MAINE STATE LEGISLATURE
Augusta, Maine 04333

THE COMMISSION ON CHILDREN IN NEED OF SUPERVISION AND TREATMENT

REPORT TO THE 114th LEGISLATURE

MARCH 1, 1989

MAINE STATE LEGISLATURE
Augusta, Maine 04333

January 30, 1989

Members of the 114th Maine Legislature
State House
Augusta, ME 04333

Dear Members:

There are children and families in Maine that are in crisis. Each of us knows a family attempting to deal with alcohol and/or other drug abuse, a runaway child, chronic truancy, acting-out behavior, or teenage pregnancy. We all know someone torn apart by a disintegrating and seemingly unsolvable problem to the family.

The Commission on Children in Need of Supervision and Treatment has spent the last eighteen months considering some of these problems and the issues involved in responding to them. Our recommendations to you follow in this report.

Our Commission worked diligently to sort out the facts from the fiction. Basically, we have determined that the services to meet children's needs ought to be in place before the state adopts a policy of involuntary or secure treatment of children. It would be tempting to rush headlong into passing a law that authorized involuntary treatment of children who need help dealing with these problems. Though it is tempting, it would be premature. The first step is to develop the full range of services necessary to meet the needs of these young people. There is some evidence that the availability of these services alone will make the need for involuntary supervision and treatment unnecessary.

My thanks are extended to Grace Cleaves, who staffed the Commission, the entire membership of the Commission, and you, the members of the 114th Legislature for your dutiful consideration. In November of 1987, a Lewiston resident wrote these words to me: "We love our children. We won't give up on them. They are confused in today's world and so are we."

The Commission stands ready to assist you in any way we can to the benefit of the children and families of Maine. We hope this report in a small way ends some of the confusion, and says we love our children, too.

Sincerely,

Dale F. Thistle

Dale F. Thistle
Commission Chairman

COMMISSION ON CHILDREN IN NEED OF SUPERVISION AND TREATMENT

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INTRODUCTION

There are families in Maine who are pleading for help. There are young people in Maine whose futures are at risk. Maine's leaders want to respond. They have found some answers.

> "Please help me. My 12-year-old daughter has run away. We think she has moved in with her 16-year-old boyfriend. He takes drugs. He gets in trouble with the law. She doesn't want our rules. She wants freedom. What can we do?"

> "My 17-year-old son is a big boy. He doesn't like it when I tell him he can't have the car. Sometimes he breaks things by accident. He says he'll move out if I don't give him money. I know he buys beer with it. He doesn't go to school. I'm a single parent and I'm scared. Can someone help me?"

The Commission on Children in Need of Supervision and Treatment herein gives direction to the State of Maine and hope to parents and youth. Its recommendations will include:[1]

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1) A complete list of proposed services can be found on page 19.

** a 24-hour hotline

** parent/child conflict mediation services

** drug and alcohol abuse treatment for youth

** peer counseling

** emergency shelters

** state-level family and child advocacy.

These services will reach children where they are. Workers will go into homes and onto the streets to talk with young people about the issues that effect them. Parents' love and authority will be recognized. Children who have run away from intolerable home lives will not be blamed.

What will be the strong foundation of this service system? Local control of services and spending. Parents and youth having advocates. Home-based family services. One point of contact to get help. Elimination of restrictive admissions requirements so that all young people who need services receive them.

Many of the parents who testified before the Commission stated that they had known that there were problems with their children in elementary school. Many stated that they sought the help of teachers, mental health professionals and others during those early times. Yet, little or no assistance was available to them. It is time to provide Maine's families and children in need with earlier, easier access to what we know is important for the health and growth of strong children and families.

If we learn to respond to the first plea for help and have

appropriate services available, we will prevent many children and families from ever needing the more intensive treatment services. If we help families learn to raise their children effectively and provide services needed to help do so, we will prevent many out-of-home placements. If we recognize that many kids who run away are running from abusive situations, we can become their allies. If we respond quickly and appropriately, we will reduce the number of children at risk. If we care about our children, we can do no less.

The Commission recognizes that this proposal, when implemented, will require new appropriations of money. It also recognizes that, without the implementation of this proposal, Maine will continue to lose far too many of its children and youth. If Maine is to do more than pay lip service to the concept that "children are our greatest resource," we must provide supports for children and families who are desperately pleading for our assistance.

THE LEGISLATIVE RESPONSE: REVIEWING, HEARING, COMPROMISING AND RESPONDING

The Commission on Children in Need of Supervision and Treatment was created by the 113th Maine Legislature as a result of a rising number of constituent concerns relating to the problems of young people who run away, become truant, defy authority, place themselves at risk and end up with problems with law enforcement officials. The services that were to have become available after the 1978 decriminalization of status offenses have not materialized.

The legislative mandate to the Commission on Children in Need of Supervision and Treatment included these charges:

1. define the population of out-of-control youth in need of supervision and treatment;

2. define the type of authority the State and parent should have over their children;

3. define legal and administrative remedies to enforce State and parental authority;

4. identify the administrative mechanisms necessary to implement the remedies and interventions;

5. identify the full spectrum of services needed to impact upon these issues, including recommendations for additional services and necessary State appropriations;

6. incorporate, as part of the research and analysis of the Commission, the related studies and reports;

7. prepare an overall plan and approach, including supporting legislation, necessary to have the State meet its obligation to these out-of-control juveniles and young adults, their families and their communities.

The Commission began its work in August, 1987. That fall,

three public hearings were held in Bangor, Portland and York. Comments were invited from parents, children, law enforcement, school officials and others, regarding the problems of out-of-control youth. The hearings were attended by a total of nearly 100 concerned citizens.

One parent's testimony highlighted the frustrations of many:

> "My son said he wanted his freedom so he just walked off into the night at midnight," reported one father. "He was belligerent and combative when we tried to get him back earlier through the police. Then the system let us down. The police told him he didn't have to come back if he didn't want to. [When he was arrested two weeks later] I got my rights back. He had to break the law for us to get control of him. Families like mine want to help before the police and the corrections system come in. We need some ammunition to do so."

The Commission also heard from law enforcement officers who shared their own frustrations regarding the inability to assist families in need of help and youth on the streets, because there were few services to which they could refer. Educators spoke about the difficulties in maintaining a young person in the classroom who was not interested or not able to obey the normal classroom rules that a teacher must have. Limited services exist to engage these young people in non-traditional ways or to

intervene with their truant behavior.

In addition to the fall hearings, Commission representatives visited homeless sites, a teen parent program and the Maine Youth Center to talk with youth who were considered to be representative of those in the population under study. The Commission and its Program Committee also heard testimony in Augusta from mental health, school, law enforcement, municipal representatives and parents, including:

1. The Augusta Mental Health Institute
2. The Jackson Brook Institute
3. The Maine Youth Center
4. The Therapeutic Foster Home Program
5. The Child and Adolescent Service System Project
6. The Interdepartmental Committee regarding Out-of-State placements
7. The Department of Educational and Cultural Services Substance Abuse Program
8. Day One
9. Steve Andrew, Substance Abuse Consultant
10. The Community School of Camden
11. The Sanford Police Department
12. The Court Mediation Service
13. The Office of Drug and Alcohol Abuse Prevention
14. The Cumberland County Child Abuse and Neglect Council
15. Mainely Families
16. Judge John Beliveau
17. The Department of Human Services
18. The Spurwink School
19. Kennebec Valley Mental Health Center
20. The Maine Association of Welfare Directors
21. David Bundy, Director of the Division of Child and Youth Services in New Hampshire
22. Lynda Dunn, Special Education Director of Bath
23. Richard Corbett, M.D., from the Seton Unit in Waterville

Commission members heard all sides of the issue. They worked creatively with department representatives, other professionals, family groups and staff to explore appropriate responses to the apparent need for services.

DEFINITION OF THE POPULATION

The young people identified as those of primary concern to the Commission are between the ages of ten and eighteen, in parental or state custody, and in need of services because they are:

* runaway or homeless
* repeatedly aggressive toward family members or property
* repeatedly disobedient of reasonable and proper orders of parent, guardian or other custodian and beyond the control of such person
* truant
* not currently or consistently being served optimally by the system or agency with whom they are involved
* not voluntarily accepting services
* in families at risk.

The numbers of young people included in these categories are difficult to estimate. However, very clear indicators exist that the numbers are substantive. First, 8600 referrals to Child Protective Services were screened out at intake because they were not serious enough to indicate that children were in serious danger of harm.[2] Of those, 1500 were considered to be related to

2) Child protective workers are so overloaded with very serious harm, injury or neglect cases, they are not able to respond to situations that present less than very serious risk to

"parent/child conflict" and 1270 were labeled as those in "family crisis." In addition, 8770 child protective cases were opened in 1987. Of those cases, 950 were in the parent/child conflict category, and 201 were runaways.[3]

The Interdepartmental Council[4] estimates that, of Maine's 320,000 children, 35,000 are estimated to have identifiable problems, with 1200-2000 exhibiting symptoms of serious emotional disturbance. A 1985 report on the need for a behavioral stabilization unit for seriously disturbed adolescents found 20-30 children needed that kind of secure treatment.

The Department of Educational and Cultural Services reports that 1109 children were truant from school in 1987-88. The Department of Human Services estimates that approximately 200 children, currently in DHS' custody, refuse to participate in services deemed appropriate for them.

These are both children who make today's headlines and those who quietly slip away. They are members of in-tact families and they are on the streets. They are children in need of supervision and treatment.

STATEMENTS OF SUPPORT

As a result of its work to address the needs of the young

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the child.

3) It is hoped that a system which addressed the needs of these groups earlier on would prevent so many from becoming active clients of the Child Protective Division.

4) See page 15.

people described above, the Commission encountered scores of dedicated individuals who, on their own or in groups, share the goal of promoting healthier children and families. The Commission especially wants to recognize the ongoing efforts of the following three work groups whose legislative mandates or work plans will have a direct impact on this population of young people: the Primary Prevention Committee, the Office of Truancy, Dropouts and Alternative Education and the Human Resource Development Council. The Commission lauds their dedication to the pursuit of clearly measurable gains in the months ahead.

1. Finding. Prevention programs are an essential component of any long-range plan to address the issues that prompted this Commission's existence. Many parents and children have not learned what falls within the normal range of expected child and adolescent behaviors. Neither are some acquainted with the everyday pressures exerted on young people to test authority and good sense in today's fast-paced life. Data are available to support the positive outcomes of programs that heighten general awareness and call for early education regarding these issues.

The Commission supports the work of the multidisciplinary Primary Prevention Committee of the Department of Corrections to develop a framework for implementation of a state-wide prevention program that addresses substance abuse, child abuse, delinquency, and legal and familial issues known to effect the target population. (DARE programs, DECS' study on affected children and

others should be explored as models.)

2. Finding. The Department of Education and Cultural Services' Office of Truancy, Dropouts and Alternative Education has conducted an in-depth study (Dropout Prevention Planning Guide) of the ways in which the problems of truancy and dropping out, which are often precursors of more problematic behavior, can be addressed.

The Commission supports the efforts of the Office of Truancy, Dropouts and Alternative Education[5] to focus on providing early intervention with high-risk youth and families, especially in the areas of a.) the use of elementary counselors, school social workers and/or home coordinators empowered to do outreach with children identified early as students-at-risk and b.) the use of positive early-intervention strategies to reduce school truancy.

3. Finding. Governor McKernon has stated that the Human Resource Development Council's Report will provide a cornerstone for this legislative session. That group's work clearly impacts on a portion of our population, as described in detail in the report.

The Commission supports Objective 4.1[6] -- and its stated plan of action -- of the Governor's Human Resource Development

5) See Attachment #4.

6) See Attachment #5.

Council's plan which says: "The percentage of Maine's secondary students who graduate from high school should be increased."

In addition to the above groups, the Commission recognizes the work of the Interdepartmental Council (IDC) and its Children's Policy Committee, comprised of the Commissioners and other representatives of the four child-serving departments (DMH & MR, DOC, DECS and DHS). The legislative intent for the IDC was to encourage the coordination of policies and programs for Maine children and families. Indeed, the need to monitor the efficacy of the public providers of these services has never been greater, given our growing expectations of programmatic and fiscal accountability.

COMMISSION RECOMMENDATIONS

The Commission on Children in Need of Supervision and Treatment firmly believes that children and families need a strong voice in planning for the services that affect them. The recommendations that follow acknowledge that belief. They are a result of hundreds of hours of communication and compromise around issues of personal and primary concern to the many people involved.

RECOMMENDATION #1: Increase Services for Children in Need of Supervision and Treatment[7]

The Commission on Children in Need of Supervision and Treatment proposes establishing a full array of services ranging from prevention and early intervention to residential treatment, to be available to children and families on a voluntary basis. Though many services currently exist, they do not provide a comprehensive solution to the problems we face as a State. There are not enough services. Some that exist are inaccessible to those truly in need. There are long waiting lists. Some services are totally absent. Prevention is not stressed.

After status offenses were decriminalized in 1978, many of the services, which were anticipated to follow young people back

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7) Commission vote: unanimous support.

out into the community, were not made available to youth and families in the affected population. The result has been disruption and chaos for those of Maine's youth, families, schools, law enforcement officers and others who deal with these difficult problems without proper support.

While a dimension of the Commission's work focused on difficulties involved with providing voluntary services to a group that includes some young people who, up to now, have been unwilling to participate, the Commission believes that offering voluntary services earlier would result in less need at the more restrictive end of the service scale.

Wherever services are established, the full spectrum (described below) should be available, whether on the state or regional level. No support would be given to funding the "treatment of last resort" without first addressing earlier types of intervention. Treatment services are the most expensive services of all. The goal should be to reduce the need for these services by preventing problems before they occur.

The Bureau of Children with Special Needs (BCSN) of the Department of Mental Health and Mental Retardation will be designated as the fiscal and administrative authority to implement and evaluate this new system of delivering services to Maine families. Evaluating the effectiveness of these services and the appropriateness of different services for different regional populations is crucial to the success of any long-range solution. Without evaluation, the effectiveness of this approach

cannot be measured.

Currently, there exists within BCSN, a regional model for the delivery of these services, under which local community entities, working together, have demonstrated their ability to develop community-based treatment plans for children with extremely complex problems. Through this coordination, children gain access to more appropriate services. With flexible funds in each region and a mandate to enhance the departments' representation on the regional level, even more positive outcomes for Maine families are expected. The adequate delivery of these services may prevent a teenager from penetrating deeper into the system -- Department of Human Services' custody, a psychiatric hospital or the Maine Youth Center.

The State will be divided into seven regions, and phase-in of services will occur over a two year period.

Spectrum of Services

It is recommended that the following spectrum of services[8] be established:

ADMINISTRATIVE

1. Regional coordination sites

2. Central placement review committee

3. Statewide program evaluation component

DELIVERY OF SERVICES

1. Specific Services

Statewide primary prevention program
Statewide public awareness program
Early intervention
24-hour hotline
Peer counseling and support
Information and referral
Educational resources
Employment resources
Case management
Transportation
Aftercare
Child protective program augmentation
Mediation
Evaluation and assessment service
Outpatient mental health services
Outpatient substance abuse services
Family support services
Homebased service teams
Homeless shelters
Emergency shelters
Semi-independent living programs
Day treatment
Therapeutic foster homes
Therapeutic group homes
Residential treatment facilities
Psychiatric hospitals
Secure treatment facilities

LEAST RESTRICTIVE

MOST RESTRICTIVE

8) Definitions follow in Attachment #1.

System Overview

The coordination system proposed herein includes an infrastructure of seven regional adolescent coordination sites and a state-level case-review committee. Regional sites will offer comprehensive treatment planning to children, many of whom have no access to services through existing systems. Regardless of the complexity of their needs, children will receive appropriate, individualized services. Regional committees will have an opportunity to develop local services and administer flexible funds, if necessary, to implement individually tailored programs. Through legislation enacting this recommendation, the regional sites, under the supervision of the Bureau of Children with Special Needs, will be directed to establish priorities for filling the service gaps that exist in each region.

Data on the effectiveness of services will be produced in the follow-up or "tracking" done by regional and state level groups. Furthermore, with the adolescent coordination sites feeding data to Central Placement Review and CPR reporting directly to the Children's Policy Committee of the IDC, a channel is established for the flow of important information to policy makers.

The Children's Policy Committee has identified a range of services needed to ensure effective implementation of treatment plans developed by regional adolescent service coordinators and by case managers. Family support services are fundamental. These services include respite care, parent support groups and

parent-to-parent networks. Home-delivered services, such as crisis intervention, parent education and family counseling, also contribute significantly to family support and increase the chances of children remaining with their families, rather than moving to out-of-home placements.

Delivery of comprehensive, community-based care also requires a range of residential options for children whose treatment needs require out-of-home placement. Depending on age and personal history, a child's treatment needs may best be served in a therapeutic foster home, therapeutic group home or a residential treatment center. To ensure successful transitions out of residential placements, aftercare services are also necessary.

The following services are also essential to comprehensive treatment planning for children and families: highly accessible outpatient services; day treatment services addressing mental health, substance abuse and educational needs; and vocational services. The initiation of this new system, including case management, family supports, home-delivered services and therapeutic residential services, will significantly advance our ability to manage or to prevent out-of-control behavior.

RECOMMENDATION #2: Establish the Maine Commission on Youth and Families [9]

There currently exists no freestanding entity whose primary focus is intersystem and statewide advocacy and public awareness on behalf of children and families. Over the last 15 years, commissions, committees and planning groups have been called together to study many important aspects of youth and family services. Caring, concerned people have committed vast amounts of time and energy studying these problems. Few results have materialized, though not for lack of effort. There has existed no ongoing, visible, effective voice for youth and family matters at the state level.

Therefore, the Commission on Children in Need of Supervision and Treatment recommends the establishment of the Commission for Youth and Families. The membership of this advisory commission will include consumers, community level providers, legislators and other appropriate representatives. The primary responsibility of this commission will be to advocate, advise and promote creative responses to improve the status of services to Maine's youth and families. In so doing, it will oversee a study (see Recommendation #3) of the efficacy of Maine's current system of services to youth and families and make appropriate recommendations.

The Commission for Youth and Families will be an

9) Commission vote: unanimous support.

independent, advisory entity, whose funds will be appropriated from the General Fund.

This fully-staffed commission will be charged with:

a. carrying out the recommendations of the Commission on Children in Need of Supervision and Treatment;

b. serving as an advocate for Maine's youth and families by making recommendations to the Governor, the Legislature and to other officials with respect to legislation, funding, policies, programs and other activities affecting or relating to youth and families in Maine.

c. working with existing departments, planning groups and organizations to acquire information, participate in planning and share expertise;

d. exploring creative funding options;

e. exploring innovative programming options;

f. informing the public about the presence or absence of opportunities and services for youth and families through heightening public awareness.

g. conducting public hearings, conferences and other such meetings to obtain information about, discuss and publicize the needs of and solutions to problems of youth and families;

h. making a biennial report to the Governor and Legislature concerning the work and interests of the commission.

The Commission on Youth and Families will act as a focal point for statewide advocacy and will be a conduit through which duplication is avoided and cooperation and accountability are fostered. This group will have direct access to the Executive branch and will be accountable to the Legislature.

RECOMMENDATION #3: Implement a Study on the Efficacy of Present Youth and Family Service System [10]

State-sponsored services for children and families are now offered primarily through the Departments of Human Services, Educational and Cultural Services, Corrections, and Mental Health and Mental Retardation. These services are not optimally coordinated. There is no centralized system of response and no established mechanism to follow families as they grow, develop and have different needs.

Approximately $110 million dollars were spent in FY 87 (see Attachment #2) by departments in the State on behalf of children with special needs. Proper and efficient administration of these programs now requires many staff in a number of different agencies to successfully develop and use interdepartmental communication mechanisms.

The Commission has been presented with issues that highlight the need to explore better consolidation of the many child-

10) Commission vote: unanimous support.

serving programs. The Commission has become aware that several models exist elsewhere in the country that consolidate child-serving departments under one umbrella. However, data also exist that identify problems inherent in this kind of reorganization. More study is indicated.

Therefore, the Commission recommends that a study be undertaken to evaluate the efficacy of the current youth and family service system in Maine. This comprehensive study will focus on the adequacy of the current response to Maine children and families in need of services and will be conducted by an independent consultant(s) or firm. The Commission on Youth and Families will oversee the study.

RECOMMENDATION #4: Create a System to Provide Involuntary Services [11]

What happens when a child refuses his parents' care? Does the child's care become the State's responsibility? Should the child be expected to care for himself? There are many questions around these issues.

Often parents have sought assistance from the State, because they could not obtain necessary services or could not persuade their children to take advantage of the available services. Indeed, much of the concern about these children lies in the

11) Commission vote: 7:2 in favor.

questions about the State's and parents' authority to control them.[12]

Many parents, affected by the problems under study here, attended the public hearings. They recounted incidents when their youngsters had left their homes precipitously after family conflict or argument. There were few resources available to help parents bring their children back home. Some children were living at home but were not willing to accept parental control. Time and again, parents presented situations in which they were informed that there would be no help for their child until the young person broke the law. Running away and living in a place different from where parents wanted them to live were not criminal offenses. Law enforcement professionals could not help. Necessary treatment could not be acquired. There were few services to intervene in these instances, for parents or for youth.

These issues prompted valuable discussion regarding the notion of providing involuntary services. Was there a need to institute a system that would provide some leverage into services for those young people who would not voluntarily participate? The answer to that question proved most difficult.

No one wanted a return to the days when these behaviors, defined as unacceptable, were dealt with through the juvenile justice system. All took seriously the duty to respond to families in need, offering hope that there would be relief for

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12) Refer to Attachment #6.

them in their pain. But a consensus decision on the involuntary services issue was not possible.

Those in favor of including court-ordered services in the spectrum of recommended services made these statements:

1. Parents sometimes find themselves in the untenable position of not being able to protect or control their children, yet having full legal and moral responsibility for their behavior.

2. There currently exist approximately 200 children who are wards of the state and are refusing services, including residential placement. Most are out of control and in charge of themselves at an age too young to make decisions based on good judgment.

3. Too often, young people test the system of normal authority to its limits and find that no punishment/consequence exists that includes safe physical restraint or mandatory services. Such consequences only exist after a young person has become involved with the juvenile justice system. It was stated that many children in this population will be unlikely to cooperate with treatment unless there is some undesirable consequence for not doing so.

Those opposing involuntary services countered with these statements:

1. The Commission received clear caution regarding the possibility of its work leading to the reinstatement of status offenses.

2. The Commission heard that court caseload sizes are already overwhelming and were cautioned not to add to that problem without providing sufficient funds to address it.

3. Implementation of an involuntary services law has the potential of reprioritizing existing resources from preventive/early intervention services to court-ordered services.

4. Some children are not in need of treatment but, nonetheless, are defiant and refuse to live at home.

5. Mediation, case management and other services will

likely lessen the number of children needing involuntary services.

6. Any law, written for a few, may be used to unnecessarily effect or restrain many.

7. Many treatment providers will not accept involuntary clients into their programs.

Members of both sides of the issue stood firm. All were resolute in their beliefs. All agreed that voluntary services were necessary. But no agreement was reached as to the nature and extent of or, indeed, even the need for involuntary services.

In its deliberation towards a recommendation on this issue, the Commission agreed that early intervention, before problems escalate, is an essential component of any plan to provide services to this population. It also recognized that families who seek help and support around these issues need access to appropriate resources.

Therefore, the Commission recommends that legislation be enacted that directs the Department of Human Services, in conjunction with the IDC, to report to the second regular session of the 114th Legislature by February 1, 1990, with recommended legislation that will create a system to provide involuntary services for children and families who refuse services on a voluntary basis.

The bill must address: which children or groups of children should be subject to involuntary services; which services or types of services will be available on an involuntary basis; what procedures must be followed to obtain involuntary services while guaranteeing due process of law; explicit definitions of the

types of secure treatment to be recommended; and proposed steps for prevention of and retrieval from leaving treatment against the advice of the treating professionals/caretakers.

The full range of services will be addressed, from least to most restrictive. The system that is developed to address involuntary service needs, however, will not be put in place until the full range of voluntary services is available.

The recommendations for a system of involuntary services will outline a progression of steps that can be utilized which (1) acknowledge the authority of legal guardians to act to protect their children, (2) protect the rights of children and parents, (3) ensure that appropriate voluntary services have been tried, (4) emphasize the use of new services in the least restrictive and most appropriate setting for the child and (5) provide for involuntary holds for evaluation and involuntary services.

The directive is made to the Department of Human Services since it is the department most often faced with trying to provide services to children in this population who are refusing services. In its role as guardian, it has much experience with the realities of trying to protect and provide for children and supports the provision of involuntary services when voluntary services have been refused.

The Department of Human Services will lead the efforts at clarifying a course of action, and it is directed to maintain a close alliance with the Interdepartmental Council throughout the

process. It is essential that the spirit of cooperative problem-solving already in place, and revisited on behalf of this Commission's work, be maintained and supported.

SUMMARY OF RECOMMENDATIONS

RECOMMENDATION #1: Increase Services for Children in Need of Supervision and Treatment

RECOMMENDATION #2: Establish the Maine Commission on Youth and Families

RECOMMENDATION #3: Implement a Study on the Efficacy of Present Youth and Family Service System

RECOMMENDATION #4: Create a System to Provide Involuntary Services

BUDGET

SERVICES

Funding Requirements - FY 90

ADMINISTRATIVE

Regional coordination sites (7)		$1,402,000
Coordinators	280,000	
Clerical staff	72,000	
Flexible funds	1,050,000	
Central placement review committee		200,000
Coordinator	40,000	
Clerical Staff	10,000	
Flexible funds	150,000	
Statewide program evaluation component		40,000

SERVICES

Services in 3 regions -- First Phase

Case management	93,000
Mediation	45,000
Evaluation and assessment service	To Be Specified (TBS)
Transportation	TBS
Family support services (includes MH aftercare)	168,000
Homebased service teams	91,500
Outpatient services - substance abuse	422,000
Aftercare - substance abuse rehab	422,000
Day treatment - substance abuse	219,000

Statewide -- First Phase

24-hour hotline	TBS
Child protective program augmentation	100,000
Day treatment - mental health	225,000
Emergency shelter	TBS
Homeless shelter	TBS
Semi-independent living program	TBS
Therapeutic foster and group homes (12 beds)	
Start-up costs	36,000
6 mos. operation	180,000
Short-term residential drug treatment	392,375
Residential treatment services (10 beds)	
Start-up only	100,000
Aftercare (delivered by treatment facility)	

Post residential treatment	110,000
Post hospital	
Residential (12 beds)	264,000
Released home	44,000
Secure treatment facility (6 beds) (Start-up $ depends on whether a new facility is developed)	150,000
Operating costs	300,000
TOTAL FY 90	$5,003,875

BUDGET

Funding Requirements - FY 91

ADMINISTRATIVE	
Regional coordination sites	$1,419,000
Central placement review	200,000
Statewide program evaluation component	40,000
SERVICES	
Services in 7 regions -- Second Phase	
Case management	434,000
Mediation	105,000
Evaluation and assessment service	TBS
Transportation	TBS
Family support services (includes MH aftercare)	952,000
Homebased service teams	427,000
Outpatient services - substance abuse	799,050
Aftercare - substance abuse	799,050
Day Treatment - substance abuse	782,250
Statewide -- Second Phase	
24-hour hotline	TBS
Child protective program augmentation	100,000
Day treatment (25 children)	375,000
Emergency shelter	TBS
Homeless shelter	TBS
Semi-independent living program	TBS
Therapeutic foster and group homes (12 beds)	
Start-up costs	36,000
6 mos. operation	180,000
Short-term residential drug treatment	588,562
	196,188*
Intermediate care facility - drug treatment (6 mos.)	250,000*
Therapeutic foster and group homes	
Ongoing from Phase 1	360,000
Residential treatment services (10 beds)	
Ongoing from Phase 1	360,000
Aftercare (delivered by treatment facility)	
Post residential treatment	120,000
Post hospital	
Residential (20 beds)	440,000
Released home	50,000

Secure treatment facility (6 beds) Operating costs	400,000
TOTAL FY 91	$9,413,100

(* denotes budget for phase 3 priority areas)

TOTAL FY 90	$5,003,875
TOTAL FY 91	9,413,100
TOTAL FY 90-91	$14,416,975

BUDGET

COMMISSION ON CHILDREN AND FAMILIES

FY 90

Staff - including fringe and support	
Executive Director	$45,000
Secretary	20,000
Member expenses	7,500
Operating Expenses (travel, public information, etc.)	10,000
Consultant - Study on delivery of services to children	30,000
TOTAL	$112,500

ATTACHMENTS

Attachment #1: Definitions of Service Components

Regional coordination sites -- Adolescent coordination sites would be established to significantly increase the State's ability to deliver quality, preventive services to children and their families. The site coordinator would establish and lead the regional committee and would oversee the planning, administering, coordinating, delivering and evaluating services to children and adolescents. An interagency agreement would be developed to clarify each department's role in this effort, including consistent participation on the team. Flexible funding is an essential component of the system, so that youth may have access to programs that are designed to more appropriately meet their needs.

Central placement review committee -- The four youth-serving departments have already planned a state-level case review committee consisting of one member from each department. The state-level committee will develop coordinated services for those children whose complex needs cannot be addressed at the local level alone. The staff will gather and systematize client records, coordinate state-level with regional activities and implement a client tracking system to monitor progress of children referred to the committee. The CPR committee would require flexible funds in order to implement programs, particularly for children who are not state wards.

Statewide program evaluation component -- In order to assess the efficacy and responsiveness of the regional system and its service components, a program evaluation component will be developed and implemented by the Bureau of Children with Special Needs. The method of evaluation will reflect regional differences and needs. Recommended changes, based on the evaluation, will be implemented in order to increase the effectiveness of the system.

Statewide primary prevention program -- Primary prevention programs address the environments in which young people live and grow by supporting strategies which promote healthy growth and development for the entire youth and child population. Such programs strengthen and support the efforts of youth and children to commit themselves to their families, schools and communities and to conventional behavior, by providing opportunities for the development of skills and productive community involvement. Youth who develop such commitment are less likely to engage in self-destructive acts.

Statewide public awareness program -- This program is a continuous, ongoing public awareness program, providing information to the general public and providing for the involvement of and communication with advocacy groups and human services agencies regarding children in need of services.

Early intervention -- Early intervention can refer to two types of services. First, one can intervene with children identified as at risk at an early age -- preschool, for example -- thus increasing the value of the long-term impact of the intervention. Secondly, one can intervene when an older child has been identified as beginning to exhibit problems. Both types of early intervention take place when risk indicators are low and result in the prevention of more crisis-oriented involvement.

24-hour hotline -- Throughout the life of the Commission, it was frequently acknowledged that there is not a single point of entry into a system of services for children. A 24-hour hotline would be utilized for parents and children to access services at any time of day. One call would result in information and/or action that would address the caller's concerns.

Peer counseling and support -- This service includes direct emotional support and skills' development (interpersonal, coping, self-control, social and recreational, problem-solving, communication) through augmented peer helper programs in the schools, peer support groups in schools or other natural settings, or augmented big brother/sister programs. It also promotes and assists the development and maintenance of self-help groups and parent-to-parent networks, which provide mutual support, information and education.

Information and referral -- This service provides information to parents, professionals and the public about available services and resources, referral for specific services and community and provider education. It is expected that I&R services would be provided through the regional coordination sites.

Educational resources -- Young people who are included in this population of children may not be educationally motivated using traditional methods. Alternatives need to be developed to provide stronger incentives for these youth to stay involved in the educational process.

Employment resources -- This service includes the teaching of pre-vocational and vocational skills. Specific activities include job exploration and job try-out, vocational assessment, motivation training, filling out job applications, work values and behavior training, job interviewing and job skills.

Case management -- Case managers coordinate treatment plans and monitor services to be provided to a child and his/her family or legal custodian in consultation with parents and a multi-disciplinary team of professionals from schools, child welfare, mental health and other agencies. Activities include: comprehensive assessment of client needs; developing a services' plan to assess those needs; coordinating and advocating for access to and utilization of services; monitoring client progress; and evaluating the appropriateness and effectiveness of services.

Transportation -- Transportation to necessary services is an essential component of the service delivery plan, given the rural character of the State and unavailability of public transportation outside metropolitan areas.

Aftercare -- Even when appropriate mental health and substance abuse residential services are available to youth in need of them and programs are successfully completed, there is inadequate follow-up to reintegrate young people back into home or community. Aftercare from residential, inpatient or other programs is essential to the long term success of recovering or reentering youth. This component will assure youth, families and significant others are assisted with the "reentry" process.

Child protective program augmentation -- The Department of Human Services anticipates an increase in potential referrals to the child protective program, based on a projected increase in new case finding. The Department will need 3 additional positions and supporting services in order to meet the demand of an expected 100-150 new cases per year.

Mediation -- This program, currently available through the court system to divorcing families in Maine, will provide a new avenue of conflict resolution. Parents and children will voluntarily meet with professionally-trained mediators to resolve conflicting issues in a manner that is fair and acceptable to both the child and the parents. Mediation is an alternative to traditional methods of resolution in that it empowers both parties in the process. The mediator is an impartial third party who builds on common areas of agreement to reach acceptable solutions to difficult problems.

Evaluation and assessment service -- Often times, youth and families may present with problems that are difficult to easily evaluate. There will be a need, in these cases, for an assessment of the presenting problems, history etc., that can lead to a more appropriate plan for the family. Comprehensive evaluations may include medical, psychiatric, psychological, personality, family/social, child developmental, educational, language, intelligence and supplemental assessments that enhance the ability to make appropriate recommendations.

Outpatient mental health and substance abuse services -- These services include direct individual, group and/or family therapy or treatment, delivered in a clinic, home or other community-based setting, such as a school or drop-in center. Outpatient services include treatment, screening diagnosis, evaluation, follow-up and case consultation. These services offer ways to improve or to stabilize the family living environment of the child, to minimize the need for disruptive and expensive out-of-home placement for the child, to assist the child, parents and family members to understand the effects of the child's problems, and to assist parents and family members to affect their child's developmental growth. Specialized treatment programs may include

those for sexual abuse victims and perpetrators and the chemically dependent.

Family support services -- These services include direct emotional support, referral to/promotion of parent self-help groups, and provision or referral to skills' training. Family support services may include the direct provision of therapeutic aides, helpers, companions or family extenders.

Homebased service teams -- Short-term (three-month maximum), home-based services include crisis-oriented family counseling provided in the home to prevent the potential removal of a child from the home or to promote reunification of a child with his/her family. Services are provided by a team of two counselors with approximately six families per team. Long-term (one-two years) home-based services are provided to families who have children with severe, chronic emotional disturbances or behavioral handicaps to maintain the child in the home setting. Homebased family services include evaluation and assessment, counseling and consultation, as well as direct emotional support, parenting training and advocacy.

Homeless shelter -- An emergency shelter designed to provide for overnight lodging and supervision of children, aged 10 years and older, for no more than 30 consecutive nights. A homeless shelter may operate only between the hours of 4 P.M. and 9 A.M.

Emergency shelters -- A children's home which operates to receive children 24 hours /day and limits placement to 30 consecutive days or less.

Semi-independent living program -- This service provides support and other services to older adolescents in their own apartments or homes. Supervision may be provided by regular outreach visits or on-site or live-in staff. Services include emotional support, information and referral to community resources and training in daily living, problem-solving and social skills. Staff are trained in crisis-intervention techniques.

Day treatment -- This service is provided for children with moderate to severe emotional or substance abuse problems. Clients in this program usually have difficulty participating in partial or full public school programs. The service may be provided in conjunction with a residential treatment program or a single, multi-district school program. Specialized staff provide a structured, therapeutic, academic program which may include vocational training, social skills training, individual/group/family therapy, recreation, transportation and services to parents. Day treatment services are generally provided between four and eight hours per day, five days per week.

Therapeutic foster homes -- Therapeutic foster homes provide long-term care using specially trained and compensated parent

substitutes. Foster parents have back-up support from mental health professionals, including respite and crisis services. They are linked to a network of other foster parents for mutual support and training. These homes are licensed by the Department of Human Services.

Therapeutic group homes -- This service provides treatment to children with moderate to severe behavior problems in a community residential setting. These children, for whom removal from the home is essential to providing treatment, attend local public schools, day treatment programs or receive education at the group home location. Older children may have job placements. The length of stay, varies depending on the child's needs. "Moderate level" group homes use trained parent substitutes or shift staffing and provide individual, group and family therapy. They provide liaison services to mobilize community and family resources and social, emotional and cognitive training. The maximum staff-to-child ratio is 2:6. "Intensive level" group homes are highly structured, have 24-hour awake staff and may be staff secure. The maximum staff-to-child ratio here is 4:6.

Residential treatment facilities -- Residential child care facilities provide 24-hour, long-term residential, educational and treatment services. Services may also include evaluation and assessment, individual/group/family therapy and parent support groups. Children who have severe developmental, behavioral, emotional or drug dependency problems are often placed through the special education pupil evaluation team process. Less restrictive alternatives for treatment must be developed.

Inpatient hospitalization for mental health and substance abuse disorders -- This service is available to children with severe emotional, behavioral or chemical dependency problems who cannot be served appropriately in a less restrictive setting. Services include: psychological and diagnostic procedures; treatment modalities including medication, psychotherapy, vocational rehabilitation, recreation therapy and milieu treatment; medical care and treatment; discharge planning; supportive services; and room and board. Both voluntary and involuntary clients may be served in this setting. This service is based on the likelihood of stabilization within a short period of time (7 - 90 days) and transfer to a less restrictive setting for continued treatment.

Secure treatment facilities -- This type of facility provides a treatment setting which limits a young person's ability to run away and protects him against harming himself or others.

Attachment #2: Estimates of Expenditures on Children with Special Needs - FY 1987

(Information obtained from Office of Fiscal and Program Review, 10/13/88)

**	Total	$110,604,883	
	General Fund	$ 61,238,345	55%
	Federal	49,098,936	44%
	Dedicated Revenue	267,602	1%
	Total	$110,604,883	

** Includes DMH & MR, DHS, DOC and DECS

ADOLESCENT SUBSTANCE ABUSE SERVICE NEEDS

I. The Problem: Substance Abuse Among Maine's Adolescents

- Twelve percent of the adolescent population in Maine experience problems as a result of the abuse of alcohol or other substances.

- Estimates of drug use by Maine's high school seniors include the following:

  92% of high school seniors have used alcohol at least once
  66% of high school seniors have used alcohol in the last month
  54% of high school seniors have used marijuana at least once
  26% of high school seniors have used marijuana in the last month
  17% of high school seniors have used cocaine at least once
  7% of high school seniors have used cocaine in the last month

- Drug use is correlated with absenteeism and poor school performance. Also, dropouts use drugs about twice as frequently as those who graduate.

- Students who drop out are at a greater risk of unemployment in the future because they do not finish their education and thus will utilize state services to a greater degree.

- Over 25% of Maine's school children come from families which are dysfunctional due to alcohol/drugs.

- Of the 10,813 persons served by OADAP funded agencies in FY 1988, less than 10% were 18 years of age and under.

- A needs assessment study which collected data on youth involved in Maine's juvenile correctional system was recently published and found the following:

  Juveniles who had commited more than one incident of crime were at least twice as likely to have substance abuse problems.

  Both truants and dropouts were higher than the overall sample in alcohol and/or substance abuse problems, and they were both more likely to be affected by such problems in their famailies.

  Sexually abused juveniles were more likely to have been affected by alcohol and/or substance abuse problems in their families.

  Seventy-four percent of the juveniles at the Maine Youth Center were identified as having substance abuse problems, and, in half of the cottages, the figures rose to 90 percent or more.

  Adolescent parents were frequently from families with substance abuse problems (71% reported a substance abuse problem in their family). Six out of every ten of these young parents were also identified as having a substance abuse problem.

- o More than half of teenage deaths are alcohol/drug related.

- o Alcohol related deaths are the leading cause of death for persons up to 24 years of age. In Maine, thirteen percent of Maine's middle school students and 26 percent of high school students have abused alcohol. Also, 16 percent of Maine's first time OUI offenders are teens.

- o Based on a national study, 25% of high school seniors drink once a week and they drink "to get high," not to relax. Thirty percent of high school seniors get drunk once a week.

- o An estimated 1,400 Maine children may be born each year with behavior and/or morphological defects due to maternal consumption of alcohol during pregnancy.

II. The Service System in Place to Respond to the Problem

Response to the problem requires a multi-level approach, including prevention, intervention, and treatment. The attached Table I outlines the range of services required and their purposes.

Focusing specifically in the treatment area, a minimum of 5 service components are required: outpatient, day treatment, short term residential rehabilitation (28-day), long term residential rehabilitation, and aftercare. Table II identifies the specific capacity determined to be needed for 3 components by the Department as the result of a formal, public review in July, 1985. For planning purposes, OADAP has also estimated the need for both aftercare and day treatment. In relation to the first, the required capacity equals the number of counselors needed to provide outpatient services. For the second, the number of slots equals the number of beds required for short term rehabilitation. The assumptions used to estimate the need are summarized in Chart III.

III. Gaps in the Service System

In order to be successful in responding to the needs of adolescents, the service provider must a) accept adolescents, and b) be fully knowledgeable and prepared to respond to the special needs of adolescents. Charts IV-VI show the difference between need for service and availability of that service in programs oriented primarily toward adolescents, by service type.

PREVENTION, INTERVENTION, AND TREATMENT SYSTEM FOR ADOLESCENTS

PRIMARY PREVENTION

Components of Primary Prevention include (1) strategies that increase people's knowledge by providing information about the negative effects of using alcohol and other drugs (long term and short term), peer pressure, and other influences to use of drugs; (2) techniques for expanding one's specific behavior repertoire for resisting negative peer pressure or "saying no"; and (3) training in life skills such as decision making. Prevention strategies include:

- o in-school curriculum
- o out-of-school curriculum
- o Just Say No clubs
- o Students Against Drunk Driving programs
- o life skills programs
- o parent groups
- o drug free support groups
- o alternative activity programs

EARLY INTERVENTION

A middle ground between the first use of a drug and the point at which the substance abuse problem has become serious and chronic is early intervention. The goal of all intervention, particularly of adolescents, should be to return the drug user to a drug-free state and self sufficiency. The process of intervention -- family and friends confronting the user, breaking through denial and selecting the solution -- has been successful in placing many a person on the road to recovery. Early intervention strategies include:

- o children of alcoholic programs
- o student assistance programs
- o OUI teen programs
- o peer and role modeling programs
- o peer counseling and facilitation programs

YOUTH TREATMENT

Substance abuse treatment's primary goal is to break the cycle of dependence after it has become firmly established. Treatment approaches include:

- o outpatient
- o day treatment
- o short-term residential (28 days)
- o long-term residential (6 months)
- o aftercare

NOTE: The development of a comprehensive system of specific services in each of these areas across the state is the responsibility of the members of the ADPC. The Department of Human Services funds <u>some</u> services in each of the three broad areas, in cooperation with the other departments.

CHART II

Summary of the Need for Adult and Adolescent Alcohol Rehabilitation Services
by County and OADAP Region, Maine, 1990

	Adult Alcohol Rehabilitation Services				Adolescent Alcohol Rehab Services		
	Residential Rehab Beds	Outpatient Counselors	Extended Care Beds	Day Treatment Slots	Outpatient Counselors	Short-term Rehabilitation Beds	Intermediate-term Rehabilitation Beds
OADAP Region I							
Cumberland	18.5	35.1	11.4	11.1	8.2	5.8	5.7
Knox	6.0	5.5	1.8	0.0	1.3	0.9	0.9
Lincoln	3.9	4.5	1.5	0.0	1.1	0.8	0.7
Sagadahoc	3.7	4.2	1.4	1.0	1.2	0.9	0.8
Waldo	3.8	4.4	1.4	0.0	1.2	0.8	0.8
York	20.8	23.8	7.8	4.3	6.1	4.3	4.2
Region Totals	56.8	77.5	25.2	16.4	19.0	13.5	13.1
Rounded Totals	57	78	*	16	19	14	*
OADAP Region II							
Androscoggin	7.4	15.0	4.9	5.2	3.6	2.6	2.5
Franklin	3.9	4.4	1.4	0.0	1.0	0.7	0.7
Oxford	6.7	7.7	2.5	0.0	1.7	1.2	1.2
Region Totals	18.0	27.2	8.8	5.2	6.4	4.6	4.4
Rounded Totals	18	27	*	5	6	5	*
OADAP Region III							
Kennebec	8.8	17.0	5.5	5.5	4.1	2.9	2.8
Somerset	6.2	7.1	2.3	0.4	1.8	1.3	1.3
Region Totals	15.0	24.1	7.9	6.0	5.9	4.2	4.1
Rounded Totals	15	24	*	6	6	4	*
OADAP Region IV							
Hancock	6.0	6.9	2.3	0.0	1.6	1.1	1.1
Penobscot	12.9	20.8	6.8	4.8	4.8	3.4	3.3
Piscataquis	2.4	2.7	0.9	0.0	0.7	0.5	0.5
Washington	4.5	5.1	1.7	0.0	1.2	0.9	0.8
Region Totals	25.8	35.5	11.6	4.8	8.3	5.9	5.7
Rounded Totals	26	36	*	5	8	6	*
OADAP Region V							
Aroostook	11.0	12.6	4.1	0.0	3.2	2.2	2.2
Rounded Totals	11	13	*	0	3	2	*
MAINE TOTALS	127	178	58	32	42	31	30

* Adult extended care and adolescent intermediate-term rehabilitation are not expected to be provided at the region level, therefore regional totals are not rounded.

Sources of Data: 1986-95 Population Projections, ODRVS, published 6/87; and the Report of the Policy Review Committee on Residential Alcoholism Rehabilitation and Related Treatment published 7/85.

Table Prepared by the Office of Data, Research, and Vital Statistics. July, 1988.

CHART III

Assumptions used in preparing these estimates

Adults (Age 20 and Older)

8% of the adult population experiences problems as a result of the abuse of alcohol or other substances.

15% of adult substance abusers will enter the treatment system each year.

94% of adults who enter the treatment system will be appropriate for treatment.

6% of adults who enter the treatment system will be inappropriate for treatment due to the advanced stage of their condition and will receive extended care.

Residential Rehabilitation Beds

20% of presenting rural population will need residential rehabilitation.

10% of presenting urban population will need residential rehabilitation.

21 days will be the Average Length of Stay for residential rehabilitation

1.1 admissions per year per client are expected.

80% occupancy rate for residential rehabilitation.

Day Program Slots

10% of presenting urban population will need intensive day treatment (no rural).

15 days will be the Average Length of Stay for day treatment.

1 admission per year per client is expected.

260 treatment days per year (5 days weekly for 52 weeks).

80% occupancy rate for day treatment.

Outpatient Counselling or Treatment Visits

100% of general substance abusers who obtain treatment will require outpatient services of some kind.

20 outpatient visits per client.

104 outpatient visits per counselor per year (24 visits per week for 46 weeks per year).

Assumptions used in preparing these estimates (Continued)

Extended Care

180 days will be the Average Length of Stay for extended care.

95% occupancy rate for extended care.

Adolescents (Age 10-19)

12% of the adolescent population experience problems as a result of the abuse of alcohol or other substances.

10% of adolescent abusers will seek treatment each year.

100% of presenting adolescent abusers will use outpatient services, assumed for this analysis to average 1 visit per week for 26 weeks.

1,104 outpatient visits per counselor per year (24 visits per week for 46 weeks per year).

20% of presenting adolescent abusers will use short-term residential rehabilitation services, assumed for this analysis to average 24 hours daily 7 days per week for 28 days (13 patients per bed per year).

3% of presenting adolescent abusers will use intermediate term residential rehabilitation services, assumed for this analysis to average 24 hours daily 7 days per week for 6 months (2 patients per bed per year).

Chart IV
Outpatient and Aftercare

County	Estimated Counselor Need	Estimated Total Cost	Available Funding	Gap (75% of state share of total)
York	12	$360,000		$270,000
Cumberland	16	480,000		360,000
Knox	3	90,000		67,500
Lincoln	2	60,000		45,000
Sagadahoc	2	60,000		45,000
Waldo	2	60,000		45,000
Androscoggin	7	210,000	$56,000	101,500
Franklin	2	60,000		45,000
Oxford	3	90,000		67,500
Kennebec	8	240,000		180,000
Somerset	4	120,000	68,400	21,600
Hancock	3	90,000	30,000	37,500
Penobscot	10	300,000	55,000	170,000
Piscataquis		30,000	30,000	<7,500>
Washington	2	60,000	30,000	15,000
Aroostook	6	180,000		135,000
Total	82	$2,490,000	$269,400*	$1,598,100*

* Does not include 14% of adult outpatient program dollars statewide that are also spent on kids - $269,300

Chart V
Short Term Rehab Beds

County	Total Estimated Need (rounded)	Total Beds Available	Number Allocated to Uninsured	Needed By Uninsured (50%)
York	6			
Cumberland	8	10	NA	
Knox	1			
Lincoln	1			9
Sagadohoc	1			
Waldo	1			
Androscoggin	4	16	NA	3.5
Franklin	2			
Kennebec	4	10		3
Somerset	2			
Hancock	2			
Penobscot	5	10		
Piscataquis	1			4.5
Washington	1			
Aroostook	3	3	NA	1.5
Total		49		21.5

Estimated cost per bed per year: $73,000 <$250/day x 80% occupancy>

- Total cost to serve indigents - 21.5 x $73,000 = $1,569,500

- Good data on true access to this service by clients who can't pay is not available. However, for planning purposes, the Office has estimated that on only half of the indigents in need of 28-day rehab actually are admitted. Based on this assumption, an additional $784,750 is needed to purchase adequate access for this population.

Chart VI

Day Treatment

- See short term rehab chart for need x county
- Availability statewide - none
- Estimated cost by DMHMR region:

Region	Total Need	Indigent Need (50%)	Indigent Cost ($125/day x .80 occ.)
1	3	1.5	$ 54,750
2	9	4.5	164,250
3	6	3	109,500
4	7	3.5	127,750
5	4	2	73,000
6	8	4	146,000
7	6	3	108,000
			$783,250

Intermediate Term Rehabilitation

- Estimated number of facilities, statewide - 3
- In place now - 2, Day One (Bar Mills); Project Rebound (Bangor)
- Needed - 1 facility, Central Maine, 10 beds
- Anticipated cost $25,000/bed, state funding = $250,000

IV. Filling the Gaps -- A Three-Phase Approach

Steps

Treatment Service	Phase 1	Phase 2	Phase 3
Outpatient	Purchase capacity in 3 regions (DMHMR 4, 6, 7)	Purchase capacity in 4 regions	
Day Treatment	Pilot, 2 locations (DMHMR 2, 1)	Expand to 5 more locations	
28 Day Rehab	Purchase 1/2 of needed capacity	Purchase 1/4 of needed capacity	Purchase 1/4 of needed capacity
6 Month Rehab			Purchase 10-bed program needed
Aftercare	Purchase capacity in 3 regions (DMHMR 4, 6, 7)	Purchase capacity in 4 regions	

Estimated Costs

Service	Phase 1	Phase 2	Phase 3
Outpatient	$422,000	$377,050	
Day Treatment	220,000	563,250	
28 Day Rehab	392,375	196,187	$196,188
6 Month Rehab	-	-	250,000
Aftercare	422,000	377,050	
Total	$1,456,375	$1,513,537	$446,188

Note: Additional funding considerations include, in part:

- Case Management for the chemically dependent population for BCSN
- Adequate Prevention services to keep the adolescent abusing population from growing larger
- Training for gatekeepers in substance abuse issues
- Inservice training of clinicians in adolescent programming

COMMISSIONER'S ADVISORY COMMITTEE ON
TRUANCY, DROPOUT AND ALTERNATIVE EDUCATION

PLATFORM STATEMENTS
September 9, 1987

(Priority Numbers Assigned April,'88)

Preschool programs should be made available for all children ages 3 to 5.

An orderly and safe school environment should be created by setting high standards for discipline and personal respect for teachers and students.

Parent-school linkages should be strengthened.

#3 Elementary counselors, school social workers and/or home-coordinators should be employed in all schools.

Literacy programs and parenting education courses should be made available in each school district.

Vocational education should be made available to all 9th and 10th grade students.

Summer youth employment programs should be developed for "high risk" students supported by private sector and state sources.

Recovery programs for school learners should be implemented by special grants on a regional basis in collaboration with the private sector and other community agencies.

#2 School truancy should be reduced by positive early intervention strategies in each school.

Teacher education and staff development programs should include courses in learning sytles, child development, competency based curriculums and assessment measurement instruments.

State planning grants (including incentive grants) should be tied to school improvement plans.

Positive action committees should be required to review school improvement plans for at-risk students k-12 as redefined.

A statewide public awareness program should be developed to focus attention on dropout prevention, the importance of high school completion and the availability of retraining/recovery programs for adults.

#4 Local-regional-state coalitions (partnerships) between the private sector, community agencies and schools should be established to assess community and state needs for developing and/or improving services for at-risk students and their families.

Teenage pregnancy prevention programs for mothers (fathers) to remain in school should be established in all schools.

#1 Special long term funding support for schools to develop and implement strategies for dropout prevention and recovery should be enacted by the legislature.

Objective 4.1 of the Governor's Human Resource Development Council's Plan

In this objective, the population at risk is addressed as follows:

"For the purposes of targeting services, planning strategies and programs and monitoring successful outcomes of new programs, the following definition of 'at risk youth' will be employed:

"Any person between 14 and 21 years of age who:

1. is below the 25th percentile on the Maine Assessment in reading/mathematics; or

2. is at least one year behind in credits earned for graduation; or

3. is pregnant or is a parent; or

4. has been assessed as chemically dependent; or

5. has been identified by DHS as abused or neglected; or

6. has been identified as a chronic acting out child; or

7. is a recipient of, or is a member of a family which is a recipient of, public assistance; or

8. has demonstrated a lack of proficiency in the English language as measured by a valid language assessment proficiency instrument."

The plan also outlines the following objectives to be achieved:

"1. A Student Tracking System . . .

2. A Plan for Incentives

The development of new programs and strategies for meeting the needs of at risk students will be reinforced by state and local incentives. Such incentives will be comprehensive, including enhanced funding, positive publicity, and other recognition strategies reaching those individuals whose efforts have 'made a difference' in the lives of at risk youth.

The Maine School Report Card already underway will be the first step towards this goal. The Maine Aspirations Compacts will be important players in this activity.

Timeline: July 1, 1988 Maine Report Card
July 1, 1989 Funding Enhancement

3. Collaborative Coordinating Councils will be formed on a regional and community basis. These councils will be formed on a regional and community basis. These councils will include representatives from schools, public service agencies, parents, business and industry and other community persons. Development of programs to meet the needs of at risk youth will be the central focus of these councils. The Department of Education will play a lead role in the development of these councils in collaboration with the Departments of Human Services and Labor.

Timeline: July 1, 1988 Aspirations Compacts

4. State level interdepartmental linkages will be strengthened by the IDC to continuously review state policies, regulations and statutes and to make recommendations for changes in those areas which will strengthen and reinforce local efforts. A plan of action for accomplishing linkages among the Departments of Labor, Human Services, Mental Health Corrections and Education will be approved by the IDC by July 1, 1988.

Timeline: July 1, 1988

5. Ongoing [in progress, led by DECS' Office of Truancy, Dropouts and Alternative Education] technical assistance will be provided to help sustain and nourish coordinating councils as they plan, implement and evaluate their goals. Assistance teams will be composed of consultants from the Departments of Human Services, Labor, Education and Corrections.

Activities will include:

a. Developing evaluation strategies for measuring success in reducing dropouts, lowering school retentions, and raising student aspirations.

b. Expanding the number of summer jobs for at risk youth age 14-21 with a schooling component.

c. Providing assistance to high school completers in finding employment in the work field where the

opportunity for career advancement is provided by the employer.

d. Creating incentives for youth dropouts already in the workforce to complete their diplomas or GED's with employer assistance.

e. Promoting and rewarding positive parent involvement with schools.

f. Increasing public awareness of the costs of not completing high school (economic and social) and the benefits for aspiring to higher attainments beyond high school completion.

g. Developing child care facilities for teen parents and transportation services to allow these parents to attend school, either through regular school or adult education.

h. Coordinating resources of private sector directed to reduce at risk youth populations.

i. Identifying needs of special populations (e.g., native Americans, language minority youth and adults, homeless youth, etc.) and making referral to appropriate services."

Martha Freeman
Children in Need Commission
6/21/88

PARENTS' RIGHTS, DUTIES, AND LIABILITIES

Parents' Rights

Generally

* "...[T]he natural parent may constitutionally place limitation on the child's freedom to locomotion and may substitute the will and judgment of the parent for that of the child and thus constrain the child's will for his own protection...." S****S**** v. State, 299 A.2d 560, 568 (Me. 1973) (holding that a statute permitting the juvenile court to treat as an offender a juvenile "living in circumstances of manifest danger of falling into habits of vice or immorality" did not violate due process)

* "The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children....

"As with so many other legal presumptions, experience and reality may rebut what the law accepts as a starting point; the incidence of child neglect and abuse cases attests to this. That some parents 'may at times be acting against the interests of their children'...creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests...." Parham v. J.R., 442 U.S. 584, 602-03 (1979) (holding that a statutory procedure permitting parents to place a child in a mental institution did not violate due process though the only review of the parents' decision was by the institution's superintendent, and the child could continue to be hospitalized upon the superintendent's finding of "evidence of mental illness" and that the child was "suitable for treatment")

* The parents' rights and interests in controlling and making decisions for their childern must always be considered in relation to children's rights and interests, and the state's rights and interests. See the articulation of these sometimes competing interests in the attached excerpt from S. DAVIS & M. SCHWARTZ, CHILDREN'S RIGHTS AND THE LAW (1987).

Force

* 17-A MRSA §106 (1): "A parent, foster parent guardian or other similar person responsible for the long term general care and welfare of a person is justified in using a reasonable degree of force against such person when and to the extent that he reasonably believes it necessary to prevent or punish such person's misconduct."

* A parent's rights with regard to a child clearly do not extend to abusing or neglecting the child. Both the civil child protective statutes, and the Criminal Code, describe this limitation and provide penalties. See the attached excerpt from 22 MRSA §4002 of the child protective statutes. Also see 17-A MRSA §552 (nonsupport of dependents), §553 (abandonment of child), and §554 (endangering the welfare of a child); and 19 MRSA §481 (criminal failure to support dependents). However, under 22 MRSA §4004 (3): "Except as specifically authorized by law, no person may take charge of a child over the objection of his parent or custodian."

Parents' Duties

Support

* 19 MRSA §442: "Every man shall support his wife and child."

19 MRSA §443: "Every woman shall support her child; and her husband when in need."

* "Support, as every other duty arising from the relationship of parent and child, is the equal responsibility of both mother and father, to be discharged in accordance with their respective capacity and ability." Pendexter v. Pendexter, 363 A.2d 743, 749 (Me. 1976) (Dufresne, C.J. concurring in result)

* 19 MRSA §301 (1): "If a parent, spouse or child reside in this State, the parent or spouse, a guardian or a municipality providing maintenance may petition the Superior, District or Probate Court to order a nonsupporting parent or spouse to contribute to the support of his spouse or child." (emphasis added)

* 22 MRSA §4023 permits the Department of Human Services to provide short-term emergency services to a child who is threatened with serious harm, a runaway, or without a guardian. However, under subsection 6: "Providing short-term emergency services to a child shall not affect a parent's obligation for the support of the child;" and subsection 7: "The department may, by agreement or court order, obtain reimbursement from a parent for the support of a child who receives short-term emergency services."

* When a child is ordered into the custody of the Department of Human Services, "The department may obtain reimbursement for child care expenses from the child's parents according to a support order or agreement." 22 MRSA §4061 (1).

* When a juvenile offender is committed to the Youth Center or the Departments of Human Services or Corrections for placement in a home or halfway house setting, the court may order the parents to provide medical insurance for and pay the cost of medical treatment of the juvenile. The court may order general support to be paid by parents of a juvenile offender committed to the Department of Human Services, a relative, or another person. 15 MRSA §3314 (4) & (5).

Education

* Parents have a responsibility to ensure their child's attendance at school or to make other arrangements for the child's education or for permission for the child to leave school. Attendance at school is compulsory for persons under 17 years of age (20-A MRSA §5001 (1)), unless certain criteria are met (§5001 (2)). Any adult having a person who should be in school under their control is responsible for that person's compliance with the school attendance laws. Civil penalties exist for persons who have control of, harbor or conceal, or induce a student to be a habitual truant (§5053).

Medical Treatment

* "It is firmly established that '[t]he right to practice religion freely does not include liberty to expose...the child...to ill health or death.'... [W]here it finds that a particular religious practice poses an immediate and substantial threat to the child's well-being...[the court] may make an order aimed at protecting the child from that threat...." Osier v. Osier, 410 A.2d 1027, 1030 (Me. 1980).

* "[C]ourts as a rule readily have intervened in the family when a child's life was threatened and the parents refused needed medical treatment. A different story is seen, however, when the treatment is not life-saving but would enhance the quality of the child's life in some measure." S. DAVIS & M. SCHWARTZ, *supra*, at 88.

"We seem to be in a period in which the trend is toward greater state involvement in the medical decision-making process. Courts are more willing now to intervene in family decision making with respect to non-life-threatening medical decisions.... On the other hand courts and legislatures seem to be fostering a greater role for children - mature minors, in particular - in making some medical decisions for themselves." *Id.* at 95.

* 22 MRSA §4071 (1): "The department [of human services], a physician or a chief administrator of a hospital may petition for a medical treatment order."

(4): "On the basis of the petition or other evidence, the court may order medical treatment for the child if the custodians are unable or unwilling to consent to it, and the treatment is necessary to treat or prevent an immediate risk of serious injury."

* Under 22 MRSA §1823, a licensed hospital or alcohol or drug treatment facility may treat a minor without his or her parent's consent and without informing the parent, as long as the facilities have been provided at the direction of a medical or mental health professional. If the hospitalization continues for more than 16 hours, the parent must be notified and the parent's consent obtained for further hospitalization.

Other Services

* Under 22 MRSA §4023, the Department of Human Services may provide short-term emergency services to certain children without parental consent. These services may include shelter, counselling, and medical treatment. The services may not extend for more than 72 hours after the department's assumption of responsibility for the child.

Parents' Liabilities

* 19 MRSA §217: "The parents or legal guardians of any minor who is between 7 and 17 years of age and is living with his parents or legal guardians, which minor willfully or maliciously causes damage to any property or injury to any person, shall be jointly and severally liable with the minor for that damage or injury in an amount not exceeding $800. Nothing in this section shall be construed to relieve the minor from personal liability for that damage or injury." (emphasis added)

* Apart from any statutory liability imposed on parents for the acts of their children, parents may be held liable for personal injury or property damage caused by their child based on the theory that the parents negligently failed to control their child. The liability does not arise simply because of the biological fact of being a parent; rather it arises from the parents' failure to exercise due care to protect others from a child's actions. The question of what standard of care should a parent be held to in a given situation depends upon several factors. Did the parent know that the child had dangerous propensities? Had the parent taken any steps to try to control the child or warn others? Did the parent have the ability to control the child? The question of ability to control is also answered by looking at the particulars of the situation. The child's age will have a bearing; i.e. clearly a

young child is easier to control than an adolescent. Also, persons who are not parents of a child, but who have assumed responsibility for the child and who have the ability to control the child, may be held liable for their negligent exercise of that control if the child does damage. See generally Alford, *Parental Failure to Control Child*, 45 Am Jur Proof of Facts 2d 549.

5595*

the courts, bringing about increased pressure for relaxed evidentiary rules to facilitate prosecution of abuse cases. These developments make it clear that the child abuse area is another area, like child pornography or employment, in which the state will continue to assume a highly protective attitude toward children. Few can argue against the protective posture itself. Given the validity of a protective policy, the real issue is how far it should go. Children should be protected from harm, but not at the cost of greater harm resulting from the intervention itself, with its consequent disruption of the family unit and important relationships. At the moment, an interventionist philosophy prevails, but this area also is one of those awaiting a shift in philosophy, in which movement back and forth will continue until a proper balance between protection and autonomy is reached.

A Final Word

The law has never assumed a monolithic attitude toward children. As illustrated here, for most purposes the law has been protective of children because of their perceived vulnerability and incapacity to make decisions or act for themselves. For some purposes, however, the law has granted autonomy to children to make decisions for themselves or to be responsible for themselves.

As mentioned earlier in this book, the basic issue is one of authority of who will decide for a child—the child, the parents, or the state. In any given area of law, this issue should be decided in reference to the various interests at stake. The interests of the child, the parents, and the state in any given case must be identified and balanced against each other to determine the appropriate rule of law to govern such cases.

Some interests of children include

adequate parental care,

educational opportunity,

certain constitutional rights,

freedom to contract, dispose of property, and engage in employment,

medical care.

Interests of parents might include

preservation of family unity,

from: Davis + Schwartz, Children's Rights and the Law

maintenance of parental authority,

protection of children,

education of children.

Interests of the state might include

preservation of life, health, safety, and general well-being of all citizens,

maintenance of order (such as in schools).

Occasionally, the interests of children, parents, and the state touch on the same area but are diametrically opposed. The case of *Wisconsin v. Yoder*[21] is an example. All parties were concerned about education, but the state insisted on universal compulsory attendance until age sixteen, whereas Amish parents and their children insisted on education in the public schools through eighth grade only (age fourteen or fifteen) followed by vocational education in the Amish community. Of course, another interest was at stake in that case as well—the right to religious freedom under the first amendment.

More often than not, the applicable interests are in conflict. In another religious freedom case, *Prince v. Massachusetts*,[22] the parental interests in religious freedom and parental authority had to yield to the state's interest in preserving the health and well-being of children. What explains the difference between the two decisions? A balancing of the interests in each case revealed that in *Yoder* the state's interest in having an educated citizenry was furthered by the Amish practice of self-education after the eighth grade, whereas in *Prince* the state's interest in protecting children from unwholesome street influences was frustrated by the aunt's insistence on having the children hand out religious pamphlets.

This analysis permits some conclusions, admittedly very broad, to be drawn. The state should act against parental wishes and children's wishes only to protect children from significant harm or to further some significant, overriding state interest. This approach would apply to laws against child pornography and sexual exploitation of children, laws addressed to the problem of child neglect and abuse, and laws requiring compulsory school attendance (except as they might conflict with religious belief, which is probably limited to the Amish). Children should be entitled to the same constitutional rights as adults, except where some paramount state interest applicable only to children is at stake (such as the juvenile curfew laws).

Me. Child Protective Statutes

§ 4034. Request for a preliminary protection order

1. **Request.** A petitioner may add to a child protection petition a request for a preliminary protection order, which shall include a sworn summary of facts to support the request.

2. **Order.** If the court finds by a preponderance of the evidence presented in the sworn summary or otherwise that there is an immediate risk of serious harm to the child, it may order any disposition under section 4036. A preliminary protection order shall automatically expire at the time of the issuing of a final protection order under section 4035.

3. **Custodial consent.** If the custodian consents in writing and the consent is voluntarily and knowingly executed in court before a judge, or the custodian does not appear after proper notice has been given, then the hearing on the preliminary protection order need not be held, except as provided in subsection 4.

4. **Preliminary hearing.** If the custodial parent appears and does not consent, or if a noncustodial parent requests a hearing, then the court shall hold a preliminary hearing on that order within 10 days of its issuance or request, unless all parties agree to a later date. The petitioner shall bear the burden of proof. If, after the hearing, the court finds, by a preponderance of the evidence, that returning the child to his custodian would place him in immediate risk of serious harm, it shall continue the order or make another disposition under section 4036.

5. **Contents of order.** The order shall include a notice to the parents and custodians of their right to counsel, as required under section 4032, subsection 2, paragraph G, and, if the order was made without consent, notice of the date and time of the preliminary hearing.

1979, c. 733, § 18; 1983, c. 184, §§ 3, 4.

1983 Amendment. Subsection 3: Chapter 184 inserted "or the custodian does not appear after proper notice has been given," and substituted "need not be held, except as provided in subsection 4" for "may be waived".

Subsection 4: Chapter 184, in first sentence, substituted "the custodial parent appears and does not consent" for "there is no consent".

Derivation:

R.S.1954, c. 25, § 249.
1957, c. 82.
1959, c. 307, § 3.
1963, c. 171, §§ 1, 2.
1963, c. 402, § 36.
1967, c. 159, § 1.
1969, c. 305.
1969, c. 590, § 31.
1971, c. 622, § 77.
1973, c. 567, § 20.
1977, c. 118, § 6.
1977, c. 511, § 2.
1977, c. 652, § 1.
1979, c. 481, § 5.
Former § 3792 of this title.

§ 4035. Hearing on final protection petition

1. **Hearing required.** The court shall hold a hearing prior to making a final protection order.

2. **Adjudication.** After hearing evidence, the court shall make a finding, by a preponderance of the evidence, whether the child is in circumstances of jeopardy to his health or welfare.

3. **Grounds for disposition.** If the court determines that the child is in circumstances of jeopardy to his health or welfare, the court shall hear any relevant evidence regarding proposed dispositions, including written or oral reports, recommendations or case plans. The court shall then make a written order of any disposition under section 4036. If possible, this dispositional phase shall be conducted immediately after the adjudicatory phase. Written materials to be offered as evidence shall be made available to each party's counsel and the guardian ad litem reasonably in advance of the dispositional phase.

→ (see attached definitions)

1979, c. 733, § 18; 1983, c. 184, § 5.

Former Sections	New Sections
3717	——
3791	(previously repealed)
3792	4005, 4031 to 4036, 4039
3793	4006, 4037, 4038
3794	4061
3795	4063
3796	(previously repealed)
3797	(previously repealed)
3798	4041
3799	4061
3800	4009
3801	4065
3802	4062
3803	4041
3851	4003, 4004
3852	4002, 4010
3853	4011
3854	4012
3855	4013
3856	4014
3856-A	4015
3857	4009
3858	4005
3859	4008
3860	4004, 4021, 4022
3861	——
3891-A	4023
3891-B	4023
3891-C	4023
3891-D	4023
3891-E	4023
3891-F	——
3901	4003
3902	4064
3903	4064
3904	4064
3905	4064
3906	4064

SUBCHAPTER I

GENERAL PROVISIONS

Section	
4001.	Title.
4002.	Definitions.
4003.	Purposes.
4004.	Authorizations.
4005.	Parties' rights to representation; legal counsel.
4005-A.	Foster parents right to standing and intervenor status in child protection proceedings.
4006.	Appeals.
4007.	Conducting proceedings.
4008.	Records; confidentiality; disclosure.
4009.	Penalty for violations.
4010.	Spiritual treatment.

Cross References

Child custody, investigation, costs, see title 19, § 751.

Elementary and secondary schools, privileged communications, application of this chapter, see title 20-A, § 4008.

School counselors, privileged communications, exceptions, see title 20-A, § 4008.

Sexual assault counselors, privileged communications, see title 16, § 53-A.

United States Supreme Court

Child abuse proceedings, federal court abstention, see Moore v. Sims, 1979, 99 S.Ct. 2371, 442 U.S. 415, 60 L.Ed.2d 994.

§ 4001. Title

This chapter may be cited as the "Child and Family Services and Child Protection Act."

1979, c. 733, § 18.

§ 4002. Definitions

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

1. Abuse or neglect. "Abuse or neglect" means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation,

deprivation of essential needs or lack of protection from these, by a person responsible for the child.

1-A. **Abandonment.** "Abandonment" means any conduct on the part of the parent showing an intent to forego parental duties or relinquish parental claims. The intent may be evidenced by:

A. Failure, for a period of at least one year, to communicate meaningfully with the child;

B. Failure, for a period of at least one year, to maintain regular visitation with the child;

C. Failure to participate in any plan or program designed to reunite the parent with the child;

D. Deserting the child without affording means of identifying the child and his parent or custodian;

E. Failure to respond to notice of child protective proceedings; or

F. Any other conduct indicating an intent to forego parental duties or relinquish parental claims.

2. **Child.** "Child" means any person who is less than 18 years of age.

3. **Child protection proceeding.** "Child protection proceeding" means a proceeding on a child protection petition under subchapter IV,[1] a subsequent proceeding to review or modify a case disposition under section 4038, an appeal under section 4006, a proceeding on a termination petition under subchapter VI,[2] or a proceeding on a medical treatment petition under subchapter VIII.[3]

3-A. **Child Welfare Services Ombudsman.** "Child Welfare Services Ombudsman" means a public official appointed to receive and investigate citizens' complaints against state agencies which provide child welfare services and which may be infringing on the rights of individuals and, when deemed necessary, propose remedial action.

4. **Custodial parent.** "Custodial parent" means a parent with custody.

5. **Custodian.** "Custodian" means the person who has legal custody and power over the person of a child.

6. **Jeopardy to health or welfare or jeopardy.** "Jeopardy to health or welfare" or "jeopardy" means serious abuse or neglect, as evidenced by:

A. Serious harm or threat of serious harm;

B. Deprivation of adequate food, clothing, shelter, supervision or care, including health care when that deprivation causes a threat of serious harm;

C. Abandonment of the child or absence of any person responsible for the child, which creates a threat of serious harm; or

D. The end of voluntary placement, when the imminent return of the child to his custodian causes a threat of serious harm.

6-A. **Licensed mental health professional.** "Licensed mental health professional" means a psychiatrist, licensed psychologist, licensed clinical social worker or certified social worker.

7. **Parent.** "Parent" means a natural or adoptive parent, unless parental rights have been terminated.

7-A. **Permanent plan.** "Permanent plan" means a plan designed to provide long-term stability for a child, which includes, but need not be limited to:

A. Reunification of the child with his family unless reunification has been determined to be inappropriate;

B. Termination of parental rights for the purposes of adoption;

C. Custody to an appropriate person;

D. Long-term foster care as defined in section 4064, subsection 1;

E. Continued care as provided for in section 4061, subsection 1; and

F. Emancipation of the child, if the requirements of Title 15, section 3506, are met.

8. **Person.** "Person" means an individual, corporation, facility, institution or agency, public or private.

9. **Person responsible for the child.** "Person responsible for the child" means a person with responsibility for a child's health or welfare, whether in the child's home or another home or a facility which, as part of its function, provides for care of the child. It includes the child's custodian.

10. **Serious harm.** "Serious harm" means:

A. Serious injury;

B. Serious mental or emotional injury or impairment which now or in the future is likely to be evidenced by serious mental, behavioral or personality disorder, including severe anxiety, depression or withdrawal, untoward aggressive behavior, seriously delayed development or similar serious dysfunctional behavior; or

C. Sexual abuse or exploitation.

11. **Serious injury.** "Serious injury" means serious physical injury or impairment. 1979, c. 733, § 18; 1983, c. 184, §§ 1, 2; 1985, c. 495, § 16; 1985, c. 739, §§ 1 to 3, eff. April 18, 1986; 1987, c. 511, § A, 2, eff. July 1, 1987.

[1] Section 4031 et seq. of title 22.

[2] Section 4051 et seq. of title 22.

[3] Section 4071 et seq. of title 22.

1983 Amendment. Subsection 1-A: Added by c. 184.

Subsection 6, C: Chapter 184 inserted "Abandonment of the child or".

1985 Legislation

Subsection 1: Chapter 739 substituted a comma for "or," preceding "mental", and inserted "or emotional".

Subsection 6-A: Added by c. 495.

Subsection 7-A: Added by c. 739.

Subsection 10, B: Chapter 739 inserted "or emotional", substituted "which now or in the future is likely to be evidenced by serious mental, behavioral or personality disorder, including" for ", evidenced by", and inserted ", seriously delayed development".

1987 Legislation

Laws 1987, c. 511, added subsec. 3-A.

Derivation:

1965, c. 68.
1969, c. 433, § 47.
1971, c. 598, § 37.
1973, c. 567, § 20.
1975, c. 167, § 1.
1975, c. 293, § 4.
1977, c. 577, § 1.
1979, c. 127, § 146.
Former §§ 3700, 3701, 3852 of this title.

Cross References

Award of parental rights and responsibilities for children in jeopardy as defined in this section, see title 19, § 752.

Child abuse or neglect, residents of home providing home day care, see § 8305 of this title.

Family support teams defined, evaluation of child abuse and neglect victims, see § 4082 of this title.

§ 4003. Purposes

Recognizing that the right to family integrity is limited by the right of children to be protected from abuse and neglect and recognizing also that uncertainty and instability are possible in extended foster home or institutional living, it is the intent of the Legislature that this chapter:

1. **Authorization.** Authorize the department to protect and assist abused and neglected children, children in circumstances which present a substantial risk of abuse and neglect, and their families;

2. **Removal from parental custody.** Provide that children will be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare;

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FIRST REGULAR SESSION

ONE HUNDRED AND FOURTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY EIGHT

AN ACT to Improve the Availability and Effectiveness of Youth and Family Services

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

Sec. 1. 5 MRSA §12004-J, sub-§7 is enacted to read:

5.	Youth and Families	Maine Commission for Youth and Families	Expenses Only	5 MRSA §7019

Sec. 2. 5 MRSA Part 16-A, is enacted to read:

PART 16-A

STATUS OF YOUTH AND FAMILIES

CHAPTER 362

MAINE COMMISSION FOR YOUTH AND FAMILIES

§7019. Maine Commission for Youth and Families

1. Established. In order to improve the status of services to the State's youth and families, there is established an independent commission to be known as the Maine Commission for Youth and Families, referred to in this chapter as the "commission."

2. Membership. The commission shall consist of 16 members appointed as provided in this subsection. Initial appointments shall be made within 30 days of the effective date of this subchapter.

A. The President of the Senate shall appoint the following number of members from the following groups:

(1) One senator; and

(2) 2 persons who represent the general public.

B. The Speaker of the House shall appoint the following number of members from the following groups:

(1) One representative; and

(2) 2 persons who represent the general public.

C. The Governor shall appoint the following number of members from the following groups:

(1) Three persons who are using or have used the services provided by the State to youth and families;

(2) Three persons who are community level youth and family service providers; and

(3) Three persons who represent the general public.

D. The Governor shall designate one member upon the recommendation of the Committee for the Interdepartmental Coordination of Services to Children and Families. This person shall serve as a non-voting member of the commission.

3. Terms of office; vacancies. The term of office for each member is 2 years, except for the first appointed members. Of the first appointed members, the Governor shall designate 6 of the gubernatorial appointees at the time they are appointed to serve for terms of one year. The President of the Senate and the Speaker of the House shall each designate one of their appointees at the time they are appointed to serve for a term of one year. The remaining members shall serve for terms of 2 years.

When a member's term expires, that member shall continue to serve until a successor is appointed. Any member may be removed for cause, including excessive absences from commission meetings, by the appointing authority. The commission shall determine when a member's absences have been excessive.

The appointing authority shall fill any vacancies on the commission in the same manner in which a regular appointment is made.

4. Chairman. The commission shall elect a chairman and vice-chairman from among its membership.

5. Meetings. The commission shall meet at least 4 times a year. Additional meetings may be held as necessary at the call of the chairman or any 2 members. Meetings shall be announced in advance and open to the public as required by Title 1, chapter 13, subchapter I.

6. Quorum. Eight members of the commission constitute a quorum. No action may be taken by the commission except by affirmative vote of a majority of those present and voting.

7. Compensation. Members shall serve without compensation but are entitled to reimbursement for necessary expenses incurred in the work of the commission as provided in Title 5, chapter 379.

§7020. Commission duties

The commission shall:

1. Advise and consult. Advise and consult with the Governor and the Legislature about the status of services to the State's youth and families;

2. Advocacy. Serve as an advocate for the State's youth and families by making recommendations on proposed budgetary, legislative and policy actions to the Governor, the Legislature and other officials with respect to policies, programs and other activities affecting or relating to youth and families in the State;

3. Acquire expertise. Work with departments of state government, planning groups and organizations to acquire information, participate in planning and share expertise;

4. Research. Explore creative or innovative program and funding options;

5. Information. Inform the public about the presence or absence of opportunities and services for youth and families;

6. Public meetings. Conduct public hearings, conferences and other meetings to obtain information about, discuss and publicize the needs of and solutions to problems of youth and families; and

7. Administration and staff. Appoint an executive director and secretary and request staff assistance from other departments of state government. The executive director shall serve at the will of the commission and is not subject to the civil service laws. The executive director shall be compensated in an amount determined by the commission within

the same pay range authorized for the Executive Director of the Maine Commission for Women. The executive director shall perform those duties assigned by the commission.

8. Reports. Prepare a biennial report to be presented to the Governor and the Legislature concerning the work and interests of the commission. The first report shall be presented by February 1, 1991.

Sec. 3. 34-B MRSA §6201, sub-§1-A, is enacted to read:

1-A. Children in need of supervision. "Children in need of supervision" means children up to the age of 18 years who may benefit from services because they:

A. Are runaway or homeless;

B. Have repeatedly exhibited violent or aggressive behavior toward property or family members;

C. Have repeatedly disobeyed reasonable and proper orders of a parent, guardian or other custodian or who are beyond the control of a parent, guardian or other custodian;

D. Are truant;

E. Are not currently or consistently being served optimally by the system or agency with whom they are involved;

F. Will not voluntarily accept services; or

G. Are in families at risk.

Sec. 4. 34-B MRSA §6204, sub-§1, ¶D, is enacted to read:

D. Ensure that a full spectrum of services is available to address the problems of children in need of supervision.

(1) The Bureau shall provide or arrange for the provision of at least the following services:

(a) Administrative services, including the establishment of:

(i) Regional service delivery coordination sites;

(ii) A central placement review committee; and

(iii) A statewide program evaluation component; and

(a) Service delivery systems, including:

(i) A statewide primary prevention program;

(ii) A statewide public education program;

(iii) Early intervention;

(iv) Peer counseling and support;

(v) Information and referral;

(vi) Case management;

(vii) Transportation to necessary services;

(viii) Aftercare;

(ix) Mediation;

(x) Evaluation and assessment service;

(xi) Outpatient mental health services;

(xii) Outpatient substance abuse services;

(xiii) Family support services;

(xiv) Home-based service teams;

(xv) Homeless shelters and emergency shelters;

(xvi) Semi-independent living program;

(xvii) Day treatment;

(xviii) Therapeutic foster homes;

(ixx) Therapeutic group homes;

(xx) Residential treatment facilities;

(xxi) Psychiatric hospital care; and

(xxii) Secure treatment facilities.

(2) The Bureau shall work with other state agencies which have primary responsibility for providing the following services to ensure their availability as part of the full spectrum of services for children in need of supervision:

(a) Employment resource services;

(b) Educational resources;

(c) Child protective program augmentation; and

(d) Establishment of a 24-hour hotline for parents and children to access services.

Sec. 5. 34-B MRSA §6204, sub-§2, is amended to read:

2. Powers. The bureau may perform the duties described in subsection 1 and may provide services to children in need of treatment and to children in need of supervision through state-operated facilities and programs or through contracts and grants to public and private agencies. In all cases, the bureau shall ensure that services are provided in the least restrictive setting consistent with the child's needs, commensurate with the resources available to the bureau and in coordination with services and resources of other state agencies serving children and families. Emphasis shall be placed on maintaining each child in his natural home or in an alternative placement within the community whenever possible.

Sec. 6. Legislation. The Department of Human Services, in conjunction with the Committee for the Interdepartmental Coordination of Services to Children and Families, shall develop legislation to be introduced by February 1, 1990, to the 2nd Regular Session of the 114th Legislature. The legislation shall create a system to provide involuntary treatment services for children who refuse services on a voluntary basis. At a minimum, the bill must address the following issues.

1. Which children or groups of children should be subject to orders for involuntary services?

2. Which services or types of services will be available on an involuntary basis?

3. What process or procedures are appropriate to prevent a child from fleeing from a treatment facility and to retrieve a child who does flee?

4. What legal procedure should be followed to obtain an order for involuntary services in appropriate cases while guaranteeing due process of law and preventing abuse of the involuntary services process?

5. What should the consequences be for failing to obey an order for involuntary services?

Sec. 7. Study. The Commission on Youth and Families shall conduct a study to evaluate the efficacy of the youth and family service system in Maine. The commission shall employ a consultant to perform the study at the direction of the commission. In particular, the study shall focus on current efforts to coordinate the provision of youth and family services by the Department of Corrections, the Department of Educational and Cultural Services, the Department of Human Services and the Department of Mental Health and Mental Retardation. The commission shall investigate the experience of other states with a centralized coordination system and determine if a such a system, or any other system, would be advantageous in Maine. The commission shall submit its report, with any recommended legislation, to the 1st Regular Session of the 115th Legislature.