INTERIM REPORT

July, 1984

COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS

STATE OF MAINE

Joseph E. Brennan
Governor

Maine Department of

Mental Health and Mental Retardation

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July 30, 1984

Dear Maine Citizen:

I am pleased to send you this copy of the Interim Report of the Commission to Study the Availability, Quality and Delivery of Services Provided to Children with Special Needs.

As its title suggests, although it represents a year of public meetings, information-gathering and hard work by the 31 members of the Commission, this Report is not yet the final one.

I hope you will share with the Commission the conviction that many things have improved in our schools, our courts, our laws and our social service system since the time Malcolm Robbins was growing up. However, the Commission is well aware that much still needs to be done, and we hope we have addressed some of these needs through our recommendations. We also recognize that many of these suggested recommendations will be expensive, or require changes in our laws.

Therefore, we are asking you to review the findings, and the recommendations presented in this Report. If you have anything you wish to add, to correct, or specific suggestions as to how to carry out the recommendations, please let me know.

We will be accepting comments from the public until the beginning of September, and then will hold another series of public hearings on the revised Report. Please send any comments to me at the Department of Mental Health and Mental Retardation, State House, Station 40, Augusta, Maine 04333.

If you do <u>not</u> wish to receive a copy of the Final Report, please let me know that too.

Thank you for your interest in this very important topic.

Sincerely,

Kevin W Concannon

Kevin W. Concannon
Commission Chair

KWC/dbs

MAINE COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS

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Commissioner Kevin W. Concannon

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III. Mandates and Purposes:

The Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs was established by a Resolve of the Maine Legislature, c.47 of the 1983 Resolves. (A copy of the Resolve is included in Appendix A.)

The Resolve established a Commission of 31 members, representing various groups such as legislators, providers of care to children with special needs, teachers, representatives of state agencies and the judicial and correctional systems, etc. (A list of the members is included at the beginning of this report.) Governor Brennan selected Commissioner Kevin W. Concannon of the Department of Mental Health and Mental Retardation as the Commission chair.

The Commission's purpose, as stated in the Resolve, is to "examine the current mechanisms for identifying and following children with special psychological, emotional and behavioral needs; to identify major gaps in the provision of services to these children; and to examine the current mechanisms used by the Department of Human Services, the Department of Corrections and the Department of Mental Health and Mental Retardation to plan for and provide services to these children...." Once the Commission has made these determinations, through meetings and consultations, it is to make a report of its findings and any accompanying legislation to the Legislature.

After an organizational meeting in August, 1983, the Commission members agreed to hold a series of public meetings throughout the state to gather information on the perceived needs of these children, through comments from members of the public, providers of services and parents. These meetings were held in Rockland, Portland, Lewiston, Bangor and Presque Isle between late September and late October. At the meetings, the Commission members heard eloquent testimony on various problems, including insufficient information on services available to children and their families, lack of coordination between state agencies, insufficient funding for existing programs, etc.

After the hearings, a list of the issues presented was drawn up and organized into various areas; the delineation of these areas formed the basis for the division of the Commission into three (3) Subcommittees on Prevention and Early Intervention, Specialized Services and Administrative and Legal Issues.

The full Commission held five (5) meetings through March, 1984, reviewing material presented to the Subcommittees and addressing additional issues, such as legislation introduced into the Second Regular Session of the 111th Legislature.

The Subcommittees have held 24 meetings since their organization last October. After internal discussions, the Subcommittees heard presentations from state agencies, private providers (both for-profit and not-for-profit) and others. The intent was to learn as much as possible about problems identified through the public hearings or discussed in the full Commission meetings and then to address various possible solutions. This process has been lengthy, as one solution often led to other problems with their attendant solutions; identifying and verifying respective state agency responsibilities has also been exacting.

The problems identified by the Subcommittees, and their recommendations for addressing them, are contained in the following sections of this Interim Report.

As a result of the process taking longer than expected, the Report will be sent to the First Regular Session of the 112th Legislature, not the Second Regular Session of the 111th as specified in the original legislation. The Resolve was also amended during 1984 (see Appendix A) to increase the appropriation so the Commission could hold hearings on its Interim Report and continue to meet to prepare the legislation and Final Report.

I. PROBLEM STATEMENTS AND RECOMMENDATIONS FOR PREVENTION AND EARLY INTERVENTION

PEI/A. <u>At the present time, no systematic and comprehensive process exists throughout Maine to identify children who are handicapped or at high risk at birth for developmental disabilities or delays</u>.

While public health nurses, hospital nursing staff, physicians, early childhood specialists, social service agencies and others recognize the high potential and high likelihood of problems for children born with biological or established handicaps, or into situations of environmental risk, the absence of a comprehensive system for diagnosis and treatment results in insufficient early preventive intervention services.

The Departments of Human Services, Educational and Cultural Services, Mental Health and Mental Retardation and private agencies are making a serious effort to provide and coordinate services to three to five year old handicapped children. Sixteen coordination projects provide services to children in most areas of the state. These coordination projects, together with private agency and State workers, are identifying and providing some services to a large percentage of the three to five year old children at "established" risk. There is now a need for improved and increased efforts not only for children at "established" risk but also for infants and children at "biological" and "environmental" risk. These terms are defined as follows:

<u>Biological risk</u> involves infants and children presenting a history of prenatal, perinatal and early developmental events suggestive of biological insult(s) to the developing central nervous system, such as prematurity, abnormalities of tone, delay in achieving gross or fine motor milestones, abnormal neurological exams, unusual behaviors, feeding difficulties, etc.

<u>Environmental risk</u> involves the potential for delayed development because of limiting early environmental experiences or family situations, such as parental age, parental stress, developmental disability of father or mother, paternal or maternal substance dependence, known history of parental child abuse or neglect, chronic unemployment, single or separated parent, etc.

<u>Established risk</u> conditions include, but are not limited to, the following kinds of disorders: Down's Syndrome, hydrocephaly, spina bifida, cerebral palsy, orthopedic problems, medical concerns expected to impinge on developmental progression, congenital abnormalities and hearing and vision impairments.

Greater focus is needed on children and families who are at risk for biological and environmental reasons with early identification and referral (prenatally if possible or at birth) of all infants and their families who fall into any of the three risk categories. Particular attention needs to be paid to those infants and families in the environmentally at-risk category who are in need of intensive intervention. The efforts of the Prevention and Early Intervention Subcommittee are aimed at these infants and families.

The needs of these multi-problem families are very great and the long-term costs to society are very high, as highlighted by Stanley Greenspan, M.D., a noted professional in the field of early intervention:

> Estimates vary regarding the use of health, social services, and welfare systems by these families. However, the significance of the challenge that they present is indicated by a study conducted some time ago, in which 6% of the study population was found to be using 45% of all public health resources and 55% of all social, psychiatric, and other auxiliary services. It has been estimated that this 6% use approximately 70% of all public expenditures for health, social, and auxiliary services (Report of the congressionally-authorized Joint Commission on the Mental Health of Children, 1965). Moreover, the problem may be much greater.[1]

There are approximately 16,000 births in Maine per year. Using the 6% incidence figure cited in the quotation above, we can assume there are between 950-1,000 infants and families who would require intensive intervention services.

The evidence that many of the 950-1,000 infants will grow up to need continued services is abundant. The needed services will be in the areas of health, special education, mental health, foster homes, residential placements, correctional facilities, unemployment and other economic payments (food stamps, Aid to Families with Dependent Children, etc.).

The following are approximate out-of-home placement costs; these costs are rising at about 10% a year:

- $5,000 for foster care;
- $10,000 - $12,000 for group home placement;
- $25,000 - $30,000 for residential treatment center placement;
- $30,000 - $40,000 for institutional placement.

Estimates are that the cost of early identification and intensive treatment would vary from $1,000 - $5,000 per year per infant/family depending on the severity of the risk factors.

There is increasing research evidence that prenatal and early postnatal identification of high-risk infants or infant-mother dyads can lead to positive treatment outcomes.[2] Identification of high-risk infants/families at the time of a child's birth or soon after would be beneficial for at least two reasons:

1. Treatment services would be starting in the early weeks or months of attachment between the infant and parent(s). Positive attachment will benefit the family. If the parent(s) is/are young, additional children are possible. The knowledge and skills gained by the parent(s) should have carryover to future children.

2. Identification and early services, utilizing existent staff for the most part, are less costly than later treatment services.

Preventive education on the dangers of alcohol consumption and cigarette smoking during pregnancy and the necessity for adequate nutrition is important, and can be accomplished at relatively low cost through public service campaigns and the coordinated efforts of various non-profit groups. Fetal alcohol syndrome, a condition caused by maternal alcohol consumption which can lead to various problems including mental retardation, is completely preventable.

The benefits, therefore, for identifying and serving these infants and their families can be seen from both a service quality and a fiscal perspective. The children will be guaranteed a better start in life while their parents are receiving needed child development, medical information and parenting support and guidance. Successfully serving both the infant and parent will be of enormous benefit to society by providing productive citizens who will be less likely to require additional costly services for special education, health, foster care, out of home placements or correctional services.

Recommendation PEI/A-1: The Department of Mental Health and Mental Retardation, the Department of Human Services and the Department of Educational and Cultural Services should jointly implement a statewide program of preventive intervention for high-risk or handicapped infants and their families. Such a program will be hospital and community-based, with regional family service teams established from among all human service providers to ensure the coordination of efforts at diagnosis, intervention, support and treatment.

The program model being recommended (for further elaboration, see Appendix B) has three components:

1. Case Finding including gross screening, assessment, evaluation and engagement;

2. Intervention; and

3. Training/Supervision/Consultation.

To develop the program on a statewide basis will take four years, with the first year devoted to a major planning effort and commitment by the three departments involved. The one-time cost of this planning (and related training) effort would be approximately $10,000, primarily for technical assistance, support staff and consultation/education activities.

In Year II, six projects (each serving the catchment area of a hospital or hospitals reporting approximately 600 live births annually) would be started, at a unit cost of $117,200. In Year III, ten additional projects would be started, and the six initial ones continued; in Year IV, twenty-six projects would be in operation at an annual, on-going cost of approximately $3,000,000.

The above figures are based on current Maine statistics of 16,000 live births annually. The cost of a single project that could provide service to an infant population of 600 live births (an estimated 12% of which are estimated to be at risk or handicapped) is as follows:

1 Assessment Coordinator @ $20,000 + 20% fringe	$ 24,000
1 Service Coordinator @ $20,000 + 20% fringe	$ 24,000
2 New Intervention Team members @ $18,000 + 20% fringe	$ 43,200
Travel Expenses	$ 8,000
Clinical supervision, consultation and training	$ 8,000
Administration/Contingencies	$ 10,000
TOTAL	$117,200

PEI/B. Maine schools provide limited, if any, education to children in a number of critical areas of their day-to-day life.

Some of these areas are mental health issues, substance abuse, family living, decision-making and parenting, all of which we include in the term "health".

There is at present no unified curriculum available to school systems. Useful and effective models for the development of such a curriculum exist in the areas of dental health, physical fitness, nutrition, drug and alcohol abuse and family life. The Subcommittee looked at a mental health curriculum unit used in Aroostook County, developed by Aroostook Mental Health Center. Members also reviewed curriculum segments used at various grade levels in several areas of the state.

The Department of Educational and Cultural Services has surveyed all schools for information on general curriculum and is still processing the results. However, preliminary information corroborates the view that public schools provide limited instruction in the above areas. There is a Nurse Consultant within the Department who works with the Bureau of Health, and the Department will soon have two Health Educators who will continue to work with the School Health Education Project (SHEP) to develop model curricula and make them available to schools.

The Subcommittee recognizes the difficulties in developing the content and materials for a mental health related curriculum. Among them are a strong commitment to local control rather than state mandates, a feeling of some parents that these topics should not be taught by schools, a reluctance of regular classroom teachers to add this area to their teaching responsibilities, and a lack of commitment of resources to provide appropriate teacher training and/or other personnel to implement such a health curriculum. The societal problems of teenage pregnancy and parenthood, teenage (and younger) suicide, children living with alcoholic parents and physically and mentally abused children require that we address these difficulties.

As a result of the deliberations of the Governor's Commission on the Status of Education in Maine, the Department is also preparing recommendations for changes in the school approval process, by which the current requirements for a health component would be expanded to include such topics as family life education, mental health and substance abuse. In addition, the Department is considering recommending that as a requirement for initial certification, teachers have course work in child development and mental health, so they may be able to assist in the intervention process.

Recommendation PEI/B-1: The Department of Educational and Cultural Services should be encouraged to continue with its development of materials for a school health curriculum.

In addition, the issue should be brought to the attention of the Governor's Commission on the Status of Education, including the Subcommittee's concerns as to who should teach the material in the curriculum, the teachers' use of available outside resources, the need for continuing education programs to familiarize teachers with these issues, etc. (This recommendation was made to the Education Commission, who included it in their Report of June 1, 1984.)

II. PROBLEM STATEMENTS AND RECOMMENDATIONS FOR ADMINISTRATIVE AND LEGAL ISSUES

AL/A. Many children in need do not have access to a case management system.

The following four vignettes describe the representative cases presented to the Administrative/Legal Subcommittee that typify youth who "fall through the cracks" of a fragmented service delivery system. They are multiple-problem children with multiple agency involvement or children whose presenting problem does not fit within the responsibilities of any existing case management system.

Sam is 14 years old and has had a history of aggressive, uncooperative behavior since entering school and has been in a number of special educational settings and placements. An ongoing specialized treatment program for Sam was interrupted and Sam returned to his family. He continually has been a behavior problem for his parents, school and community. He has recently been adjudicated for motorcycle theft. His psychological evaluator indicates that a correctionally oriented program would be not be in Sam's best interests and recommends a treatment program. Because of Sam's involvement with the criminal justice sytem, and the judge's order for the various state agencies to assist in identifying and placing Sam in an appropriate treatment setting, there is confusion about who (which state agency or the school) should assume lead responsibility for planning for Sam. With no program identified at present, Sam is currently (but temporarily) committed to the Maine Youth Center.

Tammy is 16 years old and her home situation is in such conflict that she has asked her guidance counselor to find her a place to stay outside of the home. Although the family is an open protective case with Department of Human Services, there is little evidence of abuse or neglect that would justify petitioning the court for custody. When in school, Tammy is an above-average student; this semester, however, she has been truant all but 15 days. It is suspected that she may now turn to prostitution to earn enough money to get an apartment.

Tommy is 14 years old and a patient at the Augusta Mental Health Institute's Adolescent Unit. He is not mentally ill, but is marginally retarded and responds to stress by acting out and assaulting others. He has now had five institutional-type placements in 5 years, primarily for lack of more appropriate environments. A major problem in dealing with Tommy's case is fixing legal responsibility for case management for Tommy. While Tommy has significant needs for specialized services, he does not fit into any of the existing case management systems.

Sue, age 16, was referred to Augusta Mental Health Institute on an Emergency Involuntary basis because of a violent outburst at school in which she threatened a fellow student and actually struck that student. There had been a prior history of mental health treatment, but poor follow-through. When she was evaluated at Augusta Mental Health Institute, it was felt that although there had been some dangerous behavior, she did not meet the criteria for an Emergency Involuntary admission because she did not meet the criteria for mental illness. Her parents had accompanied her to Augusta Mental Health Institute and Voluntary admission had been recommended to both Sue and her parents. Her parents were unsuccessful in convincing her to stay in the hospital for treatment. They appeared very frustrated that they could not keep her at Augusta Mental Health Institute for treatment although they wanted treatment. The family did say that they planned to follow through on out-patient treatment in their community. Due to the poor compliance in the past, it was questionable as to whether or not the family would seek the treatment that appeared necessary. This family had no contact with the Department of Human Services, nor had the child's behavior warranted her involvement in the criminal justice system. A case manager could have assisted the family in assuring follow-through on a course of treatment for Sue.

Case management is a method of assuring that individuals receive appropriate service by coordinating and assigning responsibility for assessment, case plan development, identification of and access to resources and establishment of a process for monitoring progress and reassessing case plans. To implement a case management system, a skilled advocate is assigned to each case that exceeds a certain threshold. The threshold is defined by statute or administrative action incorporating any number of criteria. Appendix C outlines the criteria and other descriptive information for case management systems currently in place in Maine, e.g., the Bureau of Mental Retardation, the Department of Human Services, the Juvenile Services Unit within the Department of Corrections. Most of the time, case management works sufficiently well for youth under the jurisdiction of these agencies. The situations where case management works less well, or not at all, generally fall into two categories:

1. The child is identified as a client of several agencies whose case management responsibilities overlap, creating interagency confusion over roles and responsibilities.

Tommy's case demonstrates this problem (reference Tommy's vignette). Tommy's need for service intervention is not in question; however, the responsibility to manage Tommy's case is not clearly defined. In addition, since Tommy's needs are specialized there will be a significant funding responsibility attached to the provision of service. Five major state agencies have been involved to some extent with Tommy's case for several months. Tommy has received transitional interim services although a long range plan for services has not as yet been developed and the responsibility to develop that plan has not been assigned. Admittedly Tommy's needs are specialized and cannot be met easily by the existing service system. However an assigned case manager could ease the "turf issues" and allow the professional time to be devoted to creative development of an appropriate service for Tommy.

Sam's case demonstrates a slightly different aspect of the same problem. A case manager for Sam might have been able to maintain continuity of treatment services for him when his treatment program closed, possibly preventing further deterioration of Sam's behavior. The case manager also could have provided linkages as Sam moved between the systems, ensuring some continuity of services.

2. The child is <u>not</u> identified as a client of one of the agencies offering case management, although he/she may be known to many of them. These clients fall into three categories as follows:

<u>Former Status Offenders:</u> The recommendations of Maine's Commission to Revise the Statutes Relating to Juveniles (March 1977) intended to implement the basic philosophy that " children who do not commit criminal offenses but who are 'incorrigible,' truant from school or run away from home should not be referred to juvenile courts but rather should be served by the social and educational agencies better equipped to deal with their behavior than are courts of law." The current social service systems, however, have not formally incorporated the responsibility for serving this population within their current case management systems. Tammy's case is a good example of this type of case. Assistance in obtaining an acceptable living situation, part-time employment and continued education might make the difference for Tammy. While acknowledging that these youth present problems to the system, their behaviors are extraordinarily difficult to define and study. More often than not, they are but one symptom of a child with multiple problems. The Subcommittee on Administrative and Legal Issues is not in any way suggesting that these offenses be recriminalized,

thereby substituting incarceration/punishment for services. The Subcommittee, however, identifies this group of youth as needing case management services.

Screened Out Protective Service Referrals: The Department of Human Services reported to the Administrative and Legal Issues Subcommittee that approximately 3600 referrals made to the Protective Services Unit are screened out because these cases do not meet the criteria for abuse and neglect under the current statutes. The type of cases screened out by the Protective Services Unit include (in order of priority):

1. Parent/child conflict which involves acting out and running away by the child but does not involve an allegation of abuse or neglect;

2. Marginal, non-specific allegations such as, "she's not a good mother" or "parents are mean to children";

3. Divorce or custody conflict;

4. Family crisis;

5. Insufficient information;

6. "Throw away" child living with relative;

7. Mental health problems;

8. Truancy and educational neglect where physical/mental/sexual abuse and neglect is not a factor and;

9. Spouse abuse.

While these cases do not qualify for intervention by the Department of Human Services Protective Services Unit, they do represent a source of referrals for multiple-problem, dysfunctional families in need of some level of service. Again, Tammy's case illustrates this target population. In addition, these referrals also may represent another type of child or family - one with a low-level set of problems affecting school behavior, behavior in the community, mental health and family stability. Services provided to these children and families may serve to prevent a situation from deteriorating into a major problem.

Children with Mental Health Problems:

Sue represents a specific client population of emotionally disturbed clients under the age of 18 who require intervention by mental health and allied agencies. These children may be conduct disordered, manifesting long term behavior problems which may include impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicide gestures and substance abuse. These children may also be suffering serious discomfort from anxiety, depression, irrational fears and concerns.

The current mental health service system is the least centralized system serving children. This forces families to deal with multiple professionals in a search for resources from many different state agencies. A case manager could assist these families and children by developing case plans and agreements to coordinate educational, residential and therapeutic services.

A coordinated case management system that would assist even some of these youth and their families is an essential first step in seeing that all children with special needs acquire services to address their needs. The Subcommittee on Administrative and Legal Issues strongly supports the development of such a system, using the Family Service Program as the case management model for a pilot project in case management. The Family Service Program model has recently been implemented by the Department of Human Services to serve AFDC families whose head of household is under age 20. The purpose of the program is to strengthen families by identifying high risk families and assisting them in obtaining needed social and health services. While the program is designed to serve all high risk families, resources will initially be targeted on a pilot basis to serve the children and their families identified above.

The program is of a voluntary nature. Families are asked if they wish to discuss their problems and needs with a Family Service Caseworker. If they wish to participate, a case plan is developed tailored to the client's individual needs and goals. Services are provided by the worker, the Departments and existing community agencies. Services provided include continuation of education, acquisition of job skills, improved health, acquisition of life management skills and coordination of existing services. Whenever a case qualifies for case management services, one individual has the authority and responsibility to bring about cooperative action among service providers from different disciplines, departments and agencies, including client and family where appropriate, and to acquire additional services to assist the child who is in need of help. Some situations will require short term intervention and others demand long term solutions.

Recommendation AL/A-1: Funding should be sought as soon as possible to set up pilot projects in case management. The pilot projects should be patterned after various models including but not limited to a school based model and the Department of Human Services Family Services Model described in the text.

Recommendation AL/A-2: The pilot case management project should be a joint effort among the Departments of Human Services, Educational and Cultural Services, Mental Health and Mental Retardation and Corrections. Department of Human Services should be identified as the lead agency.

Recommendation AL/A-3: In addition, the four departments should also explore the idea of a centralized referral/ombudsman sytem which will coordinate existing case management systems and serve as a clearinghouse for those children for whom coordination of services is problematic.

AL/B. All children have the right to equal access to services.

A large number of students require placement outside of their home in therapeutic foster homes, therapeutic group homes, residential treatment centers or temporarily in emergency shelters. For example, circumstances involving the community or the family may make it impossible for the student to reside at home, despite the fact that he has been doing well in school.

Chris, age 14, has asked his school guidance counselor to find a place for him to live out of the home because of constant conflict. The conflict, however, does not constitute an abusive or neglectful situation. Therefore, Chris is not eligible for services from the Department of Human Services. Chris has been truant from school but returned upon the urging of his guidance counselor. He is again truant and states that he is looking for a place to live. Chris will miss most of his second semester of school and will not return. His parents most likely will sign him out of school.

Mark, age 15, started doing noticeably poorly in school and acting out in the community, resulting in an arrest. It was discovered that his family was going through a temporary crisis because of unemployment, resulting in family financial problems and unrest. The school provided an alternate program for Mark and linked the family with a home-based services program. Mark's school performance has improved as well as his behavior in the community. As a result, Mark was given probation as opposed to being committed to the Maine Youth Center.

Martha is a 13 year old girl who has been in a special education program at her school for the past two years. Martha has progressed well educationally according to her evaluations; however, she is not getting along with her family and has become a behavior problem in the community after school hours. Her family, while aware of the problem, has been unable to obtain outside supportive services for their daughter. The family has broken several appointments with the mental health center with no explanation. The school district cites Martha's progress in her school program as proof that her educational needs are being met. She does not qualify for services from either the Department of Corrections or Department of Human Services.

Access to services for children and youth depend upon the child's classification, status and ability to fit within defined program criteria. A broad outline of the criteria for each of the State Departments is defined below:

The Special Education Process serves a specific population of children in need of special education and related services who are visually impaired, hearing impaired, learning disabled, physically impaired, acute health impaired, mentally retarded (maturationally delayed), multiply handicapped, behaviorally/emotionally disturbed and/or suffering from a temporary traumatic illness or injury. Students are referred for services through the Pupil Evaluation Team (PET) process.

The Pupil Evaluation Team is composed of parents, a school administrator, regular and special educators and other apppropriate individuals (evaluator, other agency profesionals involved with the child, etc.), and is responsible for determining the special education needs of students. The major responsibilities of the Pupil Evaluation Team are to determine whether or not referred students actually need special education and/or supportive assistance, develop an appropriate Individual Education Program (IEP) for each student whose exceptionality has been identified and recommend this program to the district superintendent for approval.

Children in the care and/or custody of the Department of Human Services. Major priority groups served under the Child Welfare Program are children in the care or custody of the Department of Human Services and children who are or may become abused, neglected and/or exploited and their families. A wide range of services is available to this client population, such as substitute care, advocacy, therapeutic services, etc. Additionally, services are provided through the Aid to Families with Dependent Children Program which provides financial assistance to needy families deprived of parental support. The goal of the Office of Maternal and Child Health is to assure that all mothers in Maine receive access to quality maternal and child health services.

The Department of Mental Health and Mental Retardation provides services to children through three distinct channels. The mental health institutions have the direct responsibility to provide inpatient services to adolescents who are mentally ill per legal criteria and dangerous to self or others. In addition to this mandated population, the Augusta Mental Health Institute's Adolescent Unit is able to treat disturbed adolescents who do not meet the criteria for commitment, provided they are admitted on a voluntary basis and there is a plan for discharge that includes establishing parental authority and a place for the youngster to live. The Bureau of Mental Health administers funding to eight community mental health centers (CMHC's) to provide emergency, outpatient, inpatient, consultation-and-education and community support services to clients, including children. Five of the CMHCs identify specific children's services units. The Office of Children's Services within the Department is responsible for assisting in the planning, coordination and development of mental health services for children, ages 0-20 years. The Office also works closely with the Bureau of Mental Retardation in order to ensure that services are provided in the least restrictive setting appropriate to the child's needs. The Bureau of Mental Retardation provides services for birth to five year old children who are developmentally delayed and case management and other support services for 5 to 20 year old children who are mentally retarded. Emphasis is placed on maintaining each child in his natural home or in a substitute care placement within the community whenever possible.

The Department of Corrections is responsible for the administration of three programs serving youth who are either adjudicated or who have been diverted from adjudication through the juvenile intake process. The Department purchases out of home living services for youthful offenders as an alternative to or diversion from institutionalization. Secondly, the Juvenile Services Unit within the Department of Corrections is responsible for Juvenile Intake which determines which cases referred by law enforcement agencies for formal adjudication proceedings are appropriate for informal adjustment rather than involvement in the court system. Also, the Unit is legislated to provide a continuum of pre- and post-adjudication services including diversion, probation, supervision, institutional support services, aftercare and parole services. Thirdly, the Department of Corrections, through the Maine Youth Center, provides secure detention for juvenile offenders in Maine committed by the courts.

There are a group of children whose problems do not fit within the responsibilities of the state agencies described. Generally speaking, these children with special needs are still in the custody of their parents, have not committed an offense, do not respond well to the clinical approach of the community mental health center, and do not require institutionalization. These children also generally require a combination of intervention services.

The Department of Mental Health and Mental Retardation provides the funding for services most easily accessed by this population; however, availability is limited by funding levels and community intake. Many times these children require additional residential services provided only on a very limited basis through this Department. The problems experienced by these children and their families could be alleviated through a more coordinated service delivery system coupled with an expanded case management system and provision of additional resources (see discussion of case management, Problem Statement AL/A).

Educational issues are inextricably linked to most issues relating to children's services since a child spends a major part of his day in an educational setting. There are special issues relating to the funding of services and educational programming.

Residential Treatment: Under the current statutes, a local school district is responsible for the full cost (Board/Care, Treatment and Special Education Tuition) for any student not in the care/custody of the Department of Human Services placed in a residential treatment center program through the Pupil Evaluation Team process (State subsidy occurs two years after the fact). Through administrative agreement, subject to existing funding, the Department of Mental Health and Mental Retardation pays the treatment costs for a child not in the custody of the Department of Human Services in the four in-state residential treatment centers. However, for children in the custody of the Department of Human Services, that Department pays the board/care and treatment costs and the Department of Education pays for tuition. The following matrix depicts these funding responsibilities.

	Board/Care	Treatment	Special Education Tuition
Children in Custody of DHS	DHS	DHS	DECS
Children in Custody of Parents	School District	DMHMR (in state facilities)	School District

Concern has been expressed that the entire cost of a residential treatment center (RTC) placement is paid for by the State for a child in the care/custody of Department of Human Services leading to more accessible treatment for these children than for children remaining in the custody of their own parents. In some instances there may be pressure on the family to give up custody of the child in order to obtain funding for the services.

From an educational perspective, however, local school districts are willing to pay the residential treatment costs for students requiring such services for educational reasons, but the district may be very reluctant to pay these costs if it has an appropriate special education program for the student who needs out of home placement for other reasons. School districts do not feel that it is their responsibility to pay for non-educational placements even though pressured to do so by State agency representatives or others concerned about the mental health or residential needs of the child.

Community-Based Services: In general, in order to access other residential services such as group homes, therapeutic group homes and therapeutic foster homes, the child must be a client of either the Department of Human Services or Department of Corrections. Special arrangements are made only under extenuating circumstances to provide substitute care arrangements for other children in need of such services for non-educational reasons.

The case of Mark illustrates that the intervention of an alternative school program and home-based services helped Mark to a great extent. But a majority of public schools do not operate alternative school programs and only five home-based services programs exist throughout the state. (See AL/C for further elaboration of home-based services.) Clearly, access to this service is limited by the availability of these services state wide.

Historically, less emphasis has been placed on preventing family break-up than on providing alternative placements for children in dysfunctional families. Students who are in a caring, loving family but nevertheless are having emotional difficulties or students with mildly dysfunctional families where the child is not in jeopardy do not have the same access to needed services as those young people who have come into state custody because of more serious individual or family behavior.

A final problem impeding equal access to services is created by the present special education reimbursement process. Availability of good special education programming sometimes becomes a consideration in the recruiting and/or development of foster homes, group homes and other residential placements. Many facilities have been established in communities for some time. In these instances, the constant flow of different children with different special needs who require varying levels of special educational programming may create further problems for the school. Any influx of out-of-district students to take advantage of a specialized program can create a burden on a school district. Special education programming can be expensive. State subsidy may not be at a level commensurate with the expense. The result is a disincentive to school districts for development of quality special education programs.

Recommendation AL/B-1: The Commission supports efforts such as those outlined in the 1984 legislative proposal L.D. 2061, AN ACT TO Define Eligibility for School Purposes and to Determine Financial Responsibility for the Education of State Agency Clients which attempted to:

1. authorize the Department of Educational and Cultural Services to pay for all special education costs for children in out of home placements whether or not those children are actually in state custody;

2. expand, define and place state agency responsibility for those children in need of non-educational services (residential and therapeutic) who are not in the custody of the Department of Human Services. The mechanism to implement this sub-recommendation is described in the following recommendation.

Recommendation AL/B-2: The Commission recommends that the Interdepartmental Committee, either through an existing or a specially appointed subcommittee, develop comprehensive recommendations for legislative and administrative action to address the problems defined herein.

An interdepartmental agreement should be developed to outline:

1. funding responsibilities for out-of-home placements in such a way as to improve equal access to services; and

2. individual protocol and programmatic responsibilities in the referral, placement and follow-up process of such placements.

AL/C. Limitations of Medicaid reimbursement affect the availability of some needed services.

The Medicaid Program provides all lower income families who are receiving state assistance full access to services which they might not otherwise be able to afford. Covered medical services under Medicaid include health care and a broad range of related services for children with special needs. Each provider of services is reimbursed at a rate which is intended to be consistent with the prevailing rate for services of that type which are provided by a person of that educational background. The Medicaid Program is funded by a combination of the State and Federal government, with the State currently providing approximately thirty-five cents out of each Medicaid dollar spent, and the Federal government paying sixty-five cents of that dollar.

The vast majority of Medicaid dollars spent in this state go directly to hospitals, nursing homes, physicians and similar traditional medical treatment providers. In the past little attention has been given to studying the expansion of Medicaid reimbursement in the area of mental health and related services to children and troubled youth. After a preliminary examination of the matter, the Commission has determined that a number of areas should be studied in greater depth, with an eye towards expansion of Medicaid reimbursement.

While Maine's Medical Assistance Program currently pays for a range of mental health services provided by community mental health clinics and private psychiatrists and psychologists, there is no question that State General Fund and other State-controlled dollars continue to be the major source of funds for community mental health services. For example, in FY 83, net Medicaid revenues ($944,000) represented only 6% of the total revenues ($124,981,000) of the agencies funded by the Bureau of Mental Health, while State funds, represented 54% of total program revenues. Other funds represented Federal, local, public and other fee-for-service revenues. Also, community mental health services, which may provide 'optional' services under current Federal guidelines, represent only $2 million in the Medicaid Program.

The result is that while there has been a substantial increase in the demand for mental health services to children due to the increase in the reported incidence of child abuse and other factors, available revenues to pay for these services have been unable to keep pace with this demand. The result is that in all but emergency cases there is a six week delay across the State in accessing needed mental health services for low income families receiving State assistance.

There is no question that more creative use of the Medicaid Program could increase the availability and range of mental health services to children with special needs. For example, the State's seed share of every Medicaid dollar is about thirty-five cents. Greater use of existing State General Fund dollars ($5,500,000) for mental health as Medicaid seed would result in a dramatic increase in the availability of needed mental health services.

Services Provided in a School Setting:

Reimbursable services are normally limited to those rendered at the provider's office. However, in many instances mental health or other services can be rendered most effectively to an individual client in that client's own home. In some cases that may even be the only setting in which a client might be willing to receive help. In many other instances a school, neighborhood center, or similar setting offers the best opportunity to connect a service provider with a client in need of services. For example, schools are often the place where certain children's mental health problems are first diagnosed, and are a logical place to render treatment for those problems. Schools are required to provide special education to all exceptional children between the ages of 5 and 20 years old requiring special services in the area of visual impairment, hearing impairment, learning disability, physical impairment, behavioral/ emotional disturbance, mental retardation (maturationally delayed), multiple handicaps, and/or chronic/acute health impairment. However, Medicaid generally does not reimburse for services provided at a school site.

Medicaid reimbursement site restrictions act as a barrier that prevent more children from receiving needed speech and language therapy, occupational therapy, physical therapy, psychological services or other similar treatment. These site restrictions are artificial impediments to the rendering of effective services to troubled children and family members and should be removed. Substituting some of the state dollars currently being spent by school districts with Federal Medicaid funds could provide an expanded capability to provide needed services. Many more children could be served for the same expenditure of funds.

Home-based Services:

Home-based care programs in Maine and elsewhere have successfully kept children out of residential care, and offer a constructive alternative mode of treatment to many children and families in need of services. Several projects currently funded in Maine prove clearly that dedicated management, strong community support and specially trained staff members can provide more effective services to troubled youths in home settings than is possible in any other manner. This has proven to be particularly true in the case of substance abusing families, families which normally function adequately but are temporarily in crisis and multi-problem families who are chronically in crisis.

In its first year, the Bath-Brunswick Homebuilders Program reported that 83% of families they served remained intact. Day One Homebuilders Project in Portland has had similar success rates with substance abusing families, as has Community Counseling Center working with children in foster homes and in marginally abusive families. National statistics for similar projects show that as high as 93% of families can be helped to remain intact. Along with being more desirable socially, this result is also far less expensive than alternative, out-of-home placements.

This success of keeping families "intact" is of particular importance regarding the cost-effective care of this population. In the evaluation of the Day One population, 80% of these clients were in jeopardy of being removed to a more restrictive setting. Approximately half of these clients would have been detained in the juvenile justice system (Maine Youth Center) and the other half in the child protective/foster home system. The cost of these restrictive alternatives is approximately $20,000 per year per child. The cost of the homebuilders intervention is on the average between $3,000 - $4,000 per family.

At the present time, Medicaid does not provide adequate reimbursement to mental health services provided in homes. Even where special reimbursement is made available, no mechanism exists to reimburse for travel time by agency personnel. While one may wish to retain some incentive for clients to go to mental health providers' offices whenever possible, the current severe disincentives to home-based care need to be altered.

From the standpoint of the effectiveness of therapeutic family/child interventions, particularly at the early stages of child/family development, home-based provision of services appears more therapeutically beneficial than does the more traditional office/clinic-based settings.

In dysfunctional families, the combination of intensive home-based services with ongoing, outpatient services through the mental health center appears the most effective, long-lasting approach. If the entire home-based therapy model cannot be Medicaid reimbursable, then components of that model may be reimburseable with minimum changes such as the activities/staff resources in order to conduct initial diagnosis, clinical case review, medication monitoring, ongoing clinical assessments, etc.

Alcoholism Services:

Maine law requires private insurance companies to cover the costs of alcoholism services which are provided both in residential and outpatient settings whether in a free-standing or hospital-based program. However, Medicaid does not presently reimburse for those residential and outpatient services which are provided in free-standing, non-hospital-based rehabilitation settings. Many residential and outpatient programs that are not available in a hospital setting are preferable for many individuals. Increased access to treatment services in a non-hospital rehabilitation setting may also help people avoid the need for later hospitalization at a higher cost to the State. It would appear that expanding Medicaid coverage to include residential and outpatient services in non-hospital-based rehabilitation centers removes a barrier which sometimes prevents troubled young people from acquiring needed services.

The Subcommittee supported L.D. 2207, An Act to Provide Medicaid Reimbursement for Substance Abuse Services, which was enacted as PL 1983, c.752. (See Appendix D.) As of January 1, 1985, this law requires the Department of Human Services to provide reimbursement for treatment for alcoholism and drug dependency. The Subcommittee supports the Department seeking a waiver from the Federal government for Medicaid reimbursement for outpatient and residential, non-hospital-based treatments.

The Department of Human Services has indicated to the Subcommittee that Federal statutory authority will allow for the expansion of Medicaid reimbursement in the three ways which have been outlined. The Department of Human Services has also expressed a willingness to pursue these changes, in conjunction with the other appropriate departments. We believe that the time is at hand for the development of proposals which could be presented for approval to the Federal government when necessary and which would accomplish the goals we have set forth here.

Per Hour Reimbursement Rate:

An additional concern brought to the attention of the Subcommittee on Administrative and Legal Issues is the per-hour reimbursement rate for Medicaid-eligible services. Community Mental Health Centers are funded principally by direct grants through the Bureau of Mental Health budget. Most CMHC's supplement those funds with United Way and other grants which they can acquire in their own communities. Private insurance dollars contribute toward the CMHC's management as well, as do the fees which each center charges on a sliding scale to its clients. The Medicaid program also reimburses for some services rendered. The Subcommittee received testimony that the Medicaid rate does not accurately reflect the actual cost of rendering the service; therefore, state dollars and other funding sources must make up the difference. The Subcommittee believes that effective administrative management of State dollars requires that an effort be made to raise the level of Medicaid reimbursement rates, to maximize the usage of State dollars dedicated to mental health services. This would free up money for additional units of service, which could then be given to serve the population with whom the Commission is concerned.

Reimbursable Providers

In the mid-1960's, Congress authorized Federal funding for the development and maintenance of a system of regional Comprehensive Mental Health Centers. Over the past several years, the Federal direct grant program has been gradually reduced, until it was terminated entirely in 1983. However, the distinction between Comprehensive Mental Health Centers and other types of mental health facilities has been maintained by the Department of Mental Health and Mental Retardation, by maintaining two separate categories of licensure.

During this same time period, the Medicaid program was established within the State of Maine Department of Human Services, and reimbursement was made available in the state for certain mental health services. It was decided that Medicaid reimbursement would extend only to those services provided by general hospitals, certain private mental health practioners and Comprehensive Mental Health Centers (but not other mental health facilities). That policy has remained the same so that there are some mental health facilities with a general mental health facility license which are not eligible for Medicaid reimbursement but which provide valuable mental health services to the community.

The Bureau of Mental Health is currently considering changing its licensing structure to make it reflect more accurately the demands and diversity of the mental health services system. Licensing is closely interrelated to Medicaid reimbursement policies, so that such a review should be done (at least in part) on an interdepartmental basis.

Recommendation AL/C-1: The Medicaid Review Committee currently in existence on an interdepartmental basis, or such other group as might be developed through interdepartmental cooperation, with the Department of Human Services serving as lead agency, should:

1. develop a proposal for Medicaid reimbursement allowing all service providers to render Medicaid-eligible services in the most appropriate setting, rather than only in their own facilities. Caution should be exercised to ensure that non-hospital based services such as speech and language therapy, occupational therapy, physical therapy and psychological services which are provided in clients' homes or in school settings are made reimbursable;

2. develop a proposal for Medicaid reimbursement allowing home-based care and counseling efforts to be reimbursed. The definition of eligible services under this approach should be made broad enough to include the many activities that home-based counseling workers engage in with clients in their homes. In addition, such a proposal could provide for the reimbursement of home-based services at a higher rate, to allow reimbursement for travel time. Financial disincentives to rendering home-based services should be reduced;

3. develop a comprehensive reimbursement proposal covering alcoholism services provided in free-standing, non- hospital-based rehabilitation settings;

4. provide for increased reimbursement rates of Medicaid services rendered by Community Mental Health Centers and other mental health providers;

5. Research the issue of Medicaid reimbursement for mental health services provided by all Certified Social Workers (CSWs).

Recommendation AL/C-2: The Bureau of Mental Health should conduct its planned review of mental health facility licensing requirements and reevaluate whether different licenses should be granted to Comprehensive Mental Health Centers and other mental health facilities. In conducting that review, the Bureau of Mental Health should work closely with the Bureau of Medical Services to integrate the licensing and funding mechanisms for mental health services within the state and explore various methods of increasing Federal financial support for mental health programs to children, such as providing Medicaid reimbursement to a greater number of categories of mental health providers.

AL/D. Consistent notification is a problem in the appeal process for fee setting in Community Mental Health Centers.

All community mental health centers have sliding-scale fee structures under which services are made available to every client for a fee that each should be able to afford. However, there is no ideal way to set up or administer a fee schedule, and in each community mental health center the fee structure may create an unusual hardship for some individual clients because of peculiar situations which may not easily fit into the formula or schedule applied. For example, in order to encourage effective use of available time, many centers provide that a client who misses a scheduled appointment without prior notification will be assessed a special extra fee which must be paid before further services are rendered. As another example, some centers may not take into account money which a family sends to a grown child living elsewhere, because there is no obligation to support that other family unit. Nevertheless, the family seeking the services may feel unable to pay the fee provided and yet unwilling to cease helping support their grown child.

Because of the difficulties inherent in managing sliding-scale fee structures the hardships which can result in their application to individual case situations, all community mental health centers ask second person within the center to review the establishment of the fee. Typically, a person first speaks to a program director, then to the executive director of the agency, and in some cases, can then appeal directly to the Board of Directors or to the Bureau of Mental Health. All centers are required to post information regarding this process where clients can have access to it, but some centers are less aggressive in informing all clients about this process than others. In addition, the Commission has heard that most centers do not advertise that clients or prospective clients have the right to seek assistance in appealing fee determinations, despite the fact that these appeal procedures may seem frightening or overwhelming to a client who is going through emotional difficulties. Ineffective notification of the appeal mechanism regarding fees may be a barrier to service in some cases, and further that ineffective notification of the availability of assistance in appealing fee determinations may also tend to discourage individuals from getting needed mental health services. This seems especially true in the case of children and families of children in need of mental health services.

Recommendation AL/D-1: The Department of Mental Health and Mental Retardation should ensure that Community Mental Health Centers notify all clients of their appeal rights regarding fees in a standardized, easy to understand format.

Recommendation AL/D-2: The Department of Mental Health and Mental Retardation should require Community Mental Health Centers to take additional steps (written and oral) to inform clients of external sources of assistance in questioning adverse decisions regarding fees.

AL/E. Problems exist with a loophole in reporting child abuse to the Department of Human Services.

Current law provides that anyone who is included on a broad list of child care and health professionals is mandated to make a report to the Department of Human Services whenever he "knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected," pursuant to Title 22, Section 4011, subsection 1. However, paragraph C of that law goes on to say:

> A person shall not be required to report when the factual basis for knowing or suspecting abuse or neglect comes from treatment of a person responsible for the child, the treatment was sought by that person for a problem of abuse or neglect and there is little threat of serious harm to the child.

This exception, commonly known as the "treatment loophole" but perhaps more accurately described as a "reporting loophole," was placed in the law when the mandatory reporting law was first enacted by the Legislature. Several therapists argued that the mandatory reporting law would substantially interfere with their efforts to establish a good therapeutic relationship with their clients, because it would tend to inhibit full disclosure of all aspects of a patient's personal life situation.

This loophole in the reporting law is relied on inappropriately by some therapists. Many do not understand its limitations, or choose to ignore the severe restrictions on its applicability. A child who has been victimized by past physical or sexual abuse but is not in apparent danger of repeated physical or sexual assault, may nevertheless be badly in need of treatment for the emotional trauma caused by what was done to him or her in the past. Because no report to the Department of Human Services is made, and because the therapist sees it as his duty to treat only the perpetrator who has come to him, a child who has been emotionally scarred by past trauma is left without needed treatment. In short, rather than promoting better treatment of abuse and neglect by encouraging free communication between abusers and therapists, as it was designed to do, this provision in the law often prevents the flow of information to those who are in the best situation to help, thereby inhibiting the flow of resources which might either prevent abuse or neglect from continuing or repairing damage done by past abuse or neglect.

Moreover, if the Department of Human Services receives a report of abuse or neglect and opens a child protective case, and the parents are subsequently urged to seek treatment on account of that problem, all information shared with the therapist during treatment in that situation is not protected from disclosure to the Department of Human Services protective worker as well as the courts. The loophole in the reporting law promotes full disclosure only in cases where the abuse or neglect situation is totally unknown to the Department of Human Services. The philosophy underlying the establishment of the reporting loophole, to promote the development of a relationship conducive to effective therapy, has no application to the majority of abuse or neglect cases, i.e., those which have been reported to the Department of Human Services.

Recommendation AL/E-1: The Department of Human Services should undertake an extensive educational campaign among mental health professionals and other mandated reporters to educate them about the narrow applicability and many limitations on the reporting loophole.

Recommendation AL/E-2: The Department of Human Services should undertake a review of the laws regarding confidentiality, in light of the need to encourage full disclosure during treatment by perpetrators of all forms of abuse and neglect, to determine if changes in the laws are needed in order to promote effective case management of abuse or neglect cases on the one hand, and to encourage effective treatment of conditions leading to abuse and neglect on the other hand. The Department of Human Services review should include the input from a broad range of community providers.

Recommendation AL/E-3: The Department of Human Services should explore whether or not to modify the law.

Recommendation AL/E-4: The Department of Human Services should explore the separation of the treatment process from the policing function of protective workers.

III. PROBLEM STATEMENTS AND RECOMMENDATIONS FOR SPECIALIZED SERVICES

SS/A. All children do not have equal access to mental health services.

Over and over again, Subcommittee members have listened to the stories of Maine children (and their families) who need something more than is currently available to them.

Tommy is 14 years old and a patient at the Augusta Mental Health Institute's Adolescent Unit. He is not mentally ill, but is marginally retarded and responds to stress by acting out and assaulting others. He has now had five institutional-type placements in 5 years, primarily for lack of more appropriate environments. Indications are that Tommy could benefit from a therapeutic foster home but 1) such a home has not been identified, and 2) appropriate funding source(s) have not been available.

Bobby is also 14 years old and currently lives with his adoptive parents, although the placement, as well as possibly the adoption, are in jeopardy. Adopted at the age of 4, Bobby's placement appears to have proceeded uneventfully until the birth of the parents' natural child, when Bobby was 8 years old. His behavior beyond that point has deteriorated. In a recent incident, Bobby stole the family car and went on a joy ride; his younger brother was captive in the back seat. A therapeutic foster home also appears to be the treatment of choice for Bobby, but again, neither home nor funding source has been identified.

David, age 15, attends an alternative educational program. Recently he was picked up for public drunkenness, a violation of his probation on previous charges. His mother was recently admitted to the psychiatric unit of a local hospital. David, however, continues to live at home with questionable supervision and deteriorating behavior. He needs the structure of a residential treatment center program but can be educated within his school district. Placement has not been recommended because no appropriate funding source has been identified.

The Adolescent Unit at the Augusta Mental Health Institute was originally developed to improve the quality of care for mentally ill youth who were involuntarily committed to the institution. It continues to be the obligation of the Unit to accept and treat adolescents who are mentally ill (per legal criteria) and dangerous to self or others. Criteria for commitment are not, however, clearly spelled out in statute, but reflect the collective standards of the psychiatric community and the court system. The Bureau of Mental Health within the Department of Mental Health and Mental Retardation is currently researching the commitment statutes for juveniles in other states.

In addition to its mandated population, the Adolescent Unit is able to and will treat disturbed adolescents who do not meet the criteria for commitment, provided that there is a plan for discharge that includes establishing parental authority and a place for the youngster to live. This can be done on a voluntary basis, but it must be negotiated with the parents or legal guardians who must agree to the treatment program and sign off on the treatment plan, which always involves family therapy. The focus of the Unit's program for both committed and voluntary patients is a structural/strategic family approach. This stems from a belief that adolescents need to grow up in a family and that the majority of behavior problems can be best treated by helping the parents or parental authority figures gain or regain control over the youngster's behavior. It is also believed that the combination of a structured ward environment and intensive family therapy (which most likely will include out-patient treatment beyond the in-patient stay) should be tried first, before other treatment alternatives are considered.

Residential Treatment Centers provide board and care, mental health treatment and special education to emotionally handicapped children within the confines of a single facility. To be eligible for placement in a residential treatment center, a Pupil Evaluation Team of the child's local school district must recommend such a placement for educational reasons, i.e., the educational needs of the child cannot be met within the local school district. Additionally, a mental health professional from a Community Mental Health Center or consulting to a school district must certify that the child is emotionally disturbed and needs residential treatment. Four residential treatment centers currently exist in Maine:

Sweetser Children's Home in Saco;

Spurwink School in Portland;

Elan in Poland Spring;

Homestead Project in Ellsworth.

Therapeutic Group Homes offer a viable short term alternative for adolescents who may need temporary out of home placement but whose educational needs are being adequately addressed within the public school system. Currently there are 8 therapeutic group homes in Maine, with a total system capacity of 51 placement slots. Four of these facilities are coeducational, two serve males only, and two serve females only. Admissions criteria and target populations, however, differ from facility to facility. These programs (with few exceptions) report high occupancy rates and, frequently, waiting lists of several months or more. For youth in crisis and needing immediate placement, time is a critical factor. Too often placements must be made solely on the availability of a vacant bed. In addition, 82% of these placements are funded by the Department of Human Services and 7% by the Department of Corrections. Unless the child is identified by one of these two systems, each of which carries its own personal stigma, access to such a service is not possible.

Transitional/aftercare services are intended to facilitate the return of a youngster to a less restrictive community-based placement from a more restrictive residential placement, e.g., therapeutic group home, residential treatment center, Augusta Mental Health Institute. These latter programs provide time-limited therapeutic services based upon individual case plans and progress toward goals. Any gains made by adolescents completing such programs are difficult to maintain without transitional/aftercare services. Yet with few exceptions, facilities acknowledge that aftercare is the weakest part of their service delivery system. Sufficient resources simply do not exist.

Data obtained in a recent study of adolescents served by group homes, for example, indicated that one-third of the clients discharged from therapeutic group homes were discharged according to case plan, i.e., they had successfully completed the program offered by the facility. However, one-half of these youth again needed placement in a more restrictive setting within 6 months. No single model for transitional/aftercare services is being recommended. There are advantages of course, in utilizing local resources, such as the Community Mental Health Center, for provision of transitional/ aftercare services. This would necessitate additional funding and a closer working relationship between the Centers and group homes. The major disadvantage to relying solely on the Community Mental Health Centers is the fact that for children returning to rural areas of the state, the Community Mental Health Center is not always readily accessible. Other options for transitional/aftercare services include the following configurations:

1. Home-based care with families of youths discharged from residential care;

2. Therapeutic foster homes as placement options for adolescents needing alternative placements upon discharge from residential care;

3. Specific aftercare worker(s) assigned to specific residential facilities;

4. A network of family support groups specifically for families of youth discharged from residential care.

Regardless of the model(s) chosen, consideration should be given to maximum utilization of available community resources.

Therapeutic Foster Homes likewise offer a less restrictive placement alternative for some children/adolescents who require placement outside their homes. Formal programs currently exist in Bangor (through Community Health and Counselling Services) and in Portland (through Little Brothers Association). The former has a capacity of 9 children; the latter can serve up to 15 adolescents. A third program, Spurwink School in Portland, also provides therapeutic foster home placements, but only as part of its residential treatment center program. Geographic disparity of agencies providing this service, difficulties in recruitment of qualified families and limited availability of state funds all impede access to therapeutic foster home placements. However, it is precisely these problems that make expansion of therapeutic foster care an attractive alternative:

1. individual therapeutic foster homes can be located in a number of communities, increasing the likelihood of the child/adolescent being placed closer to his home community; and

2. the cost of providing such services may be considerably lower than other types of residential care.

The development of additional placement resources is expected to become a critical issue over the next 2 years. Resources are already straining to meet the current demand for services. Maine has elected to comply with the federal initiative to remove all juveniles from county jails as places of secure detention by January 1, 1985. As a result, existing group homes and emergency shelters will no doubt be expected to accommodate some of these juveniles. A coordinated system of emergency foster homes and therapeutic foster homes would allow some of the youngsters now served in residential facilities, i.e., group homes and emergency shelters, to be placed in less restrictive alternatives. This would, in effect, alleviate the pressure on group homes and emergency shelters permitting them to serve a more dysfunctional population. Such a move would also prevent the unnecessary placement of some adolescents in residential facilities.

In other situations, the service is simply not available, or available in very limited scope. The primary source of mental health treatment to families in Maine is the Community Mental Health Center. In a state

such as Maine, it is not at all unusual for a family to live miles away from its community mental health center, or for transportation to the center to be non-existent or for the family to be reluctant, or embarrassed, to walk into such a center. For many of these families, in-home treatment would be preferable. In fact, it may be the only means of engaging such families in therapy. Maine's current Medicaid regulations prohibit reimbursement of in-home services by community mental health centers. Other programs, specifically designed to deliver such services, are relatively new to Maine. Homebuilders-type programs, for example, based on a model developed in Tacoma, Washington, in 1974, use a team approach to working with families in crisis to prevent out of home placement of children. Five such programs currently exist in Maine; however, the demand for the service far outweighs the supply.

Finally, the Commission has heard repeated testimony indicating that treatment of specific children and efforts at program development have been impeded by a lack of understanding, cooperation and trust between mental health service providers and Department of Human Services personnel.

Recommendation SS/A-1: The Interdepartmental Committee should be assigned lead responsibility in an interagency effort to identify what is needed for a statewide network of out of home placements. A specific plan should be presented to the Specialized Services Subcommittee by August, 1984. The plan should include consideration of the following points:

1. Availability of funding to ensure accessibility to therapeutic foster home and therapeutic group home placements for all Maine youth who are in need of such services;

2. Development of one or two pilot projects for provision of transitional/aftercare services and funding identified for implementation;

3. Assurances that for every child placed in a residential facility, an aftercare component is developed and funds made available for implementation.

Recommendation SS/A-2: The Department of Mental Health and Mental Retardation should be assigned lead responsibility in an interagency effort to develop a plan to address the list of gaps in mental health services for children and families that was earlier prepared for the Commission. The plan should give particular consideration to the role that the Augusta Mental Health Institute should play in a network of mental health services. An action plan should be presented to the Specialized Services Subcommittee by August, 1984.

Recommendation SS/A-3: The Interdepartmental Committee should conduct a statewide assessment to identify problems in working relations between youth-serving agencies in each region. Recommendations should be developed for improving relationships that are identified as problematic.

Recommendation SS/A-4: Specific agreements/protocols should be developed to ensure aftercare, follow-up and transition from one service to another in a way that will continually address and monitor the problems identified herein. Each of the four youth-serving departments, both individually and collectively, should require documentation of working assurances that linkages to services exist for all children.

SS/B. Substantiated reports of sexual abuse in Maine increased by more than 100% in 1983.

Sexual abuse is an alarming problem nationwide, and in Maine as well.

> William, age 11, was sexually abused by his stepfather since age 8. Abuse consisted of mutual acts of fellatio, fondling and several incidences of sodomy by stepfather. Stepfather told William that "his father was gay and did this to him so it was okay." William and his mother are now in therapy. However, prognosis is poor as a result of severe emotional damage which may well result in the commission of violent sex crimes as William gets older.
>
> Barbara, age 12, started crying at a slumber party and disclosed to the other girls at the party that she had been sexually abused by both her mother's ex-husband and current boyfriend. At one point during the party, Barbara picked up a paring knife and said, "I feel like taking this knife and sticking it in me."
>
> Mary, age 10, and her sister, Annette, age 7, were sexually abused by a 17 year old unrelated boy in the neighborhood. Mother learned of the abuse when Mary had a nightmare and woke up screaming, "no, no, go away, don't touch me." It is suspected that the perpetrator also molested his one year old niece. At the current time, his whereabouts are unknown.

Many adults coming in for psychotherapy disclose for the first time their sexual abuse as a child or adolescent, and the emotional, personal and social problems exacerbated by such abuse.

The psychological problems of sexually-abused children are enormous. They experience guilt, shame and a fear of discovery. They often lose their sense of trust in adults and acquire a fear of intimate relationships as a result of their victimization. Male victims, prior to becoming adults, often become sexual offenders. It is not unusual for some female victims to resort to prostitution. In many instances, these victims become abusing parents to the next generation of children.

The criminal prosecution system often serves to victimize further children who have already been sexually abused, particularly those who have been victims of incest. The criminal investigation and indictment before a Grand Jury can take as long as 9-12 months. Since it is to their client's benefit to delay the court proceedings, defense attorneys attempt to, and are often successful at, postponing the actual trial for an additional 9-12 months. It would not be unusual, then, for the

victim to remain in limbo, so to speak, for up to 18 months following the initial report of sexual abuse. Effective treatment for the victim, however, is predicated upon immediate crisis intervention. During those 18 months, neither the perpetrator nor the family may engage in treatment since to do so could be construed as an admission of guilt, and anything disclosed in treatment can and would be held against him/her in court. While less common, further victimization may also occur in child protective proceedings. In general, the child is not required to testify at custody hearings, or is questioned in the privacy of the judge's chambers. However, in those instances where the child is called to the witness stand, he/she may be subjected to lengthy, emotionally-draining cross-examination.

In many ways, the system has changed significantly since the days of Malcolm Robbins' childhood. With increased numbers of caseworkers, better training of multi-disciplinary professionals, and improved responsiveness from many mental health professionals, the system has become more adept at identifying, treating and working cooperatively with law enforcement personnel in cases of sexual abuse. More cases result in prosecution than ever before, as the public and professionals come to realize the therapeutic value of sentencing. By this action, society's sanction against sexual abuse is recognized and serves to reinforce with the victim that it was the offender who was to blame.

A number of treatment programs that specifically focus on sexual abuse have been developed throughout the country. The Department of Human Services here in Maine has sponsored training of professionals who work with sexual abuse issues, e.g., Department of Human Services caseworkers, law enforcement personnel, including District Attorneys, and mental health professionals.

Training workshops in Maine have been held conjointly with the Maine Criminal Justice Academy and the Council of Community Mental Health Centers. Workshops have been held in local school districts for teachers, guidance counselors, school nurses, etc., and prevention programs aimed at letting children know what sexual abuse is and where to go for help have been sponsored jointly with Child Abuse and Neglect Councils and law enforcement personnel. Within the past 5 years, two sexual abuse treatment programs have been developed in Portland largely through funding by the Office of Children's Services within the Department of Mental Health and Mental Retardation, a sexual abuse treatment team is planned in conjunction with Aroostook Mental Health Center and treatment programs are pending development in Kennebec and York counties.

Some of the most difficult problems to overcome in the area of sexual abuse involve certain attitudes still held by many persons, e.g., sexual abuse only occurs in poor or uneducated families, or what happens in the privacy of a family's home is the family's business. Some professionals, likewise, are still reluctant to report offenders of sexual abuse. These people fail to recognize or acknowledge the devastating effect that sexual abuse has on children, that it is harmful, unacceptable and hurtful. The Subcommittee was particularlyconcerned to hear the account of an offender who received a suspended sentence after being found guilty of molesting a child for 9-10 years.

The advent of mandatory reporting laws, coupled with better training of professionals in the identification of sexual abuse, has served to highlight the lack of resources, specifically for initial crisis intervention, follow-up, long-term treatment and ability to prosecute. The number of reported cases is staggering. Department of Human Services staff are unable to utilize existing expertise in resource development because they are constantly responding to referrals. The capability of community mental health agencies to respond to sexual abuse cases varies from region to region. A lack of response, or a delayed response, as victims of sexual abuse compete with other populations for service, may result in the unnecessary break-up of some families because the Department of Human Services is left with no alternative but to remove the child from the home. At least as critical is the fact that some professionals still lack expertise in the ability to differentially diagnose a "fixated" from a "non-fixated" offender, the former type being the most uncontrollable offender with a poor prognosis for treatment, and apt to repeat the offense. This, coupled with the ambivalence of some professionals to encourage criminal prosecution and sentencing of sexual offenders, results in some dangerous individuals remaining in the community.

The capacity to provide initial crisis intervention services in all reported cases is really not available anywhere in Maine. Certain areas of the state are reasonably effective in their response; other areas are just beginning to develop expertise. What works in one part of the state is not necessarily appropriate in other areas. Whatever model is utilized within a region, however, should include:

1. the ability to provide an appropriate medical response;

2. a coordinated response by social services and law enforcement personnel;

3. services/resources, particularly those aimed at initial crisis intervention and follow-up.

While Maine has progressed dramatically in its ability to address sexual abuse issues, there is still a need for improvement.

Recommendation SS/B-1: An interagency group, chaired by a member of the Specialized Services Subcommittee, should be assigned lead responsibility for developing a statewide approach to address the problem of sexual abuse in Maine. Representatives of the Department of Human Services, a Community Mental Health Center, at least one District Attorney's office, at least one innovative school program, acute health care providers, and existing sexual abuse treatment programs should be recruited to participate in this effort. Staff support should be provided by the Department of Human Services.

The approach should delineate a plan for a network of sexual abuse treatment programs. Other areas to be addressed by the group should include: training, both for mental health professionals and for others not directly involved in treatment who work with victims of sexual abuse, identification of services that are currently available, services that should ideally be available and recommendations for needed steps/resources to bridge the gap between the two.

A plan addressing these areas should be presented to the Specialized Services Subcommittee no later than August, 1984.

Recommendation SS/B-2: The Commission shall develop legislation as needed to address the issues identified in the plan described in Recommendation SS/B-1. Such legislation shall be available for consideration by the 112th Legislature.

Recommendation SS/B-3: Specific services to deal with sexual abuse should be a priority for development in each community mental health center, and because of the nature of the problem and the need for immediate intervention, victims of sexual abuse should constitute priority recipients of services from Community Mental Health Centers.

SS/C. <u>There are no formally identified behavior stabilization/secure treatment services in Maine for the acting out, incorrigible adolescent</u>.

Behavior stabilization services are short-term intervention and evaluation services utilized to bring out-of-control, acting out behavior(s) (such as those described in the following case examples) under control so that a treatment plan can be implemented. In some instances, longer term secure treatment of an involuntary nature is warranted.

<u>Timmy</u> is 14 years old and resides at home with his parents. He has been receiving special education services since he entered school, including several years in a private day treatment program. The program closed; Timmy was returned to the school district. Since that time, his behavior, both in the community and at school, has deteriorated. He is awaiting sentencing following 4 counts of grand theft, property damage and assault on a police officer. He continues to reside in the community.

<u>Terry</u>, age 16, was committed to the custody of the Department of Human Services as a result of ongoing emotional and physical abuse and neglect since birth. There is also evidence that she was sexually abused. Her mother, an alcoholic, abandoned her at age 6. In and out of foster care since age 10, Terry was finally placed in a residential treatment center. She ran from the program, and when picked up by her caseworker, attempted to commit suicide by jumping out of the car. An involuntary commitment to the Augusta Mental Health Institute was changed to voluntary when a foster family was identified to participate in family therapy with her. After 4 months, Terry was discharged. Her behavior at home, in school and in the community is again out of control. Efforts are being made to locate a residential program that can keep her from doing harm to herself or others.

<u>Cindy</u> is 17 years old. When she was in school, she attended special education classes because of hyperactivity and behavior problems. At age 14 she ran away from home. Her behaviors have included prostitution, drug and alcohol abuse and constant running. She was placed in a residential treatment center at age 15, and was discharged at age 16 because they could not control her aggressive and self-abusive behavior. Attempts to place her in several treatment settings over the past year have been unsuccessful because of her inability or unwillingness to engage in treatment. A specialized foster home placement lasted about 2 weeks; Cindy's current whereabouts are unknown.

Every major report on the status of children's services in Maine over the past 7-10 years has articulated the need for behavior stabilization/secure treatment services.

Adolescents requiring such services are not necessarily mentally ill, so placement at either of the mental health institutions may be inappropriate. They are not necessarily juvenile offenders; therefore, a commitment to Maine Youth Center may be inappropriate. They are seldom mentally retarded, making placement at Pineland Center inappropriate. Their behavior is out of control to such an extent that no residential treatment center in Maine can cope with them and continue to ensure a safe environment for other residents. At the same time, there are children's advocates who would argue against involuntary confinement of these youth. Present laws may not permit such action. Even if enabling legislation were enacted, what would treatment programs entail for these adolescents? In a state where placement resources for adolescents are limited, where would they go after stabilization?

Clearly, implementation of behavior stabilization/secure treatment services is a complicated issue that raises as many questions as it answers. The service would no doubt be expensive. Nevertheless, the need is clear. To prolong development of behavior stabilization resources serves only to perpetuate the pain these youngsters are experiencing, the pain that moves them to commit violent acts against themselves or others.

Information regarding two major efforts in this area was presented to the Commission. The first involves a study in progress by the Human Services Development Institute of the University of Southern Maine, through a contract with the Interdepartmental Committee, to research the problem more carefully and to provide concrete data regarding need and implementation.

Of an initial population of 1300 youth identified by social services providers as potential users of a behavior stabilization/secure treatment service, a sample of 308 youth between the ages of 8 and 21 was selected for more in depth data collection. Of the 456 questionnaires sent out (in some instances, more than 1 referral agent was surveyed on the same child), the Human Services Development Institute reported a 60% return. The data is currently being analyzed and a report including a profile of the target population, a description of treatment models being used in other states and a review of legal issues related to behavior stabilization/secure treatment, will be available in July, 1984.

The second effort involves pending negotiations between the Department of Human Services and the Bureau of Mental Health/Augusta Mental Health Institute to utilize the latter in the development of a therapeutic/psychiatric foster home program to serve some of these youth.

The Commission supports the efforts to move to define clearly the scope of the problem, research the legal implications and develop a proposal for the establishment of behavior stabilization/secure treatment services. It is long overdue. The Commission also encourages the Departments of Human Services and Mental Health and Mental Retardation to utilize the expertise of the Augusta Mental Health Institute in the development of a therapeutic foster home program. It, likewise, is long overdue.

Recommendation SS/C-1: Based upon the data summary from the Interdepartmental Committee/Human Services Development Institute's study, the Specialized Services Subcommittee should determine whether to recommend legislation for funding of behavior stabilization/secure treatment services. This decision should be made by August 15, 1984.

If the decision of the Subcommittee is to recommend legislation, the Commission should work with the Departments to draft any needed enabling legislation by October, 1984, for behavior stabilization/secure treatment services.

SS/D. Specialized in-patient services for pre-adolescents do not currently exist in Maine.

Of the 1300 individuals identified in the initial Interdepartmental Committee survey for behavior stabilization services referred to earlier, approximately 100 were aged 12 and under.

Brian, age 11, was brought to the emergency room of the local hospital after both threatening suicide and making suicidal gestures. At home he was prone to episodes of rage in which he physically attacked other members of his family. Special arrangements were made for Brian to be admitted to the pediatric unit with additional one to one staffing. Subsequent evaluation(s) revealed a malignant tumor of the temporal lobe.

Michael, age 10, was suspended from school after overdosing on medication, setting a fire, and physically striking out at his teacher and fellow students. At home, following the suspension, he threatened to kill himself and tried to smother a younger sibling. Because of a home situation that potentially placed him in jeopardy, an alternative placement was recommended. Through a special funding arrangement with the Office of Children's Services (Department of Mental Health and Mental Retardation), Michael was placed in a residential treatment center. Within a short period of time, however, it became clear that he needed a more secure setting. He was placed at the Augusta Mental Health Institute, and through another special arrangement, again orchestrated by the Office of Children's Services, Michael was able to return home with 24-hour emergency coverage provided by Augusta Mental Health Institute staff. Shortly thereafter, he was sent out of state to live with his father. In all probability, he will resurface in Maine.

Stephen, age 12, had a long history of behavior problems and hyperactivity, for which Ritalin had been prescribed. Problems both at home and at school had precipitated referral to a residential treatment center. Before he could actually be placed, however, Stephen had an episode at home where he threatened other family members with a butcher knife. Fortunately, the local hospital was able to admit Stephen to a "behavior development program" for stabilization prior to return home. In many parts of the state, no immediate placement resource would have been available.

Like their adolescent counterparts, these children are not necessarily psychotic, guilty of juvenile offenses, or mentally retarded. And like the older adolescent, no program currently exists in Maine to provide the specialized in-patient services required by these special needs children.

As the individual child vignettes indicate, such cases are currently handled on an individual, and somewhat haphazard basis. Some are managed (at some risk) on an outpatient basis. Others are placed (often inappropriately) in foster homes, emergency shelters or adult psychiatric units. Even placement in an adolescent program, such as the one at the Augusta Mental Health Institute, poses problems because of the unique programming needs of the younger child. Clearly, placement of a 7 or 8 year old with acting out teenagers is contra-indicated therapeutically.

In general, the children we are talking about fall into one of three categories:

1. the emergent, out of control child, whose behavior(s) need to be stabilized so that out-patient treatment can proceed;

2. the child already in residential care whose psychiatric status deteriorates such that stabilization in a secure setting is necessary; or

3. the behaviorally problematic child who requires brief inpatient hospitalization, including a thorough diagnostic evaluation.

Involvement of the family in treatment is critical. Because of this a single program somewhere in Maine could not possibly be readily accessible to all areas. A more practical solution would be a network of emergency stabilization slots in locations such as hospitals (preferably those with both pediatric and psychiatric supports) or residential treatment centers with the capacity to serve younger children. Because such stabilization services are short-term, other, more permanent placement resources, e.g., family supports, therapeutic foster homes, etc., would need to be readily available. In short, a better and wider range of services are needed that can work together to provide alternatives for children similar to a pre-adolescent Malcolm Robbins.

Recommendation SS/D-1: The Specialized Services Subcommittee recommends that funds be identified within existing departmental budgets for a more in-depth study of the pre-adolescent children in the Interdepartmental Committee/Human Services Development Institute's survey population.

Recommendation SS/D-2: The Department of Mental Health and Mental Retardation should take lead responsibility with other public and private agency representatives in identifying resources that will accept children for diagnostic/stabilization purposes. At least one facility that provides both types of services should be available in each catchment area.

SS/E. There is a critical need in Maine for secure treatment services for youth who are violent/sexual offenders.

The following cases are a small sample of the increasing number of violent/sexual offenders at the Maine Youth Center. Many have long standing histories of repetitive violent behavior.

Billy, age 16, is currently at the Maine Youth Center for the brutal murder of a 10-year old girl. This boy simply decided that he wanted to murder somebody and waited until he found the right victim.

Michael, age 16, was involved in the brutal and violent rape of a woman in her 20's, in front of her four year old and five year old children. The incident continued for a one hour period of time with the young children forced to watch the act.

Sam, age 16, is at the Maine Youth Center following the brutal rape of a 7-year old boy. His history includes attempting to murder his mother with a knife and threatening to shoot his father and stepmother.

John, age 15, was convicted of the attempted rape of a 5-year old girl. This boy had a history of committing personal violence toward others, even before entering the criminal justice system.

The Cottage I Treatment Unit houses the majority of violent/sexual offenders committed to the Maine Youth Center. Twenty-two residents of Cottage I were recently questioned regarding their commission of violent crimes in late childhood and teenage years. The following offenses were reported:

1. Nine boys reported 23 arsons;

2. One boy reported 1 murder;

3. Five boys reported 67 incidents of criminal threatening;

4. Seven boys reported 143 aggravated assaults;

5. Six boys reported 137 assaults with a deadly weapon;

6. Five boys reported 22 rapes;

7. Seven boys reported 32 incidents of threatening with a dangerous weapon;

8. Nine boys reported 213 assaults, which were not provoked;

9. Six boys reported 55 incidents of gross sexual misconduct;

10. Six boys reported 72 incidents of extreme cruelty to animals;

11. Seven boys reported approximately 85 incidents of carrying concealed weapons illegally;

12. Three boys reported 17 incidents in which they fenced dangerous weapons.

Recognizing that such self-reporting procedures may result in an embellished list of offenses, it is still clear that a small percentage of the adolescent population commit the great bulk of violent crimes. These are individuals who, presented with even minimal stress, invoke further disaster upon themselves by resorting to violent, acting-out behavior in an attempt to gain control over their equally disastrous lives.

The problems these individuals present in terms of treatment are enormous and complex. Such violent, incorrigible offenders can have a devastating effect on other correctional programs. Current literature indicates that this type of offender requires highly intensive treatment, in addition to existing correctional treatment programs. Effective treatment for this population can require anywhere from 1-5 years, with 2-3 years the average.

The cost of developing such a program is likely to be expensive, but failure to develop such a program is almost a certain guarantee that these offenders will spend a good part of their lives incarcerated and that they will continue to be dangerous both within and outside of institutions. The potential for danger is too great to ignore the problem. Resources do exist in other states to address the problem and the body of related knowledge is expanding rapidly. In short, now is the time to address the problem.

Recommendation SS/E-1: The Department of Corrections/Maine Youth Center should take lead responsibility for developing a plan for a secure treatment program for the violent/sexual offender. Because of the nature of the offenses involved, the offender's potential for violence and the need for security, the program should be housed at the Maine Youth Center, not at a mental health facility.

The plan for a secure treatment program for violent/sexual offenders should be presented to the Specialized Services Subcommittee by September, 1984. Specific funds should be identified for implementation of the plan.

SS/F. Resources for treatment of emotionally disturbed offenders in Maine are seriously deficient.

In 1972 the Hayden Treatment Unit at the Maine Youth Center was opened to provide a treatment program directed toward serving the needs of "problem" adolescents. These adolescents were those who had been identified as needing treatment directed toward psychiatric and/or emotional behavioral issues. Toward this end, the Hayden Treatment Unit was staffed to provide a full range of professional and para-professional services for up to twelve clients. The following types of disorders were representative of the original client census:

1. Clients with a full range of mental and/or emotional difficulties, and representing all levels of intellectual capacity, with the exception of mental retardation. (The Hayden Unit does not deal with persons who have been identified formally as mentally retarded.)

2. Adolescents suffering from hearing, speech and/or reading disabilities who have potentially normal abilities and performance.

3. Minimally brain-damaged individuals, with or without motor involvement, behavioral deviations or speech problems.

4. Clients with or without current emotional difficulty who have educational difficulties or functional intellectual impairments.

In addition, the Hayden Unit provided outpatient services to residents of other Maine Youth Center cottages who were in need but not sufficiently impaired to require residency within the Hayden Unit program.

From the historical perspective then, it is clear that the Legislature (through a special bond issue for building construction and the authorization of increased Maine Youth Center personnel to staff the Hayden Treatment Unit) identified a specific need and then provided measures to address this need via appropriate funding. The specialized nature of the Hayden Treatment Unit was further defined/identified through the establishment of the position of Director, Hayden Treatment Unit. As the only Unit Directorship at the Maine Youth Center, it was specifically dedicated to that unit and required special qualifications, experiences and competencies.

Originally, the Hayden Treatment Unit was staffed adequately to meet program needs. Yet today this staffing has been severely reduced due to financial shortfalls and other institutional needs. This being the case, is rather ironic that the Courts are being substantially more selective in the commitment of adolescents to the Maine Youth Center. This selectivity is exemplified by the fact that never is a youth committed to the Maine Youth Center for status offenses today. The Maine Youth Center now serves adolescents committed for a full range of crimes, including, but not limited to, murder, rape, arson, incest, burglary, theft or other serious crimes. Commitments in terms of absolute numbers continue to increase. Thus, the residents served by the Hayden Treatment Unit (those adolescents committed to the Maine Youth Center) clearly present a high degree of risk to themselves, as well as a thoroughly documented threat to their Maine communities.

The Hayden Treatment Unit also historically provided services on an outpatient basis to Maine Youth Center residents, and from 1972 to 1980, some 357 clients were so served. These outpatients included the female residents in need of therapy available at the Hayden Program and not elsewhere. However, due to the severe staff reductions, the Hayden Treatment Unit no longer provides outpatient services to other Maine Youth Center residents, including the female population. Particular note is made of the female population because their crimes and the threat they pose to the community are equally serious. They are in need of the services previously (but no longer) available through the Hayden Treatment Unit.

The mission of the Hayden Treatment Unit, namely, to deal with these very special clients, has not changed over time nor has the number of adolescents in need of services decreased. In fact, the direct opposite is true in that the clients' needs have escalated and the demand for services has continued to rise, while the staffing has continued to decrease.

Recommendation SS/F-1: The Department of Corrections should request additional funds specifically to restaff the Hayden Treatment Unit so it can adequately and realistically serve the needs of emotionally disturbed offenders who exhibit a clear need for psychological intervention.

Recommendation SS/F-2: Once an adequate staffing level has been established at the Hayden Treatment Unit, the Department of Corrections should ensure the maintenance of such staffing by dedicating revenue/resources specifically to that Unit. However, given the limited capacity of the facility, outpatient services should be made available to other committed youth exhibiting emotional problems.

SS/G. The demand for Hold for Court evaluations exceeds the system's capacity to provide such services.

The Maine Youth Center is the primary agency mandated through the Juvenile Code to perform Hold for Court evaluations. Over the past seven years, MYC's Psychology Department has performed in excess of 1600 evaluations, or an average of approximately 230 evaluations per year. The ability of the department to perform such an enormous volume of work was in large part due to the use of a corps of trained para-professional volunteers.

Recently, several groups, e.g., the Advocates for the Developmentally Disabled, the Department of Educational and Cultural Services, the Ethics Committees of the Maine Psychological Association (MePA)) and the American Psychological Association (APA) stated that the practice of utilizing such volunteers to administer psychological tests is no longer legal and is in direct violation of the Code of Ethics of the MePA and APA. Therefore, the Maine Youth Center is no longer able to utilize volunteers, who in the past have contributed 20-60 hours per week to the institution. Consequently, the Maine Youth Center's ability to perform the same number of evaluations and fulfill its obligation to the Courts has been seriously impaired.

At the same time, the demand for Hold for Court evaluations is increasing. The State of Maine supports the federal initiative which would remove all juveniles from county jails as places of secure detention. In effect, proposed legislation would result in the Maine Youth Center being the only existing facility available for secure detention of juveniles in Maine. Passage of such legislation would further increase the number of secure detentions (Hold for Courts), with a correspondingly larger number of evaluations requested by the Courts.

Qualified estimates indicate that if the requests for evaluations continued to increase at current levels, the result would be a discrepancy of about 120 psychological evaluations. The jail removal initiative can be expected to substantially increase this number, placing the Maine Youth Center in violation of the rehabilitative mandates of the Juvenile Code.

Recommendation SS/G-1: The Department of Corrections in conjunction with the Office of Court Administrators should develop a plan outlining the number of court evaluations estimated to be needed on an annual basis and should make recommendations for developing a regional capacity for secure evaluations. The plan should be presented to the Specialized Services Subcommittee by September, 1984. Consideration should be given to increasing funds in court budgets to provide specifically for community-based evaluations.

SS/H. A majority of juveniles within the various levels of the juvenile justice system require special education services that are not currently available.

Federal laws and State regulations require that educational facilities identify youth who need special education services and provide appropriate programs for these students. On a national basis, statistics indicate that such youth are disproportionately represented in the juvenile justice system. Experience in Maine parallels that of the nation.

Looking specifically at incarcerated youth, the Maine Youth Center reports that as many as one-third of its committed juveniles (60-80 clients) have been identified as juveniles who require Special Educational/Treatment Programs.

Federal laws and State regulations require that a Pupil Evaluation Team (PET) assessment be performed and an Individual Educational Program (IEP) be developed and implemented for each individual identified as needing special education services. Psychological evaluations are invariably necessary as part of the PET assessment. Psychiatric intervention is also frequently required. Psychological consultations with classroom teachers are required in the course of IEP implementation. In addition, the IEP frequently prescribes individual, group and/or family counselling by a psychologist or psychiatric social worker, as a component of the educational program.

The Maine Youth Center serves as the educational facility for youth on Hold for Court, Hold for Evaluation, and detention statuses, as well as for youth committed there, and as such, must provide the above-mentioned services for the 60-80 youth identified as special education eligible.

Because the Maine Youth Center does not have adequate psychological resources to participate in educational programming, the institution's compliance with Federal laws and State regulations is jeopardized.

Recommendation SS/H-1: The Department of Corrections should work closely with the Division of Special Education within the Department of Educational and Cultural Services to assess and make recommendations on improving and bringing special education programs for adjudicated youth into full compliance, and, where appropriate, should develop a plan for ongoing funding for special education services at the Maine Youth Center.

SS/I. Delivery of appropriate services to adjudicated youth is hampered by inadequate training of persons involved in the placement of these youth as well as a lack of community-based supports, including the availability of evaluation procedures.

Persons involved in the placement of adjudicated youth include judges, attorneys, juvenile caseworkers, law enforcement personnel, educators, and Department of Human Services caseworkers. Knowledge of placement procedures and resources vary considerably from group to group, as well as from individual to individual within each group.

> Scott, age 16, was a multi-problem juvenile with multi-agency involvement. Problems included substance abuse, an expressed hatred for his mother and aggressive outbursts, one of which involved a charge of alleged sexual assault against his younger brother. Referral to the Community Mental Health Center resulted in a six-week wait for an appointment.
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> Kevin, age 14, was suspended indefinitely from school for misbehavior. He was well-known to the community at large as a result of his involvement with the criminal justice system. The school agreed at a Pupil Evaluation Team meeting to accept Kevin back into school, but then made his failure there almost certain by imposing a condition of "no swearing."
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> Bruce, age 16, Richard, age 16 and Peter, age 17, were discharged from the Maine Youth Center on entrustment status and returned to their respective families. Away from the structure/regimentation of the Maine Youth Center program, and without adequate community supports, all three boys resumed their earlier behaviors, which ranged from staying out all night to terrorizing the family.

Progression through the juvenile justice system generally begins with an intake process, or somewhat informal contact, during which a child and family may be referred on a voluntary basis to various community agencies, followed by probation, commitment to the Maine Youth Center, absent with leave and entrustment. Treatment for the youth in this system differs from that of other youth in one subtle way - service is involuntary. Failure to participate often results in a court appearance and the next step in the progression described earlier. The therapeutic use of authority/coercion can be effective; a substantial number of Juvenile Services Unit caseloads represent juveniles who never re-enter the system at a more restrictive level.

The actual "treatment" for these juveniles (and their families) is no different than the services that should exist for all children, i.e., home-based support services for families, timely community mental health services, transitional/aftercare services for children returning from residential placements. Unfortunately, by virtue of the stigma attached to involvement with the juvenile justice system, efforts often focus on ostracizing these youth from the very community into which they could, and should, be reintegrated. Within the limits of due process, and large caseloads, juvenile caseworkers are able to respond quickly to client needs, particularly when protection of the community is paramount. But all too often they lack the resources to resist the community's natural tendency to isolate offenders in those instances where they may possibly profit from treatment services within the community.

There are, of course, instances where temporary placement outside the home, in group homes, therapeutic group homes, etc., is necessary. Despite these persons' well-intentioned efforts, placements are frequently effected without regard to state and federal regulations, resulting in:

1. placements that are made on the basis of expediency, other than on the basis of the mental health, educational, and correctional needs of the juvenile;

2. failure to adhere to due process concerning PET procedures for effecting placements; and

3. lack of recognition of departmental policies and procedures regarding appropriate funding.

For example, placement in a residential treatment center (Sweetser Children's Home, Spurwink School, Elan and Homestead), with the expectation of state funding, must originate with a Pupil Evaluation Team recommendation. In the case of children in the custody of the Department of Human Services, a State PET meeting is held; for all other children, the local school district has PET jurisdiction. Based upon a review of the child's special education needs, as well as the results of a current mental health evaluation, the Team may recommend placement outside the district, in one of the facilities previously identified.

Following such a recommendation, a referral would be made to the particular facility felt to be most able to meet the child's needs. The facility then conducts its own screening and if the child is felt to be appropriate for placement there, a tentative admissions date is set. The actual placement of the child in the residential treatment center may not occur for several weeks or months, depending upon a vacancy. Placements in the residential treatment centers are not intended to

occur on an emergency basis. The described process is intentionally deliberate, and serves as a safeguard to the child's right to a least restrictive alternative.

The decision to place a juvenile in another type of residential facility, e.g., group home or therapeutic group home, should always be based upon the individual's needs and the capability of the facility to address those needs. Psychological and educational evaluations are indispensable in effecting appropriate placements of juveniles. Communication among all the systems involved with a particular youth is imperative.

Finally, once the decision has been made that placement outside the home is in the best interests of the youth, the length of placement is sometimes restricted by the relatively arbitrary time limits of informal adjustment, probation, or to a lesser extent, entrustment. Appropriate services should be available to serve needy youth, independent of a particular system's involvement, i.e., juvenile justice or Department of Human Services.

Recommendation SS/I-1: The Interdepartmental Committee, in conjunction with the Office of Court Administrators, should ensure that regular formal training in the area of children's care/treatment/placement be required of all District Court judges. Similar training should also be part of the orientation and continuing education of juvenile caseworkers, Department of Human Services workers, Special Education Directors, mental health professionals and other appropriate service providers.

Recommendation SS/I-2: The court record of any adjudicated juvenile should include pertinent diagnostic, medical, psychological and educational information. This record should accompany the child to whatever placement is effected.

Recommendation SS/I-3: The Commissioners (or their representatives) of the four youth-serving departments should meet with the Chief Judge of the District Court to develop working agreements and protocols for assuring the appropriate flow of information to the judge for the dispositional hearing of a juvenile.

SS/J. Currently, inadequate resources exist to provide for implementation of the 1980 amendments to the Juvenile Justice and Delinquency Prevention Act of 1974 which require Maine to remove all juveniles from county jails or adult lock-ups as places of secure detention.

Maine has elected to comply with the 1980 amendments to the Juvenile Justice and Delinquency Prevention Act of 1974, thereby retaining some $200,000 in federal funds. As a result of this decision, Maine will no longer be able to detain adolescents in county jails or adult lock-ups. In order to address these youngsters' needs appropriately, it will be necessary to develop or expand the availability of the following types of resources for adjudicated youth:

1. Secure detention, including the capability for short-term behavior stabilization and diagnostic evaluation.

2. Non-secure residences, such as emergency shelters, therapeutic group homes, group homes or foster homes.

3. Supervision/support services, such as Homebuilder-type programs, to permit the maintenance of youth within their own homes pending adjudication. Additionally, short-term supervision services within the community will be needed for some youth, pending the arrival of parents/guardians. These services can also be utilized to avert residential placement post-adjudication and to assist community re-entry post-commitment to the Maine Youth Center.

4. In-home/community mental health evaluations. The current practice of referring youth in need of these services to the Maine Youth Center not only places an excessive demand on that facility's resources, but is expensive and, in many cases, is needlessly disruptive of the youth's life in his family/community.

Recommendation SS/J-1: A requisite component of services should be identified to address the need for community-based evaluations in each catchment area.

Recommendation SS/J-2: Funds should be made available and contracts developed to support the initiative of private agencies to provide needed services for juvenile justice clients in a planned, coordinated way.

SS/K. Problems still exist with certain provisions of the Juvenile Code.

Implementation of the Code has proven to vary from region to region within the state, resulting at times in a perceived abuse of the intent of certain provisions and psychological as well as physical abuse to the juveniles involved.

> Matthew, age 14, was accused of stealing an object of minimal value (less than $10). Pending his court appearance, he was housed for 10 days in a county jail with adult inmates, including one who was accused of murder.
>
> John, age 16, was housed in the juvenile section of a county jail, in a cell with other juveniles. During his incarceration, he was raped by three other juveniles, including one who was subsequently sentenced to 20 years at the Maine State Prison for two murders.
>
> Ronnie, age 16, was picked up for being intoxicated, and therefore violating a condition of his probation. He was held for several hours in a cell in the adult section of the county jail, adjacent to an area that was accessible to adult inmates. Other inmates at the time included an adult accused of murder and another accused of robbery, who had been convicted previously of assault.

The Committee to Monitor the Juvenile Code was disbanded in 1981. As a result of recent changes within the juvenile justice system in Maine, as well as a federal initiative to remove juveniles from county jails and adult lock-ups, certain provisions of the Juvenile Code need revision.

The Jail Monitoring Committee of the Juvenile Justice Advisory Group is in the process of identifying definitional changes that need to be made in the Juvenile Code. The Committee is also developing a plan for removal of juveniles from adult facilities as places of secure detention. This plan, as well as revisions to the Code, will be submitted for consideration by the 112th Legislature.

In some cases, potentially dangerous juveniles are sent to the Maine Youth Center on Hold for Court status. This occurs as a result of some judges' interpretation of the bind-over procedures within the Juvenile Code. According to these judges, unless the Maine Youth Center has been tried, they cannot state that all juvenile dispositional alternatives are inappropriate. Yet some juveniles clearly are inappropriate for juvenile facilities. The Chronic and Violent Youthful Offender Committee of the Juvenile Justice Advisory Group is currently investigating this issue.

As noted in SS/G, judges frequently order evaluations of juveniles in order to utilize short-term detention as a deterrent to future criminal activity or to bide time until a placement is secured. If the information resulting from the evaluation is not going to be used, such actions constitute an abuse of the Code.

Judges continue to commit juveniles to particular facilities, rather than to one of the youth-serving Departments. The only specific place that a judge may commit juveniles is the Maine Youth Center. Commitment to the Department of Human Services, effected solely to secure funding for a residential placement, is inappropriate and a disservice to juveniles and their families. It would be far more beneficial to place the juvenile on probation and have the Department of Corrections provide services to the family.

There is currently no capacity within the Department of Corrections to plan for services for juveniles. i.e., to tie together institutional and community needs and reconcile the differences, or to project from year to year the demand for services in different regions of the state. Efforts have been initiated in the area of data collection, but the Department lacks both the manpower to monitor the data and funding for identified services.

Recommendation SS/K-1: An on-going planning process should be instituted within the Department of Corrections to assess formally the needs of the major components of the juvenile justice system. Input should be sought from the regional juvenile caseworkers and the Maine Youth Center and recommendations should be made regarding any additional funding necessary to improve service delivery.

REFERENCES:

1. S. Greenspan, "Developmental Morbidity in Infants In Multi-Risk-Factor Families: Clinical Perspectives," Public Health Reports, Jan. - Feb., 1982, Vol. 97, No. 1.

2. Stanley Greenspan, 1982; Kathryn Barnard, 1980; Barry Nurcombe,1981; Michael Trout, 1982.

APPENDICES

APPROVED
JUL 5 '83
BY GOVERNOR

CHAPTER
47
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-THREE

H.P. 1251 - L.D. 1664

RESOLVE, to Establish a Maine Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs.

Commission established. Resolved: That the commission on the Availability, Quality and Delivery of Services Provided to Children with Special Needs is established, consisting of 31 members representing different areas of the State, 25 members appointed by the Speaker of the House of Representatives and the President of the Senate, namely a chairman; a member of the judiciary branch or a designee; a physician; a representative of municipal police; an intake worker; a newspaper editor; a chairman of a pupil evaluation team; a youth member; an elementary school teacher; a junior high school guidance counselor; a superintendent of schools; a representative of a neighborhood group; a case worker or field worker; a representative of a community counseling center; a psychologist specializing in family practice; a psychiatric social worker; a representative from the Bangor Mental Health Institute or the Augusta Mental Health Institute; a representative from the Department of Human Services; a representative from the Department of Mental Health and Mental Retardation; a representative from the Department of Corrections; a representative from the Department of Educational and Cultural Services; a representative from the psychiatric department of a hospital; a member of the clergy; a public representative; a director of an emergency shelter for children and youth; and 6 Legislators, 4 Representatives named by the Speaker of the House of

Representatives and 2 Senators named by the President of the Senate; and be it further

Resolved: That the commission will examine the current mechanisms for identifying and following children with special psychological, emotional and behavioral needs; identify major gaps in the provision of services to these children; examine the current mechanisms used by the Department of Human Services, the Department of Educational and Cultural Services, the Department of Corrections and the Department of Mental Health and Mental Retardation to plan for and provide services to children; and, based on findings, establish priorities for legislative action; and be it further

Resolved: That the commission meet at least 3 times as a committee of the whole, and at such other times in subcommittees, as necessary, to study the problem through examination of data from Maine and other states, to consult with recognized experts in these areas, to conduct public hearings throughout the State and to prepare a report which shall be distributed throughout the State and submitted, together with any accompanying legislation, to the 2nd Regular Session of the 111th Legislature; and be it further

Resolved: That the chairman of the commission be appointed within 10 days after enactment, the other members within 20 days after enactment and that the first meeting of the commission take place within 40 days after enactment.

Resolved: That the commission have sufficient staff assistance and pertinent existing information about problems and services from the Office of Legislative Assistants, the Department of Educational and Cultural Services, Department of Human Services, Department of Mental Health and Mental Retardation, Department of Corrections and the Department of the Attorney General to carry out these duties; and be it further

Resolved: That the legislative members of the commission shall receive a per diem compensation, and all members shall receive compensation for travel and other necessary expenses incurred in the performance

of their duties; and be it further

Resolved: That the sum of $9,000 be appropriated to the Legislative Account to carry out the purpose of this resolve.

APPROVED
APR 30 '84
BY GOVERNOR

CHAPTER
86
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-FOUR

H.P. 1739 - L.D. 2304

RESOLVE, Extending the Life of the Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs.

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, pursuant to Resolve, 1983, chapter 47, a Commission on the Availability, Quality and Delivery of Services Provided to Children with Special Needs was established; and

Whereas, that resolve required that the commission submit a report, together with any legislation, to the Second Regular Session of the 111th Legislature; and

Whereas, while an interim report has been prepared for submission to the 111th Legislature, an extension of the commission into the First Regular Session of the 112th Legislature would allow the commission to complete its report and prepare more comprehensive recommendations; and

Whereas, unless this legislation is enacted as emergency legislation, the commission will expire without having fully completed its very important task; and

Whereas, in the judgment of the Legislature,

these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Commission extended. Resolved: That Resolve, 1983, c. 47, 3rd paragraph, is amended to read:

Resolved: That the commission meet at least 3 times as a committee of the whole, and at such other times in subcommittees, as necessary, to study the problem through examination of data from Maine and other states, to consult with recognized experts in these areas, to conduct public hearings throughout the State and to prepare a an interim report which shall be distributed throughout the State and submitted to the Second Regular Session of the 111th Legislature and a final report which shall be distributed throughout the State and submitted, together with any accompanying legislation, to the ~~2nd~~ First Regular Session of the ~~111th~~ 112th Legislature; and be it further

Resolves 1983, c. 47, amended. Resolved: That Resolve, 1983, c. 47, last paragraph, is amended to read:

Resolved: That the sum of $9,000 for the first 9 months and $7,500 for the second 9 months be appropriated to the Legislative Account to carry out the purpose of this resolve. Any unexpended funds shall remain in the Legislative Account.

Emergency clause. In view of the emergency cited in the preamble, this resolve shall take effect when approved.

Additional information on the Infant Screening and Intervention model discussed in PEI/A-1 is given below.

Infant Screening and Intervention Model:

The Infant Screening and Intervention Model is discussed by the Prevention and Early Intervention Subcommittee in their first problem statement. Additional information on the model is as follows:

Underlying Principles of Model

1. Every child should receive preventive health and other supportive services which result in optimal physical and mental wellness for that child.

2. Functional individuals need to be able to develop trusting relationships with others in their family and community. Infants and young children need to develop this capacity within their home environments. In some situations, families need assistance in developing this capacity to trust and build relationships. This assistance may need to come through the combined efforts of individuals and private/public services.

3. Identification and treatment should be carried out to the maximum extent possible by existent public and private sector workers in Maine (physicians, hospital nurses, public health nurses , protective workers, child development workers, infant specialists, private agency staff, etc.) in order to allow for local and regional differences.

4. Implementation should be overseen by a local interagency group and, at the state level, by a state interdepartmental group.

5. Services should be family focused rather than child focused.

6. Services should be home-based rather than center-based to the maximum exteht possible.

7. Intervention with 0-3 year olds should be integrated into the current state system for 3-5 year old handicapped children so that a continuum of services is available through school-age.

8. On-going training should be developed and made available to those who will identify and intervene.

9. The delivery system should be interdepartmental in its organizational structure and multi-disciplinary in its intervention design.

Program Model Description

There are two components in the proposed model.

1. Case Finding

The case finding component has four elements as follows:

a. Case Screening

Identification of the at-risk population would come through a network of hospital-based, physician-based and community health-based providers and/or services. This identification would be initiated through broad-based screening of pregnant women and infants routinely in contact with pregnant women and children.

On a prenatal level, this would involve physicians, office nurses, hospital prenatal clinic staffs, family planning workers, WIC workers, public health nurses and others.

If the high-risk mother/family has not been identified during the pregnancy, then the time of delivery within the hospital will be important for casefinding. Important screeners within this setting will be hospital maternity nurses, public health or other maternal and infant care nurses, hospital social workers and physicians.

On a postnatal basis, those involved would be physicians, postpartum nurses, office staff, public health nurses, well baby clinics staff, pediatric clinics, WIC, EPSDT and others.

The screening by this broad spectrum of pregnancy- and infancy-related personnel will of necessity and design be relatively simple and brief. Screening tools are available which meet this criteria; once they are selected, training in their use will be made available to the screening network.

b. Assessment/Evaluation

Those pregnant women, infants or young children (up to age three) who are identified in the gross screening as being high risk will be further assessed. More detailed instruments will be used in the case of infants/toddlers. Careful interviewing of the pregnant or new mother/family will be needed to determine the level of functioning of the adult members of a family.

Both the screening and assessment procedures need to be viewed as the first part of the "engagement" process. A major deficit in the lives of the environmentally high-risk families is the inability to trust other people including those in the "helping" professions. Screeners and assessors will be trained in recognizing this characteristic in coping with the difficulties it presents.

c. Engagement

The engagement process is the first critical step in intervention and begins during casefinding. It is imperative that strong links exist among the screening system, the family's primary health care, the community services system and the intervention system. These linkages need to begin in the initial planning stages and be carefully nurtured at all stages if the program is going to work.

The infant/family in all likelihood will present multiple problems and resistance to support. Screeners, assessors and engagers will need to be prepared for this and prepared to persevere in the face of very difficult circumstances.

d. Summary

A long-term goal of this effort will be the systematic screening of every child, in the state, prenatally and up to age three. Those at environmental riskk will require special attention during screening and assessment. These procedures will need to be primarily home-based to a large extent and to focus on family interactional patterns.

2. Intervention

Intervention services to high-risk infants and families will include:

a. Advocacy and linkage to existing services for meeting basic human needs;

b. Emotional support to build trust between family (parents) and helping persons (the engager/intervenor[s]);

c. Developmental guidance for family members (child development, child health knowledge and expectations);

d. Psychotherapy for parents who need this level of intervention.

The "mix" and timing of these separate services will be highly crucial and individualized in each case. Clearly an interdisciplinary mix of knowledge, skills and abilities will make the team most effective.

It is proposed that regional intervention teams be established throughout the state to supplement existing resources in the provision of appropriate intervention services (initially, pilot regions would be selected to test and demonstrate the model). Such teams could basically be formed through the reallocation or reorientation of state positions from a variety of state agencies whose mandates related to high risk infants in some way. The primary focus of the teams would be intervention directed towards families of environmentally-at-risk infants. At the present time, the following agencies are seen as potential participants in the formation of the intervention teams.

Department of Human Services

- Protective Services
  Public Health Nursing

Department of Mental Health & Mental Retardation

Bureau of Mental Retardation
(Community Mental Health Centers)

Department of Educational & Cultural Services

(Preschool Projects)

Private Community Agencies and Programs

It is proposed that identified state agencies (or contract agencies with a close relationship with the designated state agency) reserve and designate specific positions to work on a full-time basis with the High-Risk Infant/Family Intervention Team. These teams would be interagency in nature with the staff members maintaining agency-of-origin identity while also functioning under the auspices of the interagency, interdisciplinary intervention model. Where community-based programs for high-risk infants exist (Infant Development Programs), a facilitative, support relationship would be regionally developed to maximize the impact of the existing program and integrate it with the interagency teams. Within a given region, the team and cooperating agencies would function with the advice of an existing (or newly established, if necessary) interagency coordinated council or committee whose function is closely related to high-risk infants/families, such as preschool projects or child abuse and neglect councils.

The interagency composition of the team is important for at least two reasons:

1. The four departments with major responsibility for children and/or family services (Human Services, Educational & Cultural Services, Mental Health and Mental Retardation, and Corrections) each have separate and distinct categorical high-risk families and their children;

2. The departments and such private or voluntary agencies as may be included in team composition have different services and resources that will need to be brought to bear in infant-family issues and plans for zero-to-three year olds in high risk families.

It is essential that the representatives of various agencies involved by mandate or service learn each other's potential and limitations, both as individuals and as program representatives. Intervention team training, both initial and continuing, will emphasize interagency and interpersonal team issues as well as substantive content.

CASE MANAGEMENT SYSTEMS - CHILDREN & FAMILY

Descriptive Outline - 1984

	Special Ed.	AMHI	BMR	Family Service Program	Sub.Care	Child Prot.	DOC	Preschool Coordination Sites
Target Population	children requiring residential school placement because of the severity of their handicapping condition	children who are mentally ill by legal definition & those whose "responsible adult" is able to negotiate a contract w/the Adol. Unit	children who are m.r.	AFDC families whose head of household is under age 20	children in foster care	abused/neg. children and families	Juvenile offenders	3-5 y.o. handicapped children. 0-3 for coordination & referral only.
Working Definition	All exceptional child. between ages of 5 & 20 requiring special services in the areas of: 1. Visually Impaired child; 2. Hearing Impaired child; 3. Learning Disabled child; 4. Physically Impaired child; 5. Behavior/ Emotionally disturbed child; 6. Chronic/ Acute Health Impairment	chldren who are in serious jeopardy because of family dysfunction	0-5:developmentally delayed children 5-20:m.r. children who need services not available through education system, i.e., respite, placement case management	AFDC Families whose head of household is under age 20 in the following priority order: 1.Newly granted AFDC families; 2.Referred by another agency including screened out child protective cases; 3.Not referred to the program; 4.Screened out protective service referrals who request assistance.	children who come into care or legal custody of DHS, voluntarily or court com.	chldrn who are or may be in need of protection because of child abuse or neglect,& their families	juveniles who are: chrged by law enfrce ment agencies w/com mitting a juv.offnse & referred to P&P juv casewkrs for court proceedings; placed on 'in formal adjustment';placed on probation by the court; committed to MYC preparing for release; on Absent w/ Leave status from MYC;on Entrustment status from MYC.	children: a)who have reached 3 yrs. of age; b) have not reached 5 on or before Oct. 15; c) require special services in the area of: 1.Vision 2.Hearing 3.Speech & Language 4.Cerebral or Perceptual Functions 5.Physical Mobility Functions 6.Behavior, or 7.Mental Development or maturation

	Special Ed.	AMHI	BMR	Family Service Program	Sub.Care	Child Prot.	DOC	Preschool Coordination Sites
Statutory Ref.	20A M.R.S.A.	32 M.R.S.A. 2251,2290 2331,2334	34 M.R.S.A. ch.229 & 186A 2147	22 M.R.S.A. Chapt. 1473 S.5308-10	22 M.R.S.A. 4041-4065	22 M.R.S.A. 4001-4039, 4071		20 MRSA ch.406
Clients/Year	195 NSW in residential placements	150	0-5: 412 5-20: 586	700 unduplicated Families	3043	6496	7000	
Case Management Responsibility	Special Ed. Director or Pupil Eval. Chairman	Psychiatric Nurse III, Psych.S.W.II Psychol.II	0-5:Chld Dev. Worker 5-20:Client Svc.Coord	Family Service Caseworker	Foster Care or Adoption Caseworkers	Child Prot. Caseworkers	Juvenile Casewrker	Varies from site to site, in some cases project staff in others thru cooperating agencies
# Case Managers	91	2-4	approx. 24	N/A	99	122	36	N/A
Average Caseload	N/A	6-8 inpatient 4 outpatient	CDW: 15-20 CSC: 40-60	35-40	24	24.6	50	N/A
Services Provided	residential school placements	family ther. clinical ward management; treatment	In-home train. Case managemnt inc.coord.of svcs.:respite, trans.,medical dental,eval. residential placement;asst in SSI/guard'n	Continuation of education Delay subsequent Pregnancies; Acquisition of employability and job skills;	asst.in family rehab.; activities as legal parent of chld bd/care,clothing,trans, med.care, case study/	receipt & invest./ eval. of referrals/ reports; intrvent'n to protect child & strengthen	referral to svc.providrs client supervision	Coordination of services to preschool handicapped children including: screening, referral, evaluation and direct services as well as mechanism

	Special Ed.	AMHI	BMR	Family Service Program	Sub.Care	Child Prot.	DOC	Preschool Coordination Sites
			ship appl.; family support	Improved maternal and infant health; Acquisition of life management skills; Facilitate the use of existing system; Facilitate the coordination of the existing services by agreements and compacts Prevent child abuse & neglect	supervision counslling, prep./placement;court social svc. advocacy,day care.	family;petition for a court order as necessary to protect child;case study;case managemnt; individual, group & family counselling; advocacy; prep.&placement;court soc. svc.		for interagency collaboration
Needed Services		foster homes ther.f.homes ther.group homes	More resources for teaching parenting skls staff training mechanism to better coord. svc. to multi-agency families	Day Care Serv. Transport. services; Housing; Parenting Classes; Educational Opportunities; Job Opportunities	m.h.svc.both in & outptnt svc. ther.f.homes	intensive in-home ment progs.	job bank or other employ	More direct serv. varying need from site to site

APPENDIX D

APPROVED
APR 13 '84
BY GOVERNOR

CHAPTER
752
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-FOUR

H.P. 1667 - L.D. 2207

AN ACT to Provide Medicaid Reimbursement for Substance Abuse Services.

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

Sec. 1. 22 MRSA §3173-D is enacted to read:

§3173-D. Reimbursement for alcoholism and drug dependency treatment

The department shall provide reimbursement, to the maximum extent allowable, under the United States Social Security Act, Title XIX, for alcoholism and drug dependency treatment. Treatment shall include, but need not be limited to, residential treatment and outpatient care as defined in Title 24-A, section 2842.

Sec. 2. Allocation. The following funds are allocated from the Federal Expenditure Fund to carry out the purposes of this Act.

	1984-85
HUMAN SERVICES, DEPARTMENT OF	
Medical Care, Payments to Providers	
All Other	$42,808

Sec. 3. Effective date. This Act shall take effect on January 1, 1985.