%
No Arrests	N/A	N/A	90%	92%	90%	90%	95%	57%	85%	75%
Reduced Arrests	N/A	N/A	-25%	-53%	-25%	-48%	-30%	-64%	-30%	-46%
Successful Interviews	90%	100%	60%	60%	60%	51%	60%	73%	60%	78%

* The first figure represents the percentage of clients continuing in formal treatment (e.g., outpatient care), while the second figure shows the percentage continuing in AA.

Several individual programs do conduct and use extensive and competent evaluations of their own performance, but we have not been able to find any state-wide evaluation of alcohol programs. This is not surprising, since deficiencies in the current data system make such a review impossible. Client follow-up surveys would be a principal foundation for such reviews, and our study indicated that 40 percent of all service agencies conduct no follow-up to identify the impact of their efforts on their client population.

There have been federal reporting requirements that might have provided the basis for program evaluations. However, federal agency delays in use of these data were too great for them to be useful to state managers. And the current decline in importance of federal support removes the incentive to take U.S. Government information systems seriously. New initiatives are required at the state level.

Again, other state program provide useful models. Oklahoma has developed procedures for estimating the economic effectiveness of its programs.[5] Figure IV-6 presents the data form used by Montana as the base for a standard, state-wide system of follow-up. Figure IV-7 shows how similar data are used in Colorado to pinpoint the relative success of different treatment programs.

Evaluation Research

The 1973 act called for:

> research on the causes and nature of drugs, drug-abuse or people who are dependent on drugs, especially alcoholics and intoxicated persons

OADAP has chosen to support very little research of the type called for in the 1973 legislation. Research constituted only 2 percent of the direct social responses we tabulated in our cost study. We believe the

5. Gregory, Dick & O.H. Rundell, "A Model for Service Delivery Research and Evaluation: Management Implications for Alcohol, Drug Abuse and Mental Health Organizations," in Marc Galanter (Ed.), Currents in Alcoholism, Vol III.

Figure IV-6: Sample client follow-up report from the Montana Department of Institutions.[6]

CLIENT NAME: BAGGINS (Last) ROSE (First) GLOW (Maiden)

MONTANA DEPARTMENT OF INSTITUTIONS—ALCOHOL & DRUG INFORMATION SYSTEM

CLIENT FOLLOW-UP REPORT

PROGRAM NAME: YOUR A/D PROGRAM FACILITY NAME:

CASE NUMBER: 727

1. FOLLOW-UP: 3 (1)
2. PROGRAM NUMBER: 150402 16 (2-9)
3. CLIENT ID: 15GOR0754 (10-18)
4. DATE OF ADMISSION: 02/17/81 (mo/day/yr) (19-24)
5. FACILITY: 01 (27-28)
6. DATE OF FOLLOW-UP: 01/08/82 (mo/day/yr) (29-34)
7. IS FORMER CLIENT ACCESSIBLE? 1 (1. Yes 2. No) (35)
8. IS CLIENT CURRENTLY ATTENDING MAINTENANCE PROGRAM? 1 (1 Yes 2. No.) (36)
9. MARITAL STATUS: 5 (59)
   1 Never Married; 2 Married; 3 Separated; 4 Divorced; 5 Widowed
10. EMPLOYMENT STATUS: 1 (60)
    1 Full Time (more than 35 hrs a week); 2 Part-time; 3 Unemployed
11. REASON NOT EMPLOYED: (61-62)
    Answer ONLY for Clients not employed
    01. Disabled; 02 Drinking Problem; 03 Homemaker; 04 Hospitalized; 05 In Jail; 06 Looking for work but no job available; 07 No Skills; 08. Not looking for job; 09 Retired; 10. Student; 11 Seasonal Worker; 12 Temporarily laid off; 13 Other
12. CLIENT'S MOST RECENT OCCUPATION: 04 (63-64)
    01 Professional; 02 Mgrs & Administrators; 03 Sales workers; 04 Clerical, kindred workers; 05 Craftsman, kindred worker; 06 Operatives except transport; 07. Transport equip-operators; 08 Laborers, except farm/ranch; 09 Ranch/Farm Mgr.; 10 Ranch/Farm laborers & foremen; 11 Service workers, except private household; 12 Private household work; 13 Student; 14 Homemaker; 15 None
13. PRIMARY SOURCE OF INCOME (Last 30 days): 1 (65)
    1 Job; 2 Spouse; 3 Family, Friends; 4 Public Assistance; 5. Pension (incl S S); 6 Insurance (workmens' comp, unempl. ins); 7 Savings/investment; 8 None; 9 Other
14. WAGES/SALARY EARNED FROM JOB (Last 30 days): 0800 (66-69)
15. YEARS OF EDUCATION COMPLETED: 12 yrs (70-71)
16. CURRENTLY IN EDUCATIONAL OR SKILL DEVELOPMENT PROGRAM 1 Yes 2 No: 2 (72)
17. SKILL DEVELOPMENT PROGRAM COMPLETED AFTER TREATMENT 1. Yes 2. No: 2 (73)

Item 18—DRUG TYPE(S) Indicate in the following order:
—Drug Problem(s) at the time of Follow-Up regardless of frequency of use at Follow-up
—Other Drug(s) used during month prior to Follow-Up, whether or not a problem.
If 00 for None is entered, leave Items 19-20 blank

00 = None; 01 Alcohol; 02 Opiates, Synthetics; 03 = Barbiturates, Sedatives; 04 = Amphetamines; 05 = Cocaine; 06 = Marijuana Hashish; 07 = Hallucinogens; 08 Inhalants; 09 = Tranquilizers; 10 = Other

Item 19 — SEVERITY OF DRUG PROBLEM(S) AT TIME OF FOLLOW-UP
0 = Not a Problem; 1 = Primary; 2 = Secondary; 3 = Tertiary

Item 20—FREQUENCY OF USE DURING MONTH PRIOR TO FOLLOW-UP
0 = No Use During Month Prior to Follow-up; 1 = Less Than Once Per Week; 2 Once Per Week; 3 Several Times Per Week; 4 = Daily

DRUG PATTERNS AT FOLLOW-UP	Primary Problem		Secondary Problem		Tertiary Problem	
CARD 2	79	80	81	82	83	84
18. DRUG TYPE(S) (Complete all blocks)	0	1	0	6	0	0
	85		86		87	
19. SEVERITY OF DRUG PROBLEM(S) AT TIME OF FOLLOW-UP	2		1			
	88		89		90	
20. FREQUENCY OF USE DURING MONTH PRIOR TO FOLLOW-UP	0		0			

CODED REMARKS 1 2 3 4 5 6 7 8 9 10 (91-100)

6. Montana Alcohol and Drug Information System (ADIS), Instruction Manual, Planning and Management Information Section, Reporting and Evaluation Bureau, Alcohol and Drug Abuse Division, Department of Institutions, Helena, Montana, January 1982.

Figure IV-7: Sample program evaluation: analysis of changes in client characteristics between admission and follow-up for four different treatment programs.

1980 ADMISSION-TO-FOLLOW-UP CHANGE:
OUTPATIENT, HALFWAY HOUSE, CIRT, HIRT

ITEM	OUTPATIENT		HALFWAY HOUSE		CIRT		HIRT	
	AD.	FOLLOW-UP	AD.	FOLLOW-UP	AD.	FOLLOW-UP	AD.	FOLLOW-UP
1. Productivity								
a. Employment Status								
Full-Time %	50.9	56.2	22.8	35.3	15.6	9.8	11.2	11.3
Part-Time %	9.2	10.7	14.4	20.6	11.5	45.9	14.3	25.4
Unemployed %	39.7	32.9	62.6	43.9	72.9	44.3	74.5	63.4
Total N	550	327	236	116	96	61	87	71
Missing N	7	230	4	124	0	35	0	27
b. Employability Factors								
None %	80.0	75.0	88.6	73.9	90.6	80.3	73.5	77.5
Homemaker %	6.3	9.4	0	6.9	0	4.9	4.1	4.2
Retired/Disabled %	7.0	9.7	9.6	12.1	2.1	6.6	10.2	16.9
Incarcerated	.7	.6	.4	2.6	0	8.2	10.2	1.4
Laid Off %	5.5	4.9	1.2	4.2	4.2	0	10.2	0
Total N	547	317	238	115	96	61	98	71
Missing N	10	240	2	125	0	35	0	27
c. Montly Income								
None %	34.3	24.6	56.3	34.5	72.9	19.5	69.4	16.7
$1 - $199 %	4.5	3.6	11.7	7.9	8.3	2.4	5.1	4.8
$200 - $599 %	19.9	25.2	20.1	37.1	8.3	43.9	18.4	50.0
$600 - $999 %	19.6	21.2	8.4	14.1	7.3	22.0	6.1	16.7
$1,000+ %	21.5	52.2	3.3	6.1	3.1	12.2	1.0	11.9
Mean	$536	$622	$191	$335	$122	$536	$144	$495
Total N	551	325	238	113	96	41	98	42
Missing N	6	232	2	127	0	55	0	56

ITEM	OUTPATIENT AD.	OUTPATIENT FOLLOW-UP	HALFWAY HOUSE AD.	HALFWAY HOUSE FOLLOW-UP	CIRT AD.	CIRT FOLLOW-UP	HIRT AD.	HIRT FOLLOW-UP
d. Source of Financial Support								
None %	11.4	6.3	27.1	16.2	32.3	14.0	23.5	9.5
Job %	60.7	63.8	42.6	56.4	26.0	54.0	29.6	41.3
Spouse %	3.9	3.6	0	0	23.9*	12.0*	19.4*	15.9*
Family/Friends %	9.4	7.5	15.8	7.6	-	-	-	-
Public Assistance %	5.6	7.9	4.1	6.8	3.1	14.0	6.1	11.1
Pension %	5.2	5.4	7.9	6.8	8.4*	6.0*	10.2*	20.6*
Insurance %	.3	.9	.8	1.7	-	-	-	-
Savings/Inv. %	1.6	1.8	.4	2.5	5.2	0	9.2	1.6
Other %	1.4	2.4	.8	1.7	1.0	0	2.0	0
Total N	551	329	239	117	96	50	98	63
Missing N	6	228	1	123	0	46	0	35
2. Substance Use								
a. Frequency								
No Use %	12.1	51.2	10.4	44.5	3.2	32.2	3.3	59.4
Monthly Use %	7.6	9.5	2.9	6.7	18.9	35.6	33.3	20.4
Weekly Use %	45.0	30.9	23.4	23.5	14.7	8.5	6.7	4.7
Daily Use %	35.2	8.2	63.1	25.2	63.2	23.7	56.7	15.6
Total N	551	326	239	119	96	59	90	64
Missing N	6	231	1	121	0	37	8	34
b. Avg. Days Daily Drinking Per Week								
0 %	5.6	51.5	2.1	37.8	1.1	29.8	5.4	60.0
1-2 %	30.8	30.8	10.3	25.9	11.5	29.8	33.8	20.0
3-4 %	21.6	7.7	10.0	5.0	6.9	12.8	12.2	12.7
5-6 %	7.7	3.7	10.4	2.5	18.4	10.6	10.8	3.6
7 %	34.0	6.1	66.9	28.5	62.1	17.0	37.8	3.6
Total N	531	324	230	119	87	47	74	55
Missing N	26	233	10	121	9	49	24	43

ITEM	OUTPATIENT AD.	OUTPATIENT FOLLOW-UP	HALFWAY HOUSE AD.	HALFWAY HOUSE FOLLOW-UP	CIRT AD.	CIRT FOLLOW-UP	HIRT AD.	HIRT FOLLOW-UP
c. Secondary Substance								
Yes %	17.0	15.2	10.1	21.9	16.7	25.5	15.3	11.9
No %	83.0	84.8	89.9	78.1	83.3	74.5	84.7	88.1
Total N	553	324	239	119	96	55	98	59
Missing N	4	233	1	121	0	41	0	39

* Spouse and family/friend were combined in the study with paid interviewers, as was pension and insurance.

Legislature's request for psychosocial and biological research is not appropriate for Maine. Thus, we agree strongly with the goals defined by the IDPC on page 46 of the FY 1984 plan:

> CATEGORY FOUR: RESEARCH
>
> Several important questions about the causes and consequences of alcohol problems remain to be answered. A number of universities and research centers throughout the country are now conducting research on these questions. Although Maine has few resources for conducting research, the state can benefit from the findings and products of research being conducted nationally.
>
> There is a need in Maine for assessing the existing alcohol system. Issues of program availability, accessibility, quality, and outcome effectiveness need to be addressed by research. Such research determines what exists, the level of quality, and compares it with what is needed regarding policy and programmatic issues for future development and improvement of the alcoholism system.

We wonder only why the 1984 plan makes no budget allocations to address these needs. The importance of determining better ways to manage and assess the state's system certainly warrants some investment.

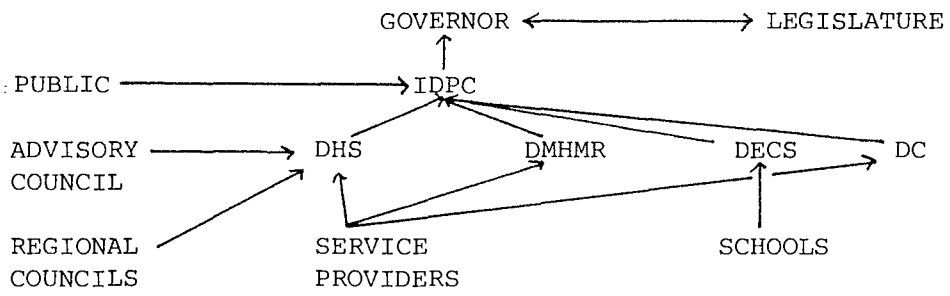
IV-6 Coordination

Even when the data systems are more effective, there will remain important ambiguities and major differences of opinion. Different agencies will pursue mutually incompatible goals, and budget requests will sum to more than what is available. Consequently, there will need to be some coordinating activity that can bring agreement on the state plan and its components.

Figure III-8 shows the relation of the principal groups in the Maine alcohol service system now involved in planning. The system is characterized by extremely efficient information sharing and by a set of generally shared goals, but several features of its decision making deny it the capacity for decision making that would be required for efficient use of the state's resources.

First, many elements of the planning and evaluation cycle operate on an informal and ad hoc basis. Most information is collected through proposal reviews, contract monitoring, aggregated client records, and licensing. Very little formal program evaluation is undertaken. Professional groups are important in the process. Their involvement does lead to rapid and efficient dissemination of important information, but it also heightens the role of special interests.

Figure IV-8: Theoretical coordination of the alcohol service system in Maine



Second, neither OADAP nor the IDPC have the authority to resolve budget disputes or enforce standards by those engaged in planning, delivery and evaluation of alcohol services in Maine. For example, when one of the four departments requested an annual budget that exceeded the amount available, the dispute could not be resolved without recourse to the four commissioners.

Third, the role of some parties is indeterminant. The influence of public comment on the annual plan is unclear. The perogatives of the Select Committee also seem to overlap with the executive agencies.

This may seem to suggest the need for a single state agency with responsibility for all alcohol treatment and prevention activities, but it is important to remember that one version of that approach has already been tried in Maine. Legislation adopted in 1973 established OADAP with broad responsibilities for the planning, conduct, and coordination of alcohol services. Despite the authorization of a "coordinating committee" consisting of representatives from other state agencies, the

legislature, the judiciary, and the Governor's office, the Office was unable to coordinate the alcohol-related activities of other state departments. The Alcohol Premium Act (Chap. 12, MRSA) removed much of the language from the OADAP-enabling legislation that had given OADAP authority for coordination. The result is still unsatisfactory. Efforts to develop a better planning system must be based on careful study of the reasons for failure by the last initiative.

IV-7. General Observations

Ten general principles and observations have influenced us in our efforts to define useful responses to the deficiencies we have observed in the state's alcohol planning system. We list them here to provide a perspective on our recommendations.

1. No formal system, even when it is spelled out through elaborate schedules, reporting relationships, and task descriptions, can substitute for the good will and energies of those who actually do the work of combatting alcohol abuse - the staff members of the service agencies directly involved with clients. If it is to improve the present system any proposal must facilitate their work, making it easier for them to decide for themselves how their programs may be improved and making their paperwork burden lighter than it is now.

2. The budgets of state alcohol programs are threatened by three forces. Tax indexation will produce significant short-term shortfalls in the public funds many important agencies were expecting, and it will reduce growth in future budgets. Economic stagnation is likely to persist for several more years at least. Thus there will be mounting pressure to invest scarce state funds in the social welfare activities that have a quicker and more tangible impact of quality of life in the state. Federal support, still 36 percent of the total, will decline further. Consequently, it is important not to divert more personnel or funds into administrative activities at the expense of services.

3. The State Advisory Council, defined in the 1973 legislation, could be a potent and constructive force complementing the efforts of others involved with alcohol prevention, education, and treatment. There is general agreement within the state that this potential has not yet been realized.

4. During its budget discussions early in 1982, the Select Committee contravened the agencies' budget recommendations by incrementing allocations to specific programs. Without any reflection on the merits of those programs so honored, we observe that continuation of this activity by the Select Committee may seriously retard progress by state agencies in improving their planning and assessment capacities. The appropriate role for the Select Committee should be first to lay out very broad policy guidelines regarding public priorities for Premium expenditures and second to monitor closely the agencies' progress in developing allocation, management, and evaluation procedures that will permit compliance with Committee guidelines.

Even if there seem to be excellent short-term reasons for changing budget allocations to specific programs, the long-term negative effects of detailed Committee interventions should prevent this. The Committee should not expect to be happy with every single budget request submitted under the Premium Bill, but it should expect that the process leading to budget requests is responsive to Committee guidelines and that it can be clearly explained by the central planning staff.

5. The Premium Bill legislation has brought a significant improvement in communication among the four departments. The FY 1984 budget submission does represent real progress in the design of an integrated program involving all four agencies. The attempt to define performance indicators for each activity is especially to be commended. Deficiencies in the plan come largely from the lack of good data, from the extreme time pressure confronting the IDPC staff in preparing the document, and from the lack of prior experience in developing a systematic plan.

6. We have heard many complaints about the state's computer system. Alleged deficiencies in its operation have been blamed by some for the absence of automated data processing in the state's alcohol planning system. We cannot judge the appropriateness of the complaints. Even if they are fully warranted, however, they are no excuse for the cumbersome data systems currently used by OADAP and some of its sister agencies. They should either combine to demand changes in the computer facility, or they should find funds to purchase the microcomputers that would be required to improve program monitoring and evaluation substantially.

7. There have been moves to disestablish the Select Committee or add substantially to its responsibilities. It seems to us either move would be premature. Eventually the Committee should be disbanded and its role taken over by one of the standing committees. But for the next two years (or four depending on the rate of departmental progress) the Select Committee has a unique and very important role to play - providing continuous, sophisticated pressure on the agencies to achieve much higher standards of data collection and use.

8. An important resource for the state is the set of formal and informal groups that meet periodically to discuss the state's alcohol programs. It is important that any new proposal complement The Second Friday Management Group, MASAP, the regional councils, NCA/Maine and other similar groups in Maine.

9. The call for better data management and program evaluation does not imply that more staff time should be spent pushing paper. Respondents to our survey claimed that 89 person-years of staff time are already spent in gathering and reporting information. Some of this effort has small returns. Implementation of consistent data and reporting standards throughout the state could reduce the time now spent with data.

10. The request for a new central planning staff does not imply creation of a major new group. IDPC has already added one excellent, full-time staff member to prepare the plan. If this person were augmented by

one or two additional people, who were also competent managers and analysts, and they were given appropriate power to coordinate and review the work by staff members in the four agencies and the service groups, major improvements could be made in the efficiency of the dollars currently expended.

IV-8. Recommendations

In response to these observations we have developed recommendations that can be grouped within five categories:

- make institutional changes,
- establish data standards,
- implement a four-year planning cycle,
- fund planning research, and
- set a schedule for implementation.

Make Institutional Changes

In theory the 1973 act creating OADAP provided a major new mandate for improved planning and coordination of activities related to alcohol abuse prevention, education, treatment, and research in the state. In practice that potential has not been realized. First, OADAP did not meet all the requirements of the act. Second, there has been growth in the alcohol service budgets of other departments. Third, many agencies came to disregard OADAP's role as central coordinator. Finally, the 1981 Premium Bill eliminated OADAP's authority to enforce its plan on the operational budgets of other agencies. That crucial authority has not been lodged elsewhere.

Planning now effectively occurs within the diffuse process that the Commissioners use to develop a joint budget proposal acceptable to the Select Committee. It is made even more difficult by the Select Committee's ability to intervene by making changes in individual budget items. The plan prepared by the Indepartmental Planning Committee does evidence more careful thought about state programs than the fiscal year

1983 submission. But it reflects the absence of any systematic needs assessment and the lack of a central authority that is empowered to resolve indepartmental conflicts over budget priorities.

We recommend that legislative action institute a small central coordinating staff, independent of the four departments. This group should have clear authority to:

- conduct a periodic needs assessment that describes the incidence of alcohol abuse within different groups and regions of Maine, determines the social consequences of the abuse, and summarizes the extent and the effectiveness of alcohol service programs in the state,
- work with the departments and the Advisory Council to define goals for alcohol services in Maine that are responsive to the needs assessment and to set priorities for attaining the goals within the constraints of available funds,
- establish data and report standards that will be observed by all state and private agencies receiving public funds,
- design performance indicators for evaluating individual programs,
- receive and respond to public inputs regarding the reports prepared as part of the planning cycle, and
- support staff members in each of the four departments as they work to develop activity statements and budget requests that reflect the state's priorities and resources.

This staff should be small, 2 or 3 people. It should not have administrative responsibility for any of the departments' programs.

Establish Data Standards

It is essential to comply with the directive of the 1973 law:

> Develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention... 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 ... 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 (22 MRSA c. 1601 § 7106:2)

The initial effort should be directed to identifying and developing standard definitions for the factors used by more than one agency in the system. Then should come the effort to design a minimal set of standard forms for client records and follow-up by service agencies. Later it will be important to determine how data gathering efforts by all state agencies might be modified slightly to provide much better information on the incidence and the consequences of alcohol abuse. Of course each agency will be free for its own purposes to accumulate additional data and prepare supplemental reports not specified by the standards. But the basic needs of all groups should be met by a few standardized data sets.

Enough work has been done in this area, that the Select Committee should expect rapid progress. The principal delay will lie in delegating authority for coordinating the effort. However, this will be accomplished rather quickly, if the Select Committee announces that it will not authorize any disbursements from the Premium Fund during FY85 to state and private agencies that have not come into compliance with the first stage of a state-wide effort to implement standards for data collection and reporting.

Implement a Four-year Planning Cycle

The stability brought to alcohol funding in Maine by the Premium Bill affords for the first time the opportunity to do long-term planning. We recommend institution of a four-year planning cycle, coinciding with the biennial budget process. It will be coordinated by a central planning staff, and it will be based on four different reports:

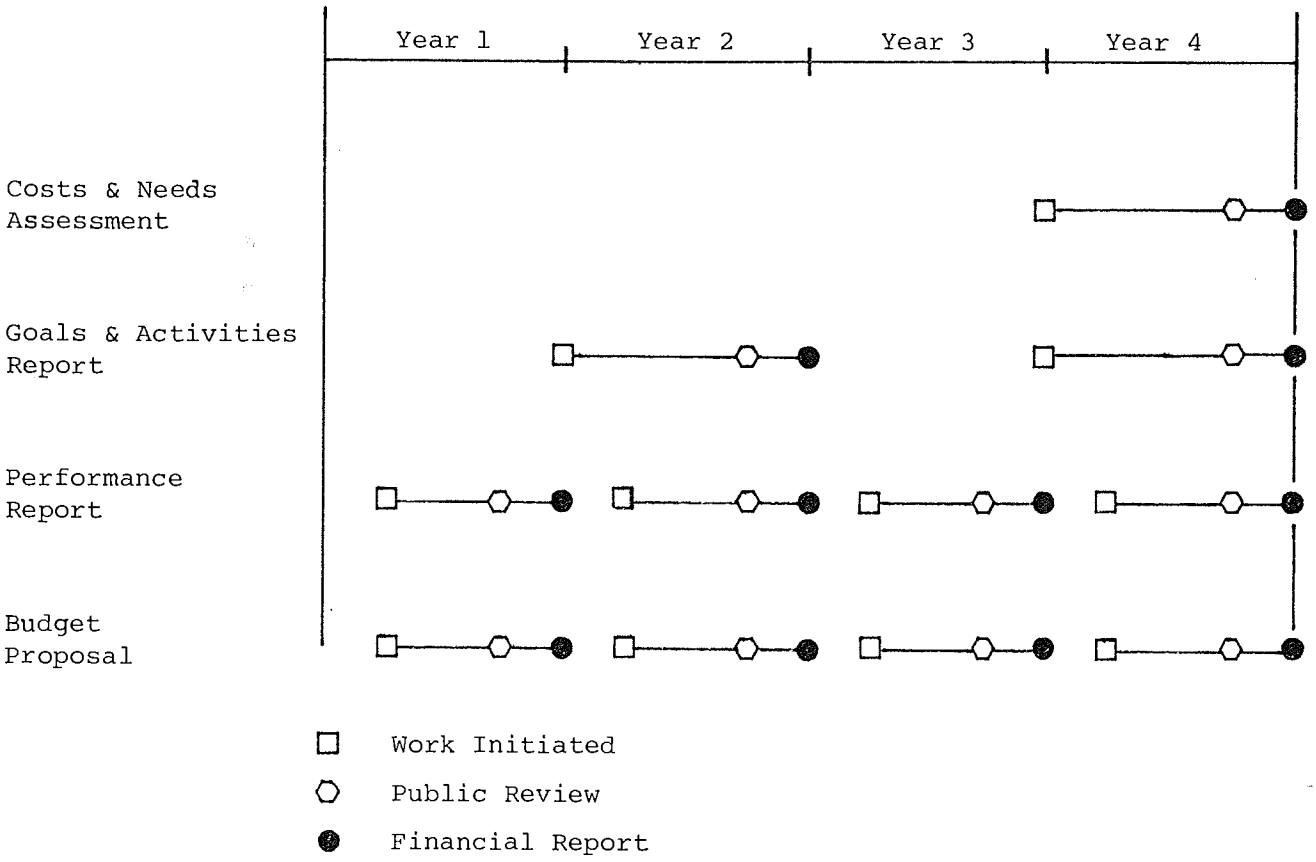
- a costs and needs assessment (every 4 years),
- a goals and activities report (every 2 years),
- a performance review (every year), and
- a budget proposal (every year).

Figure IV-9 illustrates the schedule for these documents. The costs and needs assessment would be compiled by the coordinating staff with assistance from many state agencies. It would describe consequences of alcohol use in the state through use of data on many different economic and social consequences. It would incorporate the issues we address in Chapter II of this report, but it would go beyond purely economic issues. For example, it should attempt to estimate the extent of domestic violence associated with alcohol use. Efforts should be made to disaggregate the data by region, income category, demographic features, economic sector and related factors. This assessment must have enough detail for use in designing specific responses, which include goals, activities, and associated performance measures.

The goals and activities report should contain a comprehensive set of goals for each of the costs and needs identified in the current assessment. It is essential that the goals be defined relative to objective measurements. In other words, it must be possible for a third party to perform some measurement or analysis that would permit independent determination of the extent the goal has been achieved. "Improving the quality of life in Maine" would not be an adequate goal statement. "Lowering mortality of teen-age drivers by 24 percent," would be a satisfactory goal statement.

A set of integrated service activities should be designed to achieve each goal. The report should include a set of performance indicators that can be used to measure the progress and impact of funded activities. Preparation of this report would be the responsibility of the coordinating staff.

Figure IV-9: Proposed schedule for the planning cycle reports.



The performance report and budget proposal should be submitted together annually. They would report on the past year's progress toward established goals, would evaluate individual programs, and would indicate the budgets required for the coming fiscal year. The program evaluations and budget proposals should be prepared by each of the departments for the programs they manage. The final reports should be reviewed and approved by the central coordinating group.

Fund Planning Research

A small amount of money should be allocated each year to activities that raise the quality of data and analyses available in the state. There are many possible projects. Other states have developed useful forms, computer programs, and data standards. These should be surveyed and adapted, where appropriate, for use in Maine. All state agencies and many private groups gather data that could be tailored for use in the needs assessment and performance evaluation. There should be some effort to identify these data and to experiment with their adaptation for planning purposes. There are many different ways to follow-up on clients to determine the relative impact of different treatment programs. There should be some carefully designed experiments to determine which ways are most helpful. Service agencies could benefit greatly from use of relatively inexpensive microcomputers that managed patient records, scheduled personnel, prepared accounting reports, and offered simple word processing. There should be some effort to identify the principal needs of these agencies and to define a standard micro computer system that would fulfill the requirements.

The money available in support of these activities would logically be part of the central planning staff's budget and it would be allocated in response to competitive proposals from service agencies and other groups in the state.

Set a Schedule for Implementation

The Joint Select Committee on Alcohol Services should view the next two years as a period of implementation and transition. In fact, the transition is already underway due to the efforts of the Committee, the

IDPC and the other interested groups. By the end of 1984 and the beginning of the 112th Legislature, it is reasonable to expect that the recommendations made here could be implemented and functional. Several recommendations should be operational before that time.

1. The legislation that describes and assigns authority to state agencies involved in planning and coordination of the alcohol program should be changed as early in 1983 as possible. The new planning staff should be set up before July 1983.

2. A standard set of data, forms, and reports should be defined before the end of 1983, before the second regular legislative session. The Legislature should make compliance with this system a condition for receipt of public funding. There will undoubtedly still be problems with the system at first, but it is imperative to have it started early in order to provide useful results for a 1985 needs assessment to be submitted to the 112th Legislature.

3. The goals and objectives report (now the Commissioner's Report) for the second regular session of the 111th Legislature should incorporate a full set of useable performance indicators tied to the evaluation criteria cooperatively established by the four departments. It will not be possible to complete a full needs assessment by the end of 1983, thus the goals and objectives report will not be fully integrated with the assessment until the end of 1984.

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter VI:

A DESCRIPTION OF PROGRAMS DEALING WITH ALCOHOL ABUSE IN THE STATE OF MAINE

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A DESCRIPTION OF PROGRAMS ASSOCIATED
WITH ALCOHOL ABUSE IN THE STATE OF MAINE

Table of Contents

A DESCRIPTION OF PROGRAMS DEALING WITH ALCOHOL ABUSE IN THE STATE OF MAINE

VI-1.Abstract

In the fall of 1982 we sent out questionnaires to 168 prevention, education, treatment, and service agencies. Surveys were returned by 134 of the recipients, a response rate of 79.7 percent. In this chapter we present summary descriptions of all those programs that provided enough information to be included in our review. The summaries include:

- program title, address, and contact person,
- primary activities and emphasis,
- sources of income,
- average annual number of clients, and
- counties served.

The majority of the programs listed here have formal alcohol service components, but some of the agencies included in our review provide alcohol services under another title, such as outpatient mental health counseling or children's services. A summary description of all school-based programs is included in Chapter III, Section III-5.

STRATEGIES TO ENHANCE THE EFFECTIVENESS OF ALCOHOLISM SERVICES IN MAINE'S PUBLIC AND PRIVATE AGENCIES

Chapter VI:

A DESCRIPTION OF PROGRAMS DEALING WITH ALCOHOL ABUSE IN THE STATE OF MAINE

VI-2. Introduction and Purpose

The aggregated statistics provided in Chapter III provide a summary of state and regional programs in Maine. Here we provide brief descriptions of the individual activities included in our survey. Each description is a summary of information provided by agencies in response to our fall 1982 survey. The program descriptions are intended to serve the needs of those responsible for planning and reducing costs associated with alcohol abuse in Maine; they are not presented in a way that would make them suitable for use as a referral resource.

In general, we provide descriptions only for those programs with activities specifically focused on alcoholism or alcohol abuse. We have stated earlier that many important, indirect services are provided by those outside the formal alcohol service system. Some of those activities are included here, when we have the necessary data to list them. Some types of programs, such as the DECS school-based programs, are not described individually here. The reader should refer to the discussion of program groups in Chapter III for a description of these efforts.

Section VI-5 provides an alphabetized index of all the programs we surveyed. The index includes page numbers that indicate the location of the detailed program descriptions. It also states whether or not we received a useful survey response from the organization.

VI-3. Interpretive Notes

Program descriptions clustered in six groups according to the geographical area each activity serves. First we present the programs that offer state-wide services, then we present programs within each of the five regions defined in the COTS plan[1]. Within each of the six sets, the descriptions are grouped according to program type:

- state agencies
- service providers
- regional volunteer groups (councils)
- employee assistance programs
- advocacy groups

Each description includes:

- program title, address, and contact person,
- listing of primary activities and the fraction of the program budget expended on each activity group,
- sources of income coded:

  A federal contract,
  B state-administered federal block grant,
  C state general fund,
  D state premium fund,
  E county/municipal,
  F insurance reimbursement,
  G other private,
  H fees, and
  I other.

- average annual number of clients (people affected by excessive alcohol consumption in others are also included in this category if they are seen by a program). These figures cannot be simply added for aggregate totals, because they undoubtedly include individuals who are counted more than once. Chapter III presents state and regional totals.
- Primary counties served as determined by the county of client residency. The counties listed have at least 10 percent of the program's clients. If a significant fraction of the program's clients come from counties other than those listed, an additional statement is added in the form, "__% of the total client population comes from ___ other counties."

1. The Client Oriented Treatment System. Office of Alcoholism and Drug Abuse Prevention, Bureau of Rehabilitation, Dept. of Human Services, Augusta, ME. 1979.

VI-4. Index to Programs

This section includes an alphabetized list of all the programs surveyed during the Premium Law project. At the right of each program name we provide a page number to indicate the location of the program description within this chapter. A letter code is also given to indicate the type of response we received during the study:

- R: we received a useable response, and it was incorporated into the summarized information of Chapter III.

- (R): we received a useful response. It was not incorporated into the Chapter III summaries, because the program was unique or the information arrived too late. The response was used in the related program description or description of program type (e.g. school-based teams or professional associations).

- NR: we received no response.

State Program Descriptions

Department of Corrections
State Office Building
Station 111
Augusta, ME 04333

Gerard Samson, Correctional Plans Coordinator
Telephone: (207) 289-2711

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Public Institutions, Outpatient, Halfway House	40
B. EDUCATION Inservice (staff) Education & Training	.1
C. PREVENTION Early Intervention	8
D. COORDINATION Grant Management, Planning, Interagency Coordination	3.9
E. CONTRACTED SERVICES Community Alcohol Services, Dav One, CAP-Portland, Other	48

Sources of Income: D,C

Average number of clients/ consumers served per year 960

Primary Counties Served: Cumberland, Penobscot, Androscoggin
44% of the total client population comes from 13 other counties

Chemical Alternative Program
Division of Probation & Parole
Department of Corrections
P.O. Box 444
Skowhegan, ME 04796

Paul K. Vestal, Jr., Manager
Telephone: (207) 474-2275

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services	25
B. PREVENTION Primary Prevention, Early Intervention	40
C. RESEARCH	10
D. COORDINATION Interagency Coordination, Planning, Grant Management	25

Sources of Income: D

Average number of clients/consumers served per year 600+

Primary Counties Served: Somerset, Penobscot, Oxford, York, Washington

Emergency Alcohol Treatment Fund
Division of Probation & Parole
Department of Corrections
State Office Building, Station 111
Augusta, ME 04333

Edmund J. Tooher, Court Intake Manager
Telephone: (207) 289-2711

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Public Institutions, Residential Rehabilitation, Self-Help	85
B. PREVENTION Early Intervention	15

Sources of Income: D

Average number of clients/consumers served per year 150

Primary Counties Served: Aroostook, Penobscot, Kennebec
10% of the total client population comes from 2 other counties

Maine State Prison
Department of Corrections
Thomaston, ME 04861

Judith Anderson, Contractee for MSP Alcohol & Drug Services
Telephone: (207) 354-2535

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT*	100

*All services are provided under contract by Community Alcohol Services, Bangor Halfway House, and Crisis & Counseling.

Sources of Income: D,C

Average number of clients/consumers served per year 100

Primary Counties Served: Knox, Penobscot
24% of the client population comes from 3 other counties

Maine Youth Center
Alcohol Services Unit
Department of Corrections
675 Westbrook Street
South Portland, ME 04106

Lee H. Carter, Unit Director
Telephone: (207) 772-7434

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Residential Rehabilitation	77
B. EDUCATION Inservice (staff) Education & Training, Other Training	11.3
C. COORDINATION Interdepartmental Coordination, Inter-agency Coordination	11.7
D. CONTRACTED SERVICES All services are provided under contract by Day One, Community Alcohol Services, Crisis & Counseling, Tri-County M.H., York County Counseling, Reserve, Bath-Brunswick M.H., Counseling Association	* (see treatment)

Sources of Income: D

Average number of clients/consumers served per year 82

Primary Counties Served: Cumberland, York, Kennebec, Penobscot
35% of the total client population comes from 10 other counties

Division of Alcohol & Drug Education Services
Department of Educational & Cultural Services
State House Station 57
Stevens School Complex
Augusta, ME 04333

Carl O. Mowatt, Division Director
Telephone: (207) 289-3876

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Team Development Institutes & Follow-up Conferences, Resource & Information Services, Inservice (staff) Education & Training, Community Education	60
B. PREVENTION School & Team Technical Assistance & Consultation, Primary Prevention, Health Promotion	35
C. COORDINATION Planning, Interagency Coordination, Grant Management	5

Sources of Income: D, I*, C

Average number of clients/consumers served per year N/A**

Primary Counties Served: N/A**

*Dept. of Public Safety
**Team Development Training/Institutes are available to all school systems in the State. Currently there are 33 school districts/communities utilizing these services. See discussion of school/community teams in section III.

Bureau of Rehabilitation
Department of Human Services
32 Winthrop Street
Augusta, ME 04330

Ronald F. Hanson, Director of Field Operations
Telephone: (207) 289-3484

Primary Activities	% of Budget Spent on this Activity
A. CONTRACTED SERVICES Bangor Halfway House, Serenity House	100

Sources of Income: B,C

Average number of clients/consumers served per year 200

Primary Counties Served: Cumberland, Penobscot

Driver Education & Evaluation Program
Department of Human Services
Office of Alcoholism & Drug Abuse Prevention
32 Winthrop Street
Augusta, ME 04330

Tom Hughes, Manager
Telephone: (207) 289-2028/2054

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Inservice (staff) Education & Training, Resource & Information Services	5
B. PREVENTION D.E.E.P.	76
C. CONTRACTED SERVICES Independent Instructor Services	19

Sources of Income: H

Average number of clients/consumers served per year 6500

Primary Counties Served: Cumberland, Penobscot, York
64% of the client population comes from 12 other counties

Interdepartmental Planning Committee
Dept. of Human Services
Deputy Commissioners Office
Station 11
Augusta, ME 04333

Lisa Cavanaugh, Staff
Telephone: (207) 289-2636

Primary Activities	% of Budget Spent on this Activity
A. COORDINATION Interdepartmental Coordination/Planning including Premium Fund Activities of the Departments of Human Services, Corrections, Educational and Cultural Services, and Mental Health and Mental Retardation	100

Sources of Income: C

Average number of clients/consumers served per year N/A

Primary Counties Served: N/A

Office of Alcoholism & Drug Abuse Prevention (OADAP)
Dept. of Human Services
32 Winthrop Street
Augusta, ME 04330

Mel Tremper, Grants Manager
Telephone: (207) 289-2781

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT In-house	1
B. EDUCATION In-house	1
C. PREVENTION D.E.E.P., In-house EAP and Prevention	6
D. RESEARCH	1
E. COORDINATION In-house Coordination, Planning, Inter-agency Coordination	21
F. CONTRACTED SERVICES	70

Sources of Income: D, B, C, H, A

Average number of clients/consumers served per year N/A*

Primary Counties Served:* All counties/statewide services

*(refer to Driver Education & Evaluation Program for client numbers)

Staff Education & Training Unit
Department of Human Services
Capitol Shopping Annex
Augusta, ME 04333

Richard A. Handrahan, Director
Telephone: (207) 289-2961

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Training & Technical Assistance to D.H.S. & Provider Agency Caseworkers	100

Sources of Income: B

Average number of clients/consumers served per year 80

Primary Counties Served: All counties*

* (specific % distribution not indicated)

Department of Mental Health & Mental Retardation
State Office Building, Room 411
Augusta, ME 04333

Jamie Morrill, Comprehensive Health Planner
Telephone: (207) 289-3161

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT* Public Institutions, Outpatient, Home-based (Alternative Living)	55
B. EDUCATION In-service (staff) Education & Training, Community Education	20
C. PREVENTION Early Intervention, Primary Prevention	25
D. CONTRACTED SERVICES *All services are provided under contract with Community Mental Health Centers and other Treatment Providers	*

Sources of Income: D

Average number of clients/consumers served per year N/A

Primary Counties Served: See descriptions of AMHI and BMHI programs

Maine Health Systems Agency
9 Green Street
Augusta, ME 04330

Patricia Engdahl, Senior Health Planner
Telephone: (207) 623-1182

Primary Activities	% of Budget Spent on this Activity
A. RESEARCH	30
B. COORDINATION Certificate of Need Review, Planning	70

Sources of Income: A

Average number of clients/consumers served per year N/A

Primary Counties Served: N/A

Al-Anon Family Group Headquarters, Inc.
115 East 23rd Street
New York, New York 10010

Eleanor Way O'Brien, Executive Director
Telephone: (212) 254-7230

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Self-help (support group for families of alcoholics)	100

Sources of Income: I*
*self-supporting through membership donations

Number of Active Groups in Maine: (includes Al-Ateen) ≤125

Estimated number of Al-Anon and Al-Ateen members in Maine 2500

Alcoholics Anonymous, Inc.
General Service Board
P.O. Box 459
Grand Central Station
New York, New York 10163

Helen Turnquest, General Service Staff
Telephone: (212) 686-1100

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Self-help Fellowship	100

Sources of Income: I (self-supporting through membership donations)

Number of Active Groups in Maine	200
Estimated Number of AA Members in Maine	4000

Maine Sheriff's Association (representing county jails)
2 High Street
Skowhegan, ME 04976

Ralph Nichols, Standards Compliance Coordinator
Telephone: (207) 474-9591

Primary Activities*	% of Budget Spent on this Activity
A. TREATMENT Self-help, Residential Rehabilitation, Detoxification, Shelter, Halfway House	30
B. EDUCATION Inservice (staff) Education & Training, Community Education, Resource & Information Services, Consultation & Technical Assistance, Other Training	20
C. PREVENTION Primary Prevention, Employee/Student Assistance Program	5
D. RESEARCH	5
E. COORDINATION Planning, Grant Management	40

*(The majority of services are provided by substance abuse treatment providers outside of the county jail system. Androscoggin County jail employs a half-time counselor/provider. Cumberland, Penobscot, Kennebec, Somerset, and Aroostook County jails employ "coordinators" to hook inmates up to existing provider agencies in the community.)

Maine Sheriff's Association, con't.

Sources of Income: I*, A, E
*Grants

Average number of clients/consumers served per year 17500**
**(this number represents 70% of the total inmate population in county jails)

Primary Counties Served: All counties

School Health Education Program
Maine Lung Association
128 Sewall Street
Augusta, ME 04330

Valorie E. Nybo, Director
Telephone: (207) 622-6394

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Training and Education for School Teachers, Resource & Information Services, Other Training, Consultation & Technical Assistance	100

Sources of Income: B

Average number of clients/consumers served per year 400

Primary Counties Served: Kennebec, Somerset, Cumberland
60% of the total client population comes from 13 other counties

Veteran's Administration (VAMROC)
Alcohol Dependency Treatment Program
Togus, ME 04330

Sally Tasker, MHA
Telephone: (207) 623-8411 Ext. 531

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Detoxification, Outpatient	70
B. EDUCATION Inservice (staff) Education & Training, Consultation & Technical Assistance, Community Education	10
C. PREVENTION Employee/Student Assistance Program, Early Intervention, Health Promotion, D.E.E.P. Evaluations	5
D. RESEARCH	2
E. COORDINATION Interagency Coordination	3
F. CONTRACTED SERVICES Serenity House, Bangor Halfway House	10

Sources of Income: A

Average number of clients/consumers served per year 1500

Primary Counties Served: Client population distributed over all 16 counties relative to county population
5% of the total client population comes from "out-of-state"

Women's Christian Temperance Union
Education Department
P.O. Box 84
East Holden, ME 04429

Rachel Kelly, Director
Telephone: (207) 843-7773

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Community Education	100

Sources of Income: I*
*WCTU (self-supporting)

Average number of clients/consumers served per year 74000 (audience)

Primary Counties Served: All 16 counties (no specific % distribution indicated)

Employee Assistance Program
Room B-5
State Office Building
Augusta, ME 04330

Edward J. Renaud, Jr., EAP Counselor
Telephone: (207) 289-2949 (Mon. & Thur.)

Primary Activities	% of Budget Spent on this Activity
A. PREVENTION Employee Assistance Program	100

Sources of Income: C

Average number of clients/consumers served per year 65

Primary Counties Served: Kennebec, Penobscot, Cumberland
25% of the total client population comes from 5 other counties

Maine AFL/CIO
72 Center Street
Brewer, ME 04412

Arnold (Bing) Gross, EAP Director
Telephone: (207) 469-3131 Ext. 334

Primary Activities	% of Budget Spent on this Activity
A. PREVENTION Employee Assistance Programs (Technical Assistance)	100

Sources of Income: I*
*General funds from the AFL/DIO Treasury

Average number of clients/consumers served per year N/A

Primary Counties Served: Penobscot

Mainers Against Drunk Drivers (MADD)
P.O. Box 1038
Augusta, ME 04330

Mary Ann Fortin, President
Telephone: (207) 622-9954

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Community Education, Miscellaneous Activities	*
B. PREVENTION Advocacy for OUI Legislation & Enforcement, Other Miscellaneous Activities	*

Sources of Income: *

*MADD is currently in it's developmental stage. They have no budget. The Ken/Set Alcohol & Drug Abuse Council provides funds on an "as-needed" basis for operating expenses. Level and scope of activities is contingent upon funding of a grant submitted to the Maine Department of Public Safety.

Number of Current Members ~70**

**membership is available on a statewide basis to anyone holding an interest in the prevention of alcohol-related highway fatalities.

Primary Counties Served: All counties/statewide services

National Council on Alcoholism In Maine, Inc.
128 State Street
Augusta, ME 04330

Earle (Dick) R. Loomer, Jr., Executive Director
Telephone: (207) 622-4704

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Self-help, Referrals	10
B. EDUCATION Professional Associations, Resource & Information Services, Consultation & Technical Assistance, Community Education, Inservice (staff) Education & Training	25
C. PREVENTION Employee/Student Assistance Program, Health Promotion, Primary Prevention, Early Intervention	25
D. COORDINATION Conference Development & Planning, Public Policy Development (Legislation), Interagency Coordination, Planning, Grant Management	40

Primary Sources of Income: B,C

Average number of clients/consumers served per year 350

Primary Counties Served: Kennebec, Hancock, York
48% of the total client population comes from 13 other counties

Association of Labor-Management Administrators and Consultants on Alcoholism, Inc. - Maine Chapter (ALMACA)
P.O. Box 709
Augusta, ME 04336

Almon N. Young, President
Telephone: (207) 623-3521

"ALMACA is an organization which is made up of specialists in occupational alcoholism programming and consulting, who join together in a professional association to serve the members' interests. It serves primarily as a center for communication and information exchange. The chapters are self-supporting and the costs of operation are derived from seminars and regional conference contributions. The members' expenses for meeting participation are borne by the individual members. It does not become involved in any way with clients or contracts for employee services."

Maine Association of Prevention Providers (MAPP)
c/o YWCA Intervention Program
248 Turner Street
Auburn, ME 04210

Raymond Cook, President
Telephone: (207) 786-0659

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Consultation & Technical Assistance, Community Education, Resource & Information Services	30
B. PREVENTION Primary Prevention, Health Promotion, Advocacy for Prevention	60
C. COORDINATION	10

Sources of Income: I*
*self-supporting through membership dues

Number of current association members 30

Primary Counties Served: N/A**
**services are available statewide to individuals/agencies interested or involved in Prevention Activities

Maine Association of Substance Abuse Programs, Inc., (MASAP)
51 Center Road
Bowdoinham, ME 04008

Ronald Anton, President
Telephone: (207) 666-5583

Primary Activities	% of Budget Spent on this Activity
A. RESEARCH Fiscal Research, Insurance Reimbursement, Standards, Special Populations, DATA Systems	25
B. COORDINATION Planning, Interagency Coordination, Legislative Education, Prevention	75

Sources of Income: I*
*membership dues and interest on savings

Total Number of Current Full Members 24

Primary Counties Served: N/A**
**services/membership is available on a statewide basis to individuals/aggencies interested or involved in the treatment of substance abuse

Occupational Program Consultants Association of Maine, Inc. (OPCAM)
c/o Bath/Brunswick Mental Health Association
18 Pleasant Street
Brunswick, ME 04011

Stephen Boyett, President
Telephone: (207) 729-4171

"The Association was formed primarily as an organization for the mutual support of those of us who are attempting to promote or market Employee Assistance Programs in the State of Maine. We have no financial support other than our annual association dues. As stated in our By-Laws, the purpose of the organization shall be as follows:

1. To provide training and education information on the benefits of Employee Assistance Program services on a statewide basis to public and private profit and non-profit organizations.
2. To act as a central clearinghouse for providers and consumers of EAP services, and to provide a forum for the exchange of ideas and information.
3. To develop marketing training packages for Occupational Program Consultants.
4. To broaden citizen awareness and involvement and assist in mobilization of concerned parties.
5. To evaluate OPCAM performances as to the Association's goals and objectives.

We have developed our own ethical guidelines, EAP policy statement guidelines, and standards for Employee Assistance Programs along the lines of the national organization Occupational Program Consultants Association, Inc. in order to encourage the development of consistently high quality occupational programs within the State."

Region 1 Program Descriptions

Choice for Men
Waldo County Committee for Social Action
Community Alcohol Services
385 Main Street
Rockland, ME 04841

Judith Anderson, Administrator
Telephone: (207) 594-2176

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Detoxification	76
B. EDUCATION Community Education, Resource & Information Services, Inservice (staff) Education & Training	3
C. PREVENTION Early Intervention, Primary Prevention	3
D. COORDINATION Planning, Grant Management, Interagency Coordination	12
E. CONTRACTED SERVICES PhD, MD Pen Bay Medical Center	6

Sources of Income: B, D, C, A, H, E, I*
*Fees collected for training services

Average number of clients/consumers served per year 600

Primary Counties Served: Knox, Waldo
10% of the total client population comes from 8 other counties

Community Alcoholism Services
175 Lancaster Street
Room 219
Portland, ME 04101

Paul McDonnell, Director
Telephone: (207) 775-5671

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	95
B. PREVENTION Primary Prevention	5

Sources of Income: C, D, H, I*, B, E
*United Way

Average number of clients/consumers served per year 595

Primary Counties Served: Cumberland
3% of the total client population comes from 3 other counties

Community Counseling Center
614 Congress Street
P.O. Box 4016
Portland, ME 04101

Henry Neilson, Executive Director
Telephone: (207) 774-5727

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT	100

Sources of Income: G*, H, F
*United Way

Average number of clients/consumers served per year 700

Primary Counties Served: Cumberland

Community Schools, Inc.
Box 555
Camden, ME 04843

Dora Lievow, Co-Director
Telephone: (207) 236-3000

Primary Activities	% of Budget Spent on this Activity
A. PREVENTION Primary Prevention, Early Intervention	95
B. COORDINATION Grant Management, Planning, Interagency Coordination	5

Sources of Income: B, C, D, G, H, E, A

Average number of clients/consumers served per year 11

Primary Counties Served: Androscoggin, Knox, Kennebec
34% of the total client population comes from 7 other counties

Crossroads
Pine Tree Alcoholism Treatment Center for Women Inc.
1040 Main Street
South Windham, ME 04082

Griffith C. Matthews, Administrator
Telephone: (207) 892-2192/2146

Primary Activities	%of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Detoxification	100

Sources of Income: B, D, F, G, H, I*
*Food Stamps, Visitors' Pavments for Meals, Interest Income

Average number of clients/consumers served per year 154

Primary Counties Served: Cumberland, York, Out-of-State
17.3% of the total client population comes from 8 other counties

Cumberland County Jail
P.O. Box 308
Dowtown Station
Portland, ME 04111

Jim Garity, Substance Abuse Coordinator
Telephone: (207) 774-1444

Primary Activities

See Program Profile on Maine Sheriffs Association

Day One, Inc.
Box 41
Bar Mills, ME 04004

Stephen Andrew, Executive Director
Telephone: (207) 929-5166

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Home-based Family Service, Public Institutions, Outpatient	93
B. PREVENTION Primary Prevention	5
C. CONTRACTED SERVICES Youth Opportunities, Gray/New Glouster Schools	2

Primary Sources of Income: D

Average number of clients/consumers served per year 112

Primary Counties Served: Cumberland, Androscoggin, York
72.6% of the total client population comes from 9 other counties

Full Circle
Bath-Brunswick Mental Health Services
24 Jordon Avenue
Brunswick, ME 04011

Herman J. Stegeman, Program Director
Telephone: (207) 729-8706

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Public Institutions	70
B. EDUCATION Community Education, Consultation & Technical Assistance, Inservice (staff) Education & Training	5
C. COORDINATION Treatment Planning & Coordination, Interagency Coordination, Planning, Grant Management	25

Sources of Income: C,A

Average number of clients/consumers served per year 175

Primary Counties Served: Cumberland, Sagadahoc, Lincoln

Ingraham Volunteers, Inc.
142 High Street
Portland, ME 04101

Neva S. Cram, Executive Director
Telephone: (207) 773-4830

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Crisis Intervention & Referral	100

Sources of Income: I*
United Way, Dept. of Mental Health, Bureau of Resource Development, and County/Municipal sources are the major contributors to the overall program. There are 21 funding sources totaled, several being contracted services with other service providers.

Primary Counties Served: Cumberland

Graduate Mental Health Center

Maine Medical Center
22 Bramhall Street
Portland, ME 04101

Jackie Robinson, R.N., Alcoholism Consultant
Telephone: (207) 871-2378

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Information & Referral, Inservice (staff) Education & Training	100

Sources of Income: (no response)

Average number of clients/consumers served per year 200+

Primary Counties Served: (no response)

Merrymeeting House
Bath-Brunswick Mental Health Center
51 Center Road
Bowdoinham, ME 04008

Ron Anton, Director
Telephone: (207) 666-5583

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Outpatient	90
B. EDUCATION Community Education, Inservice (staff) Education & Training, Consultation & Technical Assistance	3
C. PREVENTION Employee/Student Assistance Program, D.E.E.P. Evaluations, Primary Prevention, Early Intervention	2
D. RESEARCH	1
E. COORDINATION Grant Management, Interagency Coordination, Planning	4

Sources of Income: B, D, G, F, E, H

Average number of clients/consumers served per year 240

Primary Counties Served: Cumberland, Sagadahoc, Lincoln
18.6% of the total client population comes from 9 other counties

Milestone Foundation, Inc.
88 Union Avenue
P.O. Box T
Old Orchard Beach, ME 04064

Paul McDonnell, Director
Telephone: (207) 883-2815

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Extended Care	90
B. COORDINATION Grant Management, Planning, Interagency Coordination	10

Sources of Income: C, D, H, I*
*Food Stamps

Average number of clients/consumers served per year 55

Primary Counties Served: Cumberland, Penobscot, York, Kennebec, Androscoggin
10% of the total population comes from 2 other counties

Projects, Inc. Community Service Corps
Box 261
Camden, ME 04843

Deborah Davis, Community Service Coordinator
Telephone: (207) 236-8206

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Community Education	10
B. PREVENTION Recreational/Employment Related Alternative Activities Program	80
C. COORDINATION Planning, Grant Management, Inter-agency Coordination	10

Sources of Income: B

Average number of clients/consumers served per year 80

Primary Counties Served: Knox

4% of the total client population comes from 2 other counties

Sacopee Valley Health Center
Project S.E.A.R.C.H.
Kezar Falls, ME 04047

Peter Zack, Jr., Project Coordinator
Telephone: (207) 625-8126

Primary Activities:	% of Budget Spent on this Activity
A. EDUCATION Community Education, Resource & Information Services, Inservice (staff) Education & Training, Consultation & Technical Assistance	25
B. PREVENTION Primary Prevention, Early Intervention, Employee/Student Assistance Program	50
C. COORDINATION Grant Management, Planning	10
D. CONTRACTED SERVICES Independent Provider	15

Sources of Income: B, I*, F
*contract for service from KVRHA/KVCATP

Average number of clients/consumers served per year 180

Primary Counties Served: York, Oxford, Cumberland

Salvation Army Rehabilitation Center
88 Preble Street, P. O. Box 1298
Portland, ME 04101

Major Walter Crouch, Administrator
Telephone: (207) 774-7818

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation	100

Sources of Income: G

Average number of clients/consumers served per year 300

Primary Counties Served: Cumberland

10% of the total client population comes from "out-of-state"

Serenity House
30 Mellon Street
Portland, ME 04101

Dave Finn, Director
Telephone: (207) 774-2722

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation	100

Sources of Income: C, D, B, A, I*, H, E
*Food Stamps

Average number of clients/consumers served per year 130

Primary Counties Served: Cumberland, Androscoggin

31.7% of the total client population comes from 10 other counties

Skyward for Women
Waldo County Committee for Social Action
Community Alcohol Services
5 Beech Street
Rockland, ME 04841

Susan Galbraith, Project Director
Telephone: (207) 594-9508

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Detoxification	69
B. EDUCATION Community Education, Inservice (staff) Education, Consultation & Technical Assistance, Resource & Information Services	3
C. PREVENTION Employee/Student Assistance Program, Early Intervention, Primary Prevention, Health Promotion	6
D. RESEARCH	6
E. COORDINATION Grant Management, Planning, Inter-agency Coordination, Coordination with Funding Sources, Fund Raising	8
F. CONTRACTED SERVICES Ph.D., M.D., Evaluators, Pen Bay Medical Center	8

Primary Sources of Income: B, D, A, H, E, F

Average number of clients/consumers served per year 225

Primary Counties Served: Knox, Waldo, Lincoln
4.5% of the client population comes from 5 other counties

Twenty-Four Hour Club, Inc.
65 India Street
Portland, ME 04101

John T. Seddan, Jr., Executive Director
Telephone: (207) 773-7881

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Detoxification, Shelter	93
B. EDUCATION Inservice (staff) Education & Training, Other Training	1
C. PREVENTION Health Promotion	1
D. COORDINATION Grant Management, Planning	5

Primary Sources of Income: C, I*, E, H
*Donations

Average number of clients/consumers served per year 1482

Primary Counties Served: Cumberland
19% of total client population comes from 15 other counties

Western Maine Counseling Service
Box 170
Bridgton, ME 04009

Robert Kay, Director
Telephone: (207) 647-5629

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Emergency Walk-in, On-call After Hours	90
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services	5
C. COORDINATION Grant Management, Planning, Interagency Coordination	5

Sources of Income: B, D, E, F, H

Average number of clients/consumers served per year 50

Primary Counties Served: Cumberland, Oxford

York County Alcohol Shelter, Inc.
Box 20
Alfred, ME 04002

Michael Kelly, Director
Telephone: (207) 324-6591

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Shelter	85
B. COORDINATION Planning, Interagency Coordination, Grant Management	15

Sources of Income: D, G

Average number of clients/consumers served per year 950

Primary Counties Served: York
20% of the total client population comes from 15 other counties

York County Jail
Route 4
Alfred, ME 04002

Madeline Salamomski, Program Specialist
Telephone: (207) 324-1111

See Program Profile on Maine Sheriffs' Association

United States Navy Substance Abuse Program
Counseling & Assistance Center
Naval Air Station, Building #12
Brunswick, ME 04011

ETCS Larry W. Earl, Director
Telephone: (207) 921-2184/2188

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Individual Counseling, Group Counseling, Crisis Intervention, Rehabilitation, Other Miscellaneous Activities	* N/A
B. EDUCATION Inservice (staff) Education & Training, Outreach, Community Awareness, Information & Referral Services, Other miscellaneous Educational Activities	* N/A
C. PREVENTION Primary Prevention, Early Intervention, Employee Assistance Program, Other Miscellaneous Prevention Activities	* N/A

Sources of Income: * N/A

Average number of clients/consumers served per year * N/A

Primary Counties Served: * N/A

"The CAAC serves all active duty and retired Army, Navy, Marine Corps, and Coast Guard personnel, their dependents, the Department of Defense employees and their dependents in northern New England.

The primary mission of the CAAC is to screen and evaluate personnel for problem areas associated with all substance abuse/dependency and to recommend appropriate education, counseling, and/or treatment/rehabilitation. Additionally, the CAAC provides outreach education/awareness training to military and local community organizations and offers individual and/or group counseling."

*This information is not available

Area V Mental Health Board
169 Lancaster Street
Portland, ME 04101

Paul H. Adams, Executive Director
Telephone: (207) 772-6222/8980

"The Area V Mental Health Board is a non-profit agency and totally funded by the Department of Mental Health and Mental Retardation. Therefore, our resources are limited to funding mental health services only. . . the ten agencies (see list below) that we fund do provide mental health services to 'substance abusers'"...

Community Health Services, Inc.; Portland
Shalom House; Portland
Ingraham Volunteers, Inc.; Portland
Little Brothers Association; Portland
Community Counseling Center; Portland
Western Maine Counseling Services; Bridgton
Holy Innocents Home Care Services'; Portland
Family Crisis Shelter; Portland
Y.W.C.A.; Portland
Alliance for the Mentally Ill of Maine; Portland

Region 2 Program Descriptions

Androscoggin County Jail
2 Turner Street
Auburn, ME 04210

Sheriff Joseph Laliberte
Telephone: (207) 784-7361

*See Program Profile on Maine Sheriffs' Association

Bonney Youth Network
200 Main Street
Lewiston, ME 04240

Rockie Graham, Director
Telephone: (207) 783-9151

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Resource & Information Services, Community Education, Inservice (staff) Education & Training	10
B. PREVENTION Primary Prevention, Early Intervention	70
C. COORDINATION Interagency Coordination, Planning, Grant Management	20

Sources of Income: I*
*Juvenile Justice Advisory Group (JJAG)

Average number of clients/consumers served per year 40

Primary Counties Served: Androscoggin

Fellowship House
95 Blake Street
Lewiston, ME 04240

Bob Flaherty, Director
Telephone: (207) 784-2901

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Detoxification, Shelter	95
B. COORDINATION Grant Management, Planning, Interagency Coordination	5

Sources of Income: D, G*, H, F
*United Way

Average number of clients/consumers served per year 1000

Primary Counties Served: Androscoggin
36.2% of the total client population comes from 8 other counties

Oxford County Jail
26 Western Avenue
South Paris, ME 04281

Sheriff Alton Howe
Telephone: (207) 743-8934

See Program Profile on Maine Sheriffs' Association

St. Mary's General Hospital
Alcoholism Rehabilitation Center
45 Golder Street
Lewiston, ME 04240

Luther Cloud, M.D., Director
Telephone: (207) 786-2901

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Aftercare	90
B. EDUCATION Inservice (staff) Education & Training, Community Education, Resource & Information Services	10

Sources of Income: F, G, C, D

Average number of clients/consumers served per year 300

Primary Counties Served: Androscoggin, Cumberland, Sagadahoc
23% of the total client population comes from 8 other counties

Tri-County Mental Health Services
Substance Abuse Unit
106 Campus Avenue
Lewiston, ME 04240

Roy Estabrook, Substance Abuse Unit Coordinator
Telephone: (207) 743-7911

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	60
B. EDUCATION Community Education, Consultation & Technical Assistance, Inservice (staff) Education & Training, Resource & Information	10
C. PREVENTION D.E.E.P. Evaluations, Employee/Student Assistance Program, Primary Prevention	15
D. COORDINATION Grant Management, Planning, Interagency Coordination	15

Sources of Income: B, C, D, H, F, I*
*unrestricted agency funds

Average number of clients/consumers served per year 400

Primary Counties Served: Androscoggin, Oxford, Franklin

Y.W.C.A. Intervention Program
248 Turner Street
Auburn, ME 04210

Raymond C. Cook, Director
Telephone: (207) 786-0659

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	20
B. EDUCATION In-school Drop-in Groups * Classroom Activities, Community Education	20
C. PREVENTION Primary Prevention, Health Promotion	50
D. COORDINATION Grant Management, Planning, Inter-agency Coordination, Advocacy in Local & Statewide Organizations, Media, etc.	10

Sources of Income: B, D

Average number of clients/consumers served per year 230

Primary Counties Served: Androscoggin

Western Regional Council on Alcoholism
200 Main Street
Box 3068
Lewiston, ME 04240

John Coffey, Executive Director
Telephone: (207) 783-9151

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Miscellaneous Activities	10
B. EDUCATION Miscellaneous Activities	30
C. PREVENTION Miscellaneous Activities	30
D. RESEARCH	5
E. COORDINATION Review & Comment, Planning, Inter-agency Coordination	20
F. CONTRACTED SERVICES	5

Sources of Income: C, D

Average number of clients/consumers served per year 150

Primary Counties Served: Oxford, Androscoggin, Franklin

International Paper Company
Androscoggin Mill
Jay, ME 04239

Jay A. Hanchett, Personnel Supervisor
Telephone: (207) 897-3431

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Inservice (staff) Education & Training, Community Education, Other Training	95
B. PREVENTION Early Intervention, Employee Assistance Program	5

Sources of Income: I*
*International Paper Company Funds

Average number of clients/consumers served per year 10

Primary Counties Served: Franklin, Androscoggin

Region 3 Program Descriptions

Augusta Mental Health Institute
P.O. Box 724
Augusta, ME 04330

Alan Boufford, Director of Social Services
Telephone: (207) 622-3751

Primary Activities	% of Budget Spent on this Activity
A. CONTRACTED SERVICES Kennebec Valley Comprehensive Alcholism Treatment Program	100

Sources of Income: D

Average number of clients/consumers served per year 240

Primary Counties Served: *Cumberland, York, Kennebec, Androscoggin
*specific % distribution not indicated; AMHI serves the entire state

Crisis & Counseling Centers
79 Sewall Street
Augusta, ME 04330

Andrew B. Loman, Executive Director
Telephone: (207) 623-4511

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	75
B. EDUCATION Inservice (staff) Education & Training, Consultation & Technical Assistance, Community Education, Resource & Information Services	10
C. PREVENTION Early Intervention, Primary Prevention, Student Assistance Program, D.E.E.P. Evaluations	5
D. RESEARCH	5
E. COORDINATION Interagency Coordination, Planning	5

Sources of Income: B, D, C, E, H

Average number of clients/consumers served per year 175

Primary Counties Served: Kennebec
15% of the total client population comes from 6 other counties

Kennebec County Jail
18 Perham Street
Augusta, ME 04330

John Lambert, Program Coordinator
Telephone: (207) 623-3591

See Program Profile on Maine Sheriff's Association

Kennebec Valley Comprehensive Alcohol Treatment Program (KVCATP)
Mid-Maine Medical Center
Waterville, ME 04901

David Merk, Director
Telephone: (207) 873-0621

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Outpatient, Shelter	91
B. EDUCATION Community Education, Inservice (staff) Education & Training, Resource & Information Services	4
C. COORDINATION Interagency Coordination, Grant Management, Planning	5

Sources of Income: F, B, C, H

Average number of clients/consumers served per year 940

Primary Counties Served: Kennebec, Somerset
28.5% of the total client population comes from 13 counties

New Directions
122 State Street
Augusta, ME 04330

Mary E. Loach, Program Director
Telephone: (207) 622-6136

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Women's Component at Seton	75
B. EDUCATION Community Education, Consultation & Technical Assistance, Resource & Information Services, Other Training, Inservice (staff) Education & Training	20
C. PREVENTION Primary Prevention (Children of Alcoholics Program)	5

Sources of Income: A, H, I*
*Trainings, Fundraising

Average number of clients/consumers served per year 2169*
*Includes family members and D.E.E.P. referrals

Primary Counties Served: Kennebec, Somerset
3% of the total client population comes from 2 other counties

Somerset County Jail
5 High Street
Skowhegan, ME 04976

Charlie Wietzski, Administrator
Telephone: (207) 474-9591

See Program Profile on Maine Sheriffs' Association

Substance Abuse Demonstration Project
Kennebec Valley Regional Health Agency
Box 728
Waterville, ME 04901

Nancy Hoch, PhD, Project Director
Telephone: (207) 873-1127

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Community Education, Training for Regional Health Centers' Staff	11
B. RESEARCH "This project is basically a research project with a treatment section in order to test a model of service delivery".	61
C. CONTRACTED SERVICES* Crisis & Counseling, Aroostook Mental Health Center, Tri-County Mental Health, Youth & Family Services, York County Counseling Services, Blue Hill Hospital, Kennebec Valley Comprehensive Alcohol Treatment Program	28

*all treatment services delivered through the project are contracted; counseling services provided in 11 Rural Health Centers via linkages between health centers and substance provider agencies

Sources of Income: A

Average number of clients/consumers served per year 189

Primary Counties Served:* Androscoggin, Aroostook, Franklin, Hancock, Kennebec, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, York

*no specific % distribution indicated

Youth & Family Services, Inc.
P.O. Box 502
Skowhegan, ME 04976

David Fraser, Executive Director
Telephone: (207) 474-8311

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	50
B. EDUCATION Inservice (staff) Education & Training, Consultation & Technical Assistance, Community Education, Resource & Information Services	10
C. PREVENTION Employee/Student Assistance Program, Primary Prevention, Early Intervention, Health Promotion	20
D. COORDINATION Interagency Coordination, Grant Management, Planning	10
E. CONTRACTED SERVICES Greenville Schools, Kennebec Valley Regional Health Agency	10

Sources of Income: B, C, D, G, H, E

Average number of clients/consumers served per year 200

Primary Counties Served: Somerset

Kennebec-Somerset Alcohol & Drug Abuse Council, Inc.
P.O. Box 1038
Augusta, ME 04330

Paul Wheelock, Executive Director
Telephone: (207) 289-2141

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Technical Assistance to Individuals/ Agencies in the Planning Stage of Offering Treatment	5
B. EDUCATION Community Education, Inservice (staff) Education & Training, Consultation & Technical Assistance, Resource & Information Services, Other Training, Media Work	35
C. PREVENTION Primary Prevention, Early Intervention, Health Promotion, Other	35
D. RESEARCH	5
E. COORDINATION Planning, Interagency Coordination, Grant Management	20

Sources of Income: B,D

Average number of clients/consumers served per year 50*
*actual clients seen for screening and referral

Primary Counties Served: Kennebec, Somerset

Central Maine Power Company
Employee Assistance Program
Edison Drive
Augusta, ME 04336

Almon N. Young, Director of Employee Assistance
Telephone: (207) 623-3521

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Out-patient, Self-help	49
B. EDUCATION Other Training, Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance	29
C. PREVENTION Employee Assistance Program, Early Intervention, Primary Prevention	17
D. RESEARCH	5

Sources of Income: G

Average number of clients/consumers served per year 25

Primary Counties Served: Kennebec, Androscoggin, Cumberland, Knox
35% of the total client population comes from 10 other counties

Region 4 Program Descriptions

Bangor Halfway House, Inc.
Men's Program
98 Cumberland Street
Bangor, ME 04401

Mary Jane Bush, Executive Director
Telephone: (207) 945-3163

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Halfway House, Outpatient	78
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services	1
C. RESEARCH	2
D. COORDINATION Grant Management, Planning, Inter-agency Coordination	14
E. CONTRACTED SERVICES Psychologist, Accountant, Physician	5

Sources of Income: C, D, I*, G, A, H
*Bureau of Rehabilitation Contract

Average number of clients/consumers served per year 60

Primary Counties Served: Penobscot, Kennebec, Cumberland
35% of the total client population comes from 13 other counties

Bangor Halfway House, Inc.
Women's Program
319 State Street
Bangor, ME 04401

Mary Jane Bush, Executive Director
Telephone: (207) 947-1108

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Halfway House	78
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services	1
C. RESEARCH	2
D. COORDINATION Grant Management, Planning, Inter-agency Coordination	14
E. CONTRACTED SERVICES Psychologist, Accountant, Physician	5

Sources of Income: C, D, I*, G, H
*Bureau of Rehabilitation Contract

Average number of clients/consumers served per year 55

Primary Counties Served: Penobscot, Kennebec
49% of the total client population comes from 14 other counties

Bangor Mental Health Institute
P.O. Box 926
Bangor, ME 04401

David Spang, Director of Social Work
Nancy Moody, Alcohol Counselor
Telephone: (207) 947-6981

Primary Activities	% of Budget Spent on this Activity
A. CONTRACTED SERVICES Eastern Maine Medical Center (The Alcohol Institute)	100

Sources of Income: D

Average number of clients/consumers served per year 300

Primary Counties Served: Penobscot, Hancock, Aroostook
19% of the total client population comes from 3 other counties

Blue Hill Memorial Hospital
Water Street
Blue Hill, ME 04614

Suzanne Lawrence, S.A. Counselor
Telephone: (207) 374-2836 Ext. 295

See Program Profile on Project Hancock

Bucksport Area Pastoral Counseling Center
Elm Street Congregational Church
Drawer 878
Bucksport, ME 04416

Dr. Denis T. Noonan III, Director
Telephone: (207) 326-8810

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient (individual and family	80
B. EDUCATION Inservice (staff) Education & Training, Community Education, Resource & Information Services	20

Sources of Income: H, I*
*nonprofit support

Average number of clients/consumers served per year 35

Primary Counties Served: Hancock
5% of the total client population comes from 1 other county (Waldo)

Calais Regional Hospital
50 Franklin Street
Calais, ME 04619

Tom Watson, Alcohol Counselor
Telephone: (207) 454-7521 Ext. 138

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	43
B. EDUCATION Inservice (staff) Education & Training, Community Education, Resource & Information Services	17
C. PREVENTION D.E.E.P. Evaluations	20
D. COORDINATION Planning, Grants Management & Reporting	20

Sources of Income: H, I*, C, D
*cross subsidy from other services provided by C.R.H.

Average number of clients/consumers served per year 170

Primary Counties Served: Washington
2% of the total client population comes from out-of-state

Castine Community Hospital
Court Street
Castine, ME 04421

Suzanne Lawrence, S.A. Counselor
Telephone: (207) 326-4348

See Program Profile on Project Hancock

Community Health & Counseling Services
43 Illinois Avenue
Bangor, ME 04401

Jill Johnston, Management Analyst
Telephone: (207) 947-0366

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Residential Rehabilitation, Children's Day Programs, Crisis Intervention	88
B. EDUCATION Inservice (staff) Education & Training, Resource & Information Services, Community Education, Foster Parent Training	10
C. PREVENTION Employee/Student Assistance Program	1
D. COORDINATION Grant Management, Planning, Inter-agency Coordination	1

Sources of Income: C, I*, F, H, G, E
*State Department Contracts

Average number of clients/consumers served per year 8270

Primary Counties Served: Penobscot, Hancock
18.4% of the total client population comes from 11 other counties

Cutler Health Center
University of Maine
Orono, ME 04469

David Van Doren, Substance Abuse Counselor/Educator
Telephone: (207) 581-7511

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	45
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services	20
C. PREVENTION Early Intervention, Employee/Student Assistance Program, Primary Prevention, Health Promotion	20
D. RESEARCH	5
E. COORDINATION Planning, Interagency Coordination	10

Sources of Income: I*
*University of Maine

Average number of clients/consumers served per year 80

Primary Counties Served: All counties (no specific % distribution indicated)
15% of the total client population comes from "out-of-state"

Down East Community Hospital
Substance Abuse Program
Upper Court Street
Machias, ME 04654

Drusilla Myers, Director
Telephone: (207) 255-3356 Ext. 22

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Detoxification	75
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services, Other Training	18
C. PREVENTION Early Intervention	5
D. COORDINATION Grant Management	2

Sources of Income: F, H, C, D, G

Average number of clients/consumers served per year 120

Primary Counties Served: Washington, Hancock

Family Therapy Associates
61 Main Street
Room 59
Bangor, ME 04401

Albert Dietrich, A.C.S.W., Director
Telephone: (207) 947-4658

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Public Institutions, Family Support Services	70
B. EDUCATION Community Education, Inservice (staff) Education & Training, Consultation & Technical Assistance, Resource & Information Services	10
C. PREVENTION Primary Prevention, Early Intervention, Health Promotion	10
D. COORDINATION Planning, Interagency Coordination	10

Sources of Income: H

Average number of clients/consumers served per year 200

Primary Counties Served: Penobscot, Hancock
10% of the total client population comes from 2 other counties

Harbor House
542 Hammond Street
Bangor, ME 04401

Carl DeFilippo, Jr., Owner
Telephone: (207) 942-0337

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Home-based (Alternative Living) 3/4 Way House	100

Primary Sources of Income: I*
*Self-supporting, Residents Share Expenses

Average number of clients/consumers served per year 25

Primary Counties Served: Penobscot, Aroostook, Somerset, Franklin

Homestead Project, Inc.
P.O. Box 663
Ellsworth, ME 04605

Patrick F. Moore, Executive Director
Telephone: (207) 667-2021

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT*	

*"Homestead is a residential treatment center for Maine adolescents. (No specific alcohol program/component.) Our records reveal that a significant portion of our population have drug and alcohol related abuse patterns. A rough estimate would be about 20% of our population at any given time. Also, in a study of 55 case histories, 56% of the adolescents had one or both guardians reported to have alcohol related problems."

Homestead has a capacity of 26 with an average stay of 1 year

Hope House, Inc.
43 Illinois Avenue
Bangor, ME 04401

Kenneth Thompson, Director
Telephone: (207) 942-1808

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Detoxification, Shelter, Residential Rehabilitation, Aftercare & Crisis Intervention	85
B. EDUCATION Consultation & Technical Assistance, Inservice (staff) Education & Training, Community Education, Resource & Information Services, Other Training	2
C. PREVENTION Employee/Student Assistance Program	5
D. COORDINATION Planning, Grant Management, Fiscal Management, Interagency Coordination	3
E. CONTRACTED SERVICES M.D., St. Joseph Hospital, Ambulance, CPA	5

Primary Sources of Income: D, I*, H
*Food Stamps, MSCSP

Average number of clients/consumers served per year 400

Primary Counties Served: Penobscot
23% of the total client population comes from 8 other counties

Maine Coast Memorial Hospital
Ellsworth, ME 04605

Carl Allan, S.A. Counselor
Telephone: (207) 667-5317

See Program Profile for Project Hancock

Maine Maritime Academy
Peer Counselor Training Program
Castine, ME 04421

Dr. Denis T. Noonan III, Academy Counselor
Telephone: (207) 326-8810/4311 Ext. 287

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Individual Counseling	50
B. EDUCATION Inservice (staff) Education & Other Staff Training, Community Education, Resource & Information Services	5
C. PREVENTION Peer Counselor Training Program	45

Sources of Income: I*
*Student Tuition and General Academy Funds

Average number of clients/consumers served per year 70

Primary Counties Served: All counties and out-of-state (no specific % distribution indicated)

Mayo Regional Hospital
75 West Main Street
Dover-Foxcroft, ME 04426

Denise Nutter, S.A. Counselor
Telephone: (207) 564-8401

See Program Profile on Plummer Memorial Hospital

Millinocket Regional Hospital
Dept. of Alcohol Services
200 Somerset Street
Millinocket, ME 04462

Tom Watson, Alcohol Counselor
Telephone: (207) 723-5161 Ext. 36

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient	74
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance	10
C. PREVENTION D.E.E.P. Evaluations	10
D. COORDINATION Planning	5
E. CONTRACTED SERVICES Eastern Maine Medical Center (for clinical supervision)	1

Sources of Income: I*, H
*Cross-subsidy by M.R.H. from other services

Average number of clients/consumers served per year 140

Primary Counties Served: Penobscot

Mount Desert Island Alcohol and Drug Abuse Group, Inc.
16 Wayman Lane
Bar Harbor, ME 04609

Anne E. Kinter, Founder
Telephone: (207) 288-5081

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Community Education, Resource & Information Services, Consultation & Technical Assistance, Inservice (staff) Education & Training	40
B. PREVENTION Employee/Student Assistance Program, Health Promotion	40
C. COORDINATION Planning, Interagency Coordination, Community Liason for M.D.I. Hospital Chemical Dependency Service	20

Sources of Income: G*
*Community Fund Raising

Average number of clients/consumers served per year 1800(audience)

Primary Counties Served: Hancock

Mount Desert Island Hospital
16 Wayman Lane
Bar Harbor, ME 04609

Ann Kinter, S.A. Coordinator
Telephone: (207) 288-5081

See Program Profile on Project Hancock

Penobscot County Jail
85 Hammond Street
Bangor, ME 04401

Sherry Barghi, Program Specialist
Telephone: (207) 947-4585

See Program Profile on Maine Sheriffs' Association

Pleasant Point Health Center
Alcoholism Services Program
Box 351
Perry, ME 04667

Mary Bassett, Assistant Director
Telephone: (207) 853-2551 Ext. 270

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Residential Rehabilitation, Detoxification, Outpatient	45
B. EDUCATION Consultation & Technical Assistance, Inservice (staff) Training, Other Training	45
C. PREVENTION Primary Prevention, Early Intervention, Employee/Student Assistance Program, Health Promotion	10

Sources of Income: A

Average number of clients/consumers served per year 16

Primary Counties Served: Washington

Plummer Regional Hospital
51 High Street
Dexter, ME 04930

Mayo Regional Hospital
75 West Main Street
Dover-Foxcroft, ME 04426

Denise Nutter, Office Manager
Telephone: (207) 924-7313 (P) (207) 564-8401 (M)

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Detoxification, Self-help, Aftercare	75
B. EDUCATION Inservice (staff) Education & Training, Community Education	5
C. PREVENTION D.E.E.P. Evaluations	20

Sources of Income: D, C

Average number of clients/consumers served per year 240

Primary Counties Served: Piscataquis

Project Antrium, Inc.
265 Hammond Street
Bangor, ME 04401

Sandra Wells, Director
Telephone: (207) 942-5686

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Adolescent Group Home	30
B. PREVENTION Miscellaneous Activities	60
C. COORDINATION Miscellaneous Activities	10

Sources of Income: D

Average number of clients/consumers served per year 56

Primary Counties Served: Penobscot, Androscoggin
10% of the total client population comes from 2 other counties

Project Hancock
50 Union Street
Ellsworth, ME 04605

Barkley Van Vranken, Controller
Telephone: (207) 667-5311 Ext. 270

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Detoxification	82
B. EDUCATION Inservice (staff) Education & Training, Community Education, Consultation & Technical Assistance, Resource & Information Services	4
C. PREVENTION Early Intervention, Primary Prevention, Health Promotion	7
D. COORDINATION Planning, Interagency Coordination, Grant Management, Hospitals Involved Include Maine Coast Memorial Hospital, Blue Hill Memorial Hospital, Castine Community Hospital, Mt. Desert Island Hospital	7

Primary Sources of Income: D, I*, H, F
*In-kind, income from other hospital programs, endowment funds, investment income, donation

Average number of clients/consumers served per year 1000

Primary Counties Served: Hancock

Eastern Regional Council on Alcohol & Drug Abuse
396 Griffin Road
Bangor, ME 04401

Barbara Niznik, Executive Director
Telephone: (207) 947-0511 Ext. 419

Primary Activities	% of Budget Spent on this Activity
A. PREVENTION Advocacy for Treatment, Research, Prevention & Education	50
B. COORDINATION Grant Management, Review & Comment, Council Coordination	50

Sources of Income: B, D

Average number of clients/consumers served per year N/A

Primary Counties Served*: Hancock, Penobscot, Piscataguis, Washington
*no specific % distribution indicated

University of Maine at Orono
Employee Assistance Program
Orono, Me 04469

Dr. Robert Graves, EAP Director
Telephone: (207) 581-1110

Primary Activities	% of Budget Spent on this Activity
A. PREVENTION Employee/Student Assistance Program, Early Intervention, Health Promotion	100

Sources of Income: I*
*University of Maine General Funds

Average number of clients/consumers served per year 100

Primary Counties Served: Penobscot
5% of the total client population comes from 2 other counties

Region 5 Program Descriptions

Aroostook County Action Program
P.O. Box 1116
Presque Isle, ME 04769

Jo-Anne Putnam, Regional Prevention Resource Coordinator
Telephone: (207) 764-3721

Primary Activities	% of Budget Spent on this Activity
A. EDUCATION Resource & Information Services, Consultation & Technical Assistance, Community Education	10
B. PREVENTION Primary Prevention, Health Promotion	80
C. COORDINATION Interagency Coordination, Planning, Grant Management	10

Sources of Income: B, D

Average number of clients/consumers served per year 91000(audience)*
*not included in client totals

Primary Counties Served: Aroostook

Aroostook Mental Health Center
Alcoholism Program
1 Vaughn Place
Caribou, ME 04736

Wesley R. Davidson, Associate Director
Telephone: (207) 498-6431

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Outpatient, Residential Rehabilitation	82
B. EDUCATION Consultation & Technical Assistance, Community Education, Inservice (staff) Education & Training, Resource & Information Services	2
C. PREVENTION Employee/Student Assistance Program, Primary Prevention, Early Intervention, Health Promotion	10
D. COORDINATION Grant Management, Planning, Interagency Coordination	2
E. CONTRACTED SERVICES Ashland Health Clinic, Patton/Danforth Clinic	4

Sources of Income: C, B, I*, H, I**, F, E
*AMHC Non-specified Funds
**Contracts

Average number of clients/consumers served per year 3119

Primary Counties Served: Aroostook
2% of the total client population comes from 2 other counties

East Grant Health Center
Danforth, ME 04424

Ken Schmidt, Administrator
Telephone: (207) 448-2347

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT* Outpatient	100

*All services are provided under contract by Aroostook Mental Health Center

Sources of Income: I*
*Contract from Kennebec Valley Regional Health Agency

Average number of clients/consumers served per year 18

Primary Counties Served*: Washington, Aroostook
*No specific % distribution indicated

Aroostook Alcoholism Council
5 Mechanic Street
Houlton, ME 04730

James B. Sabine, Executive Director
Telephone: (207) 532-9531

Primary Activities	% of Budget Spent on this Activity
A. TREATMENT Information & Referral	5
B. PREVENTION Prevention Education, Health Promotion	10
C. COORDINATION Planning, Networking	85

Sources of Income: B

Average number of clients/consumers served per year N/A

Primary Counties Served: Aroostook