DRUG ABUSE IN MAINE
The Needs of Special Populations, The Costs, and The Geographical Distribution of Services/Programs and Funding

A Report to the 113th Maine State Legislature

Submitted by the
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Introduction

P.L. 1981, c. 454, "AN ACT Promoting Alcoholism Prevention, Education, Treatment, and Research" was signed into law on June 11, 1981. This law established a nonlapsing fund based upon a premium on the sale of alcoholic beverages under a "self insurance" concept. The goal was to ensure that programs for alcoholism prevention, education, treatment, and research were adequately supported by shifting the financial burden to those who choose to drink. The law also initiated a new process of joint planning and coordination by requiring the Commissioners of the Department of Corrections, Department of Educational and Cultural Services, Department of Human Services and Department of Mental Health and Mental Retardation to jointly prepare and submit a report on alcoholism prevention, education, treatment, and research to the Legislature on or before the first day of every regular session.

The 111th Legislature enacted P.L. 1983, c. 464, which reorganized the administration of State alcohol and drug abuse activities and established the Alcohol and Drug Abuse Planning Committee (ADPC).[1] The ADPC is comprised of the Commissioners of the Departments of Corrections, Educational and Cultural Services, Human Services, and Mental Health and Mental Retardation and is responsible for planning, monitoring,

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[1]P.L. 1983, c.464, "AN ACT to Provide for the Development of a Centralized Coordinated Planning and Evaluation Process for State Alcohol and Drug Abuse Activities."

evaluating, and coordinating Maine's alcohol and drug abuse services. The long-term mandates include the implementation of a four-year cycle of planning, periodic needs assessments, statements of service goals, biennial allocation plans, and regular performance evaluations. This report is in response to the mandate that the ADPC submit to the Maine State Legislature:

> "...an assessment of the costs related to drug abuse in the State and the needs of various types of services within the State including geographical disparities in needs and the needs of special populations of drug abusers."

These mandates were based in part upon a report submitted to the Maine State Legislature in 1982[2]. Known as the Meadows Report, the authors utilized national statistics and estimates of Maine substance abuse professionals to estimate that alcohol was a significant factor in 50% of fatal accidents, 80% of fire deaths, 60% of child abuse cases and 36% of pedestrian accidents. The costs associated with substance abuse in Maine were estimated to be approximately $700 million per year. The following table identifies the cost areas.

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[2]Strategies to Enhance the Effectiveness of Alcoholism Services in Maine Public and Private Agencies. Foundation Associates, Plainfield, N.H., 1982.

Six Areas of Cost Estimates in the
Foundation Associates Report, 1982

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

The methodologies utilized by Foundation Associates to estimate incidents and costs of substance abuse/misuse continue to be valid. However, as with any assessment conducted within a specific time period, the estimates are based upon the "knowledge" of the time. This ADPC report builds upon the "bottom line" estimates of the Foundation Associates Report and gives major consideration to changes in society's attitudes, the results of studies of special needs populations not previously considered, and the estimates/recommended actions of providers/consumers concerning needs and the strategies for addressing these needs.

This report is divided into four (4) sections. The first two sections present estimates of Maine substance abuse problems and associated costs. The third section identifies the program and service gaps that existed in Maine in 1982-1988 and the

activities of the ADPC to address these gaps. The last section identifies continuing substance abuse prevention, education and treatment needs in Maine. Throughout the report it is clearly noted that Maine's Alcohol and Drug Abuse Planning Committee has made substantial changes in its needs assessment and planning process to assure an accurate and meaningful documentation of need.

The Problem of Substance Use/Abuse in Maine: 1982-1987

Since the 1982 Foundation Associates Report, there has been a substantial increase in the known incidence of alcohol abuse/misuse and associated costs. This can be attributed to a number of factors including changes in public attitudes concerning the "disease of alcoholism," the "knowledge" that alcoholism influences all socio-economic groups, the enforcement of new legislation (e.g., OUI arrests), increased knowledge concerning the needs of underserved/unserved populations (e.g., the elderly, Native Americans, and women)[3], and the public's willingness to seek out alcohol and other drug abuse services when in need.

Numerous studies have been conducted since 1982 concerning the needs of specific Maine populations. It has been estimated that 13% of Maine's middle school students and 26% of our high school students have abused alcohol.[4] An estimated 40,000 Maine women[5] and 19,000 (or more) of our elderly[6] have severe problems with alcohol. Estimates of alcohol abuse among

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[3]Reports concerning the needs of various Maine populations are available through The Alcohol and Drug Abuse Planning Committee.

[4]An Assessment of the Treatment Needs of Youthful Substance Abusers in Maine. Social Science Research Institute, Orono, Maine, 1983.

[5]Women as a Special Population. Eastern Regional Council on Alcohol and Drug Abuse, Bangor, Maine, 1982.

[6]The Elderly: A Special Population. Kennebec Valley Regional Health Agency, Waterville, Maine, 1983.

Maine Native Americans,[7] island residents,[8] and county jail inmates,[9] are much higher than those related to other Maine populations.

Studies have also revealed the significance of the effects of substance abuse upon individuals other than the user. An estimated 1400 Maine children may be born each year with behavioral and/or morphological defects due to maternal consumption of alcohol during pregnancy. One (1) percent to three (3) percent of these children will be severely handicapped and require life-long care while the large majority of the remaining children will not reach their potential due to intellectual, motor, or emotional problems.[10] Over 25% of Maine school childen come from families with severe problems with alcohol/drugs and have a high potential of experiencing academic, personal, vocational and growth problems due to family dysfunction associated with substance abuse/misuse. These children are four times more likely to become alcoholics and are more likely to enter into a potentially dysfunctional marriage. Their mothers and fathers

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[7]Native American Alcohol and Other-Drug Abuse Service Needs. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1985.

[8]Alcoholism Program/Service Needs of Casco Bay and Penobscot Bay Island Residents. Department of Human Services, Augusta, Maine, 1984.

[9]Maine County Jails: A Survey of the Substance Abuse Treatment Needs of Inmates. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[10]Fetal Alcohol Effects: A Maine Problem. Department of Mental Health and Mental Retardation, Augusta, Maine 1983.

tend to be far more abusive than non-alcoholic parents.[11] Alcohol users/abusers also engage in other crimes (e.g., rape, theft, and OUI) which involve victims who may suffer long-term consequences for which they may not receive appropriate services and/or compensation.[12]

Although there are significant substance abuse/misuse problems in Maine and nationally, the recent media "hype" may in fact reflect an increase in our knowledge and recognition of the problem rather than an actual increase in substance use/abuse. A 1985 national study (which included a Maine sample) shows a steady decline in alcohol and marijuana use by high school seniors between 1979 and 1985. The data concerning cocaine use by high school seniors is inconsistent. The number of individuals who had used cocaine at least once increased. The number of students who used cocaine within the last year, or the last 30 days, decreased during the early 1980's and increased from 1984 to 1985. Daily use remained relatively stable with an increase from 1984 to 1985. Although there was an increase in cocaine use by high school seniors between 1984 and 1985, one must use caution as the figures are relatively small (e.g., daily use increased from 0.2% to 0.4%) and there was a great deal of variance in use over the period 1979-1985.[13]

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[11] Children of Alcoholics/Adult Children of Alcoholics. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[12] Victim Services: The Missing Links Conference. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[13] Drug Use Among American High School Students, College Students, and Other Young Adults. National Trends Through 1985. U.S. Department of Health and Human Services, Rockville, Maryland, 1986.

Nationally, for the population as a whole, there has been a significant decrease in the per capita ethanol consumption of beer, spirits, and wine.[14] Maine statistics (Bureau of Alcoholic Beverages) show a decrease in the per capita ethanol consumption of spirits and alcoholic beverages combined and an increase in the ethanol consumption of beer and table wine. A national study[15] concerning cocaine use among young adults presents inconsistent findings. The number of young adults who have used cocaine at least once within the past year increased during the post high school years. However, when one compares 1984 with 1985 (which appears significant for high school seniors) the use during the "last 30 days" and "daily use" remains approximately the same.[15] Again, the data concerning cocaine use is not clear. The numbers are small and there is a great deal of variance.

The conflicts between actual and perceived use/abuse of substances is further substantiated by the results of recent Maine reports. Although there has been a significant increase in the number of individuals arrested for the sales/distribution of cocaine in Maine,[16] this has not been accompanied by an

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[14] Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1977-1984. U.S. Department of Health and Human Services, Washington, D.C., 1986. Follow-up data for the years of 1985 and 1986 are available through various sources.

[15] See footnote 13.

[16] Cocaine Symposium Report. U.S. Department of Justice, Office of the U.S. Attorney, District of Maine. Portland, Maine, 1986.

increase in the number of individuals being treated for cocaine addiction in Maine's more intrusive treatment programs: detoxification and residential rehabilitation.[17] This report also suggests major discrepancies between the service providers' perceptions of the problem and actual cases. A study of the workplace shows similar disparities between estimated actual and perceived work impairment due to workplace substance use/abuse.[18]

Our "new" emphasis upon drugs other than alcohol may also be misleading and lead to ineffective and inappropriate activities. Without question, Maine has significant problems with drugs other than alcohol. However, we must address these problems within a meaningful context. For example, the previously cited national study[19] concerning high school seniors found:

1. Alcohol: Alcohol is by far the most problematic drug. In 1985, 92% of the high-school seniors surveyed had used alcohol at least once in their

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[17] Alcohol and Cocaine Abuse in Maine: A Follow-Up Survey. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[18] A Survey of Private Sector Management and Labor Concerning the Impact of Workplace Alcohol and Illegal Drug Use/Abuse Upon Work Performance and the Value of Workplace Referral and Treatment Programs. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[19] Drug Use Among High School Students, College Students, and Other Young Adults. National Trends Through 1985. U.S. Department of Health and Human Services, Rockville, Maryland, 1986.

lifetime, 66% used it in the past month, and 5% used it on a daily basis. By definition (the legal age for consuming alcohol), few (if any) of these students could legally consume alcoholic beverages.

2. Marijuana: In 1985, 54% of the high school seniors surveyed had used marijuana at least once in their lifetime, 26% used it in the last month, and 5% used it on a daily basis. In addition to the legal issues, recent research has shown the addictive properties and significant side effects of the chemicals in marijuana, e.g., the severe bronchial problems associated with the smoking of 2-3 "joints" daily.

3. Cocaine: In 1985, 17% of the high school seniors surveyed had used cocaine at least once in their lifetime, 7% had used it in the last month, and 0.4% used it on a daily basis. Although the problem with cocaine is relatively small in terms of numbers, it is highly addictive and an estimated 30% of the individuals who try cocaine will have problems and 10% will have severe problems.[20]

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[20]Cocaine Symposium Report. U.S. Department of Justice, Office of the U.S. Attorney, District of Maine. Portland, Maine, 1986.

If these statistics are applied to Maine's 17,000 high school seniors, the use of the three most common "mind" or "mood" atering drugs (excluding tobacco) can be seen in relative terms.

Estimated Use of Drugs by Maine's 17,000 High School Seniors

	Used at least once in life		Used in last month		Used daily	
	%	N	0%	N	%	N
Alcohol	92%	15,640	66%	11,220	5%	850
Marijuana	54%	9,180	26%	4,420	5%	850
Cocaine	17%	2,890	7%	1,190	.4%	68

It is clear that a substantial number of Maine's high school seniors are at risk in terms of their use of alcohol, marijuana, and cocaine. Utilizing Maine statistics,[21] it is estimated that approximately 4,000 seniors abuse/misuse alcohol with approximately 50% (2,000) of this population having severe problems with alcohol. Using national statistics,[22] it is estimated that 850 Maine seniors experience problems (including physical reactions) as the result of using cocaine with approximately 290 experiencing severe problems.

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[21] An Assessment of the Treatment Needs of Youthful Substance Abusers in Maine. Social Science Research Institute, Orono, Maine, 1983.

[22] See footnote 20.

Although the studies show that cocaine use continues to increase during the young adult years, alcohol continues to be the major drug problem among adults.[23] Further, a 1986 Maine survey shows that almost 100% of the adults being treated for cocaine addiction in Maine detoxification and residential rehabilitation programs, had significant problems with alcohol.[24] Without question, alcohol is the major problem drug in terms of the number of students and adults experiencing associated problems.

Overall, there has been a significant increase in the "known" numbers of Maine citizens with alcohol and other drug abuse/misuse problems. This is in part due to changes in attitudes as well as the increase in knowledge resulting from studies of the needs of special needs populations e.g., the elderly and Native Americans. Concomitantly, there has been a significant increase in the media's interest in substance abuse/misuse. Although drugs other than alcohol present significant problems that must be addressed, alcohol abuse/misuse continues to be the major problem.

The problems associated with drug abuse/misuse are varied. What are the financial costs?

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[23]See footnote 19.

[24]Alcohol and Cocaine Abuse in Maine: A Follow-Up Survey. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

The Financial Costs: 1982 - 1987

In 1982 it was estimated that the health care, crime, deaths, etc., associated with substance abuse cost Maine approximately $700 million per year. Inflation increased these costs to approximately $780 million in 1986.

The financial commitments of Maine's non-substance abuse health/educational/social systems have increased significantly since 1982. This includes the support for major expansions in the number of public service announcements and programs, the inclusion of substance abuse prevention/education within on-going school programs, and the provision of generic psycho/socio/health services for the substance abusing population. It is difficult, if not impossible, to assess the total financial commitment associated with these changes.

The changes in Maine's commitment of categorical substance abuse funds are more easily identified. The funding (State and Federal) of Maine's substance abuse prevention, education and treatment programs/services increased from $6.7 million to $10.1 million during the period of FY83-FY87. Overall, these funds which are controlled by the State and specifically limited to substance abuse (categorical), increased by 75% during this period. The following table presents the sources of the FY83 and FY87 categorical funds of the four ADPC Departments.

STATE AND FEDERAL FUNDING FOR ALCOHOL AND DRUG ABUSE PROGRAMS/SERVICES IN MAINE[25]

FY87

Agency	State Premium	General Fund	Federal	Dept. Total
ADPC	$ 78,174	$ 43,539	$ 66,607	$ 188,320
DOC	431,559	127,475	—	559,034
DECS	921,788	106,768	34,612	1,063,168
DHS	2,536,847	2,479,444	1,740,598	6,756,889
DMH/MR	599,477	858,849	37,400	1,495,726
Total	$4,567,845	$3,616,075	$1,879,217	$10,063,137

FY83

Agency	State Premium	General Fund	Federal	Dept. Total
ADPC	(not established until July 1983)			
DOC	$ 237,189	$ 77,344	$ —	$ 311,533
DECS	275,000	74,955	84,000	433,955
DHS	1,847,065	1,542,643	2,322,587	5,712,295
DMH/MR	247,500	—	—	247,500
Total	$2,603,754	$1,694,942	$2,406,587	$6,705,283

ADPC (Alcohol and Drug Abuse Planning Committee), DOC (Department of Corrections), DECS (Department of Educational and Cultural Services), DHS (Department of Human Services), and DMH/MR (Department of Mental Health and Mental Retardation).

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[25] State and Federal Funds Allocated Specifically for Alcohol and Other Drug Programs in Maine. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

A number of factors must be considered when evaluating the potential impact of the changes in the funding of Maine's categorical substance abuse programs over the period of FY83-FY87.

1. State funds increased by approximately 100% while Federal funds decreased by 21%.
2. Although the General Fund increased by approximately $2 million, $800,000 reflects a more precise identification of the use of existing funds, while $500,000 was utilized to replace lost Federal funds. In fact, approximately $1 million of the original Premium Fund was utilized in 1982 to replace lost Title XX Federal funds.
3. Prior to the initial Premium Fund in 1981, neither the Department of Corrections nor the Department of Mental Health and Mental Retardation had categorical substance abuse funds. The Department of Educational and Cultural Services had less than $55,000 and the Department of Human Services (the designated "state agency") had less than $1.5 million General Fund dollars for substance abuse prevention, education and treatment.
4. The $5 million in Premium Funds spent for substance abuse services/programs in FY88 is a relatively small proportion of the $32 million profit (sales and taxes) the State will make from the sales of alcoholic beverages.

5. The overall $10.1 million categorical substance abuse budget[26] is relatively small when one considers the health, correction, etc., problems associated with substance abuse which is estimated to cost Maine over $780 million in 1988.

6. The Omnibus Drug Legislation passed by Congress in 1986, would increase Maine's Federal funds for treatment to approximately the amount of the Federal Block Grant Maine received in 1981. Further, only 13% of these funds are for prevention, education, and treatment.

It is clear that over the past 5 years, society's attitude towards the use/abuse of alcohol and other drugs has changed significantly. This has been accompanied by a significant increase in the financial commitment by the non-substance abuse system. Categorical funding (State and Federal) was minimal in 1981 and has not kept pace with our increased knowledge of the problem.

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[26]Details of expenditures of categorical substance abuse funds are available for each Department and by program/service. For the latest report, see Alcoholism Prevention, Education, Treatment, and Research Fund. FY86 Progress Report and FY86 Programs to Be Continued in FY87. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1987. For a report on the expenditures of Premium Funds approved by the 112th Maine Legislature, see Alcohol and Drug Abuse Planning Committee FY87 and FY88 Priorities Funded By the 112th Legislature of the State of Maine. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

In order to more clearly identify "the problem" and substantiate the need for categorical resources, in 1983 the ADPC made significant changes in its needs assessment and planning processes. In addition to including the public and special needs groups in the identification of local needs, the process allowed for the assessment of the geographic distribution of needs, funding, services, and clients served.

An Assessment and Adjustment of the Geographical Distribution of Maine's Programs/Services and Funding: 1982-1988

Since 1983, The Alcohol and Drug Abuse Planning Committee (ADPC) has made substantial changes in the needs assessment and planning process. This allowed for meeting the legislated mandates and implementing a more objective and systematic method of identifying and addressing the substance abuse prevention, education and treatment needs of Maine citizens.

As an initial step, the ADPC adopted program/service terminology that (1) allowed for more precise and measurable definitions of program/service and client/student outcomes and (2) was accepted and understood by a broad base of the providers, consumers, and interested citizens.[27] This terminology has and continues to be utilized as the basis of the ADPC reports to the Legislature as well as the community-based needs assessment and planning process.

In addition to adopting a common terminology, the ADPC developed a plan and report format that allows for a degree of consistency over time, across reports, and across ADPC Departments. As with previous progress reports submitted to the

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[27] Alcoholism Prevention, Education, Treatment, and Research Fund Plan and Priorities: Overview of FY85 Programs and Costs to Be Continued in FY86/87. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1984.

Legislature, the FY86 report[28] to the Legislature clearly identifies all (approximately 140) of the programs provided/ purchased by the Departments of the ADPC during that fiscal year. The information includes the State agency sponsor, the goals of the program/service, the population to be served, the geographical location of the population, the costs, and the provider. As a result, the ADPC has an on-going mechanism that presents the geographic distribution of services and funding in Maine's substance abuse system.

Table 1 presents the residence of individuals receiving the Department of Human Services treatment services in FY86. The top row presents the percentage of Maine's population that resides in each of these geographic locations. This is followed, for each major treatment service, by (1) the number of individuals residing in the geographical area who received the service and (2) the percent of total individuals who received the service who reside in the area. Although it is evident that there are a number of discrepancies in terms of population and population served, these must be considered within a context and carefully evaluated. For example:

[28]Alcoholism Prevention, Education, Treatment, and Research Fund: FY86 Progress Report and FY86 Program to Be Continued in FY87. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1987.

Table 1

Number of Individuals who Reside in Various Geographic Locations Receiving Department of Human Services Funded Substance Abuse Treatment Services for FY86

		Geographic Area									
		York	Cumberland	Mid-Coast	Tri-County	Kennebec/ Somerset	Penobscot	Piscataquis Washington Hancock	Aroostook	Other	Total
% of State's Population		13%	20%	10%	15%	14%	12%	9%	8%	-	100%
Program Service											
Residential Rehab.	N	40	103	52	67	19	51	20	105	21	478
	%	8%	22%	11%	14%	4%	11%	4%	22%	4%	100%
Intermediate Rehab.	N	5	6	2	8	1	3	1	1	0	27
	%	-	-	-	-	-	-	-	-	-	-
Halfway House	N	16	95	41	54	41	34	13	7	23	324
	%	5%	29%	13%	17%	13%	10%	4%	2%	7%	100%
Shelter Services	N	726	1,401	34	257	54	321	61	27	346	3,227
	%	22%	43%	1%	8%	2%	10%	2%	1%	11%	100%
Detox. Service	N	106	691	65	373	61	163	28	16	40	1,543
	%	7%	45%	4%	24%	4%	11%	2%	1%	3%	100%
Extended Care	N	5	20	1	6	7	5	-	2	2	48
	%	-	-	-	-	-	-	-	-	-	-
Outpatient Services	N	746	846	347	555	780	149	867	625	153	5,068
	%	15%	17%	7%	11%	15%	3%	17%	12%	3%	100%

1. Client Population: By design, the Office of Alcoholism and Drug Abuse Prevention serves individuals who are unable to pay. This population has limited access to hospital-based programs and the services of the private practitioner. Thus, the data reflects services provided to a sub-population of the substance abusing population.

2. Non-State Funded Services: The State does not collect client data from agencies/individuals that they do not fund. This includes most of the hospital-based programs and the private practitioners. Thus, the discrepancies may partially reflect this factor.

3. Shelter Services: These clients tend to migrate to urban areas for a number of reasons and give the urban area as their address. Thus, the low level of shelter services in the Mid-Coast area may reflect a reporting rather than a service problem.

4. Service Use: In some areas of the State, it appears that there are high use and low use services. This may reflect use of services which are accessible/available rather than the most appropriate service.

5. Related Systems: Depending upon the area of the State, non-substance abuse programs vary in terms of services provided to substance abusers.

Overall, it is clear that these statistics reflect a number of interacting factors. However, when one analyzes the number of individuals served from a particular part of the State (not the location of the service), a number of results are evident:

1. York County: Although York County residents appear to be underserved in terms of residential rehabilitation and detoxification, they are well served in outpatient and shelter services. The latter may be due to the existence of the Alfred Shelter.
2. Cumberland County: The residents of this area appear to be well served. However, this is based in part on the high percentage receiving shelter and detoxification services and may reflect Portland's transient population who are highly likely to give Portland as an address.
3. Mid-Coast: The rural nature of this area may account for the low percentage of the population receiving shelter and outpatient services. The discrepancy between the percentage of services received (table 1) and

the percentage of funds received (table 2) may reflect the high cost of delivering rural services, and the level of services provided to "significant others" (data not collected by OADAP).

4. Tri-County: The number of residents receiving shelter and outpatient services is relatively low considering the potential treatment population.
5. Kennebec/Somerset Counties: A low percentage of the population received residential rehabilitation, detoxification, and shelter services. This is especially significant when one considers the relatively large transient population in Augusta. A significant percentage received outpatient services. These figures do not include the significant number of individuals served by the Seton Unit of Mid-Maine Medical Center.
6. Penobscot County: A low percentage of the population received outpatient services.
7. Piscataquis/Washington/Hancock Counties: The population is underserved in all service areas except outpatient. The outpatient services figure is in part due to the Mount Desert Island Hospital outpatient program that reports all clients served, regardless of source of funding.

8. Aroostook County: This area shows a high percentage use of resident rehabilitation and a low percentage use of shelter and detoxification services.

Overall, there are strengths and weaknesses in each area of the State. It was clear that in 1986, Piscataquis/Washington/ Hancock counties are underserved in all areas, Kennebec/Somerset lacked shelter/ detoxification programs, and Penobscot County had limited outpatient services. Although the hospital-based programs and the private practitioner may address some of these problems, it is highly unlikely that they make a significant impact on the non-paying population. The goal of the ADPC was to utilize new Premium Funds to address these gaps (see following pages).

It is difficult to concisely present the geographical distribution of the programs/services provided/purchased by the other ADPC Departments in FY86. This is due in part to the statewide nature of their programs/services. However, these are presented in detail in the FY86 Progress Report[29] and the proposals submitted to the Maine legislature for FY87 and FY88 funding.[30] An analysis of these documents shows that major gaps existed in the system in FY86 as they relate to the

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[29]See footnote 28.

[30]Alcohol and Drug Abuse Plannning Committee FY87 and FY88 Priorities Funded by the 112th Legislature of the State of Maine. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

programs provided/funded by the Departments of Corrections, Educational and Cultural Services, and Mental Health and Mental Retardation. For example:

1. Department of Corrections: Based upon the estimates of the problem for this population, the inmates of Maine's correctional facilities and the probation/parole clients with substance abuse problems were less than minimally served in 1986.
2. Department of Educational and Cultural Services: Approximately 63 of 144 school units had formalized school/community teams in FY86. Rural areas (e.g., Down East and Aroostook County) were underserved and the limits of the resource center had almost been reached. Only minimal assistance was available to early school and post-secondary school programs.
3. Department of Mental Health and Mental Retardation: The treatment needs of the dual-diagnosed (mental health-substance abuse or mental retardation-substance abuse), the county jail inmates and their families, the families as a unit, and the elderly were only minimally addressed. Note: The County Jail issues are jointly addressed with the Department of Corrections.

Overall, assessments of Maine's substance abuse prevention, education, and treatment programs/services show that in 1985-86, the ADPC had identified severe gaps in the system related to special needs populations and the geographic distribution of substance abuse prevention, education, and treatment programs.

Table 2 presents a summary of the 1985-1986 geographical distribution of the ADPC categorical substance abuse program/service funds as contained in the FY86 Progress Report.[31] A program was considered statewide if it clearly served as a single state resource for clients from throughout the State (e.g., the Correctional Center and the Maine State Prison), or was clearly accessible or available to individuals and groups from throughout the State (e.g., the Department of Educational and Cultural Services Resource Library). Programs/services were considered to be in a particular geographical area if they (1) served clients primarily from that geographical area of the State (e.g., outpatient services) or (2) provided a service that was of primary benefit to the geographical area, although it may have served the whole State (e.g., residential rehabilitation programs may serve a statewide population but are a major benefit to a particular area of the State in terms of accessibility/availability of services).

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[31]Table 2 does not include (a) funds generated by hospital-based programs, (b) insurance payments or (c) payments from sources other than the categorical substance use/abuse funds. Also, it does not include the 1986 increase in the Premium Fund. The distribution of the new Premium Funds is present in Tables 6 and 7 to show the ADPC actions in addressing gaps in services.

Table 2

FY86 Categorical Substance Abuse Programs/Services Funding by Geographical Area For Each of the ADPC Departments. Based Upon the FY86 Progress Report

Department	Statewide	York	Cumberland	Mid-Coast	Tri-County	Kennebec/ Somerset	Penobscot	Piscataquis Washington Hancock	Aroostook	Total
	Geographic Area									
Corrections	$ 260,257	$ 29,400	$ 56,375	$ 16,000	$ 14,610	$ 5,188	$ 11,476	$ 1,546	$ 6,235	$ 401,087
Human Services	203,999	562,113	1,059,493	833,513	585,994	707,282	727,589	121,941	415,839	5,217,763
Mental Health	179,775	—	62,000	—	22,225	—	—	—	—	264,000
Educational and Cultural Services	609,324	—	—	—	—	—	—	—	—	609,324
Total	$1,253,355	$591,513	$1,177,868	$849,513	$622,829	$712,470	$739,065	$123,487	$422,074	$6,492,174
	% of non statewide funds ($5,238,819)	11%	22%	16%	12%	14%	14%	2%	8%	-
	% of State population	13%	20%	10%	15%	14%	12%	9%	8%	-

The discrepancies between the geographical distribution of ADPC programs/services funds and population must be considered within a broader context. For example, although the Mid-Coast area appears to be getting more than it's "fair" share of funds, this is a large rural area in which services are difficult (and costly) to deliver. A major problem area was Piscataquis/Hancock/Washington counties which included 9% of the population and received only 2% of Maine's categorical substance abuse funds in FY86.

It should also be noted that the discrepancies in the geographical distribution of funds are historical. The FY86 Progress Report represents a more detailed approach to retinement of identifying and reporting the content of the Maine substance abuse system based upon a relatively stable and consistent funding base that was established in 1981-1982. Thus, any funding changes brought about between 1982 and 1986 represented changes within existing funds.

In order to further improve the planning and needs assessment processes, local workshops were instituted by the ADPC. The workshops involved providers, consumers, and interested citizens as well as special needs groups. The initial regional workshops focused upon the program/service needs and priorities of adolescents/adults and urban/rural populations.[32] Subsequent special interest workshops focused

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[32]Alcoholism Program/Service Needs and Priorities Identified through the Regional Needs Assessment Workshops. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1984.

upon the elderly, Native Americans, children of alcoholics, cocaine use,[33] substance abuse in the workplace,[34] etc.

As a result of these many efforts, in FY85 the ADPC developed and submitted to the Maine State Legislature a series of 14 well-documented service/program priorities that addressed geographical disparities and the needs of special populations.[35] These were approved by the Legislature in FY86 for funding in FY 87/88. Table 3 presents these priorities showing the FY88 funding level and primary geographic service areas.

An analysis of table 3 shows that the new Premium Funds ($2.1 million) were utilized to address prevention, education, and treatment needs that were identified in the ADPC FY86 Progress Report and through the general and special needs population public workshops. The needs addressed through the new Premium Funds include:

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[33]Public Forum Document. The Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[34]See previous footnotes for special needs populations, addressed geographical disparities and the needs of special populations.[35] These were approved by the Legislature in FY86 for funding in FY87/88. Table 3 presents these priorities showing the FY88 funding level and primary geographic service areas

[35]Alcohol and Drug Abuse Planning Committee FY87 and FY88 Priorities Funded by the 112th Legislature of the State of Maine. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986 (see Appendix A).

Table 3

FY88 Distribution of New Premium Funds
as Approved by the Legislature

Program:	Statewide	York	Cumberland	Mid-Coast	Tri-County	Kennebec/ Somerset	Penobscot	Piscataquis Washington Hancock	Aroostook
				County					
1. Rural Adolescents	-	-	-	-	-	-	(Rural) $166,739	Hancock $166,739 Piscataquis $166,740 Washington $166,740	-
2. Woman's Halfway House	-	-	$172,200	-	-	-	-	-	-
3. County Jails	$ 37,500	-	-		Andros. $ 26,670 Oxford $ 47,040 Franklin $ 47,040	Kenn. $ 43,260	-	-	-
4. School Community Education	$287,620	-	-	-	-	-	-	-	-
5. DOC Correctional Facilities	-	-	-	Knox $ 20,508	-	Kenn. $ 6,300	Bangor $ 5,127 Charleston $ 5,127	Wash. $ 12,600	-
6. Crisis Unit	Aug. MH Inst. $250,000	-	-	-	-	-	-	-	-

Program:	Statewide	County: York	Cumberland	Mid-Coast	Tri-County	Kennebec/ Somerset	Penobscot	Piscataquis Washington Hancock	Aroostook
7. Rural Outpatient Services	$ 20,000	$ 30,000	-	Sagadahoc $ 15,000	Oxford $ 15,000 Franklin $ 15,000	Kennebec $ 30,000 Somerset $ 15,000	$ 30,000	-	$ 30,000
8. Elderly Training	$ 24,000	-	-	-	-	-	-	-	-
9. Correctional Center	-	-	$ 62,334	-	-	-	-	-	-
10. School/ Community Education	-	-	-	-	-	-	-	-	$ 48,733
11. Correctional Outpatient Services	$ 5,200	-	(Portland) $ 3,200	(Lewiston) $ 3,000	Kennebec $ 3,000 Somerset $ 1,500	Bangor $ 5,300	-	- -	(Houlton) $ 5,200
12. Detox. Unit	-	-	-	-	-	Augusta $ 55,125	-	-	-
13. MR Substance Abuser	$ 30,000	-	-	-	-	-	-	-	-
14. Post-Secondary Education	$ 14,378	-	-	-	-	-	-	-	-
15. DHS Adolescent Housing	-	-	$ 36,845	-	-	-	-	-	-
Total $2,120,565	$663,498	$30,000	$ 274,579	$35,508	$153,750	$154,185	$212,293	$512,819	$83,933

1. Rural Adolescents: This represents a major initiative in adolescent and family prevention, education, and treatment in Piscataquis, Washington, Hancock, and rural Penobscot counties. This was the most serious service and funding gap.
2. Women's Halfway House: This provides for a service in Southern and Central Maine that was previously obtainable out-of-state or in Bangor.
3. County Jails: Previously under/unserved populations of whom an estimated 80% were using, or under the influence of, substances at the time of the crime.
4. School/Community Education: Allows for expansion into underserved rural areas (Aroostook and Down East), follow-up of previously trained school/community teams, the training of coaches, the expansion of the resource library, as well as expanding the efforts in training school/community teams from throughout the State.
5. Corrections (Priorities #5,9 and 11): These priorities address major gaps in the treatment of the correctional population. Although this

is a high risk population, less than 50% of the population in need was served.

6. Mental Health/Mental Retardation (Priorities #3, 6, 8 and 13): These address major special needs populations including county jail inmates and their families, the dual-diagnosed (MH and alcoholism, MR and alcoholism) and the elderly. Note: The County Jail issue is jointly addressed with the Department of Corrections.

7. Rural Outpatient: Addresses the outpatient service needs of rural populations, especially in Tri-County, Kennebec/Somerset Counties, and Penobscot County as previously noted.

8. School/Community Education: Addresses the school/community education and adolescent treatment needs of Aroostook County.

9. Detoxification Unit: Provides detoxification and shelter services in Augusta.

10. Post-Secondary Education: Initiates a more systematic approach to addressing substance abuse problems in the VTI's, the University of Maine, and Maine colleges.

In general, the 14 Priorities identified by the ADPC and funded by the Maine State Legislature, addressed gaps in the

Maine substance abuse prevention, education, and treatment system identified through the revised needs assessment process.

Table 4 presents the FY88 geographical distribution of ADPC substance abuse funds. Although the primary goal of the ADPC was to utilize the new Premium Funds to address local needs, a secondary result was a more equitable distribution of ADPC funds.

It is clear that "equitable" funding is not necessarily synonomous with "equitable" services. For example, Cumberland County has a large number of high unit-cost services (e.g., residential rehabilitation), while Kennebec/Somerset Counties have a large number of low unit-cost services (e.g., outpatient services). Further, some areas of the State utilize significant portions of the statewide services provided by the Department of Educational and Cultural Services. Most important is the fact that although the Premium Fund allowed the ADPC to address inequities in the system, major gaps continue to exist.

Table 4

Geographic Distribution of ADPC Categorical Substance Abuse Prevention, Education, and Treatment Funding in FY88
(Combined Table 2 and Table 3)

	Geographic Area									
	Statewide	York	Cumberland	Mid-Coast	Tri-County	Kennebec/ Somerset	Penobscot	Piscataquis Washington Hancock	Aroostook	Total
Table 2	$1,253,355	$591,513	$1,177,868	$849,513	$622,829	$712,470	$739,065	$123,487	$422,074	$6,492,174
Table 3	663,498	30,000	274,579	35,508	153,750	154,185	212,293	512,819	83,933	2,120,565
Total	$1,916,853	$621,513	$1,452,447	$885,021	$776,579	$866,655	$951,358	$636,306	$506,007	$8,612,739
	% of non statewide funds ($6,695,886)	9%	22%	13%	12%	13%	14%	10%	8%	—
	% of State population	13%	20%	10%	15%	14%	12%	9%	8%	—

Gaps in Maine's Categorical Substance Abuse Services/Program System: 1988

The Alcohol and Drug Abuse Planning Committee has made significant strides in addressing geographical disparities in terms of funding/providing substance abuse prevention, education, and treatment services/programs. However, the major changes have occurred as they relate to relatively traditional populations and "known" needs. As the ADPC improved its needs assessment, planning, and reporting process, it became more evident that the needs of special needs groups are not being fully addressed. For example:

1. Native Americans: The Native American tribes and off-reservation groups report that substance abuse (primarily alcohol) affects up to 80% of the families. At the present time, the State provides approximately $132,000 for substance abuse prevention, education, and treatment programs/services for 7 Native American groups in Maine. At a minimum, they would require an additional $280,000 to meet the basic outpatient service requirements of their population.[36]

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[36] Native American Alcohol and Other Drug Abuse Service Needs. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1985.

2. County Jail Inmates: Our county jails serve over 30,000 individuals each year. Although an estimated 80% have problems with alcohol, only 4 of the 15 county jails have formal substance abuse prevention, education and treatment services that can be considered even basically adequate. An estimated $250,000 is required to establish basic substance abuse programs in our county jails.[37]

3. The Elderly: An estimated 17,000 Maine senior citizens have severe problems with alcohol. We are just beginning to address this problem. There is a need to establish substance abuse prevention, education, and treatment programs that are designed for Maine's elderly.[38]

4. The Workplace: Neither management nor labor appears to be aware of the extent of workplace impairment and methods required to prevent/treat the problem. There is a need to educate both groups so that they are able

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[37]Maine County Jails: A Survey of the Substance Abuse Treatment Needs of the Inmates. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[38]Public Forum Document. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

to identify the problem and refer the person for appropriate assistance.[39]

5. Our Schools: Without question, prevention starts when the child is able to understand the ideas and concepts we deal with. We need to introduce proven primary prevention/education programs at the pre-school level and continue them throughout the school years. As with the prevention of any disease, timing is of the essence.

6. Post Secondary School Programs: There is a need to expand upon current post secondary school initiatives, such as the inclusion of chemical dependency/use issues in pre-service teacher preparation courses, the provision of chemical free alternatives, etc.

7. Adolescents: There is a need to assess the current adolescent service system and develop a system that is balanced, represents a continuum of services, and is designed specifically for adolescents.[40]

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[39] A Survey of Private Sector Management and Labor Concerning The Impact of Workplace Alcohol and Illegal Drug Use/Abuse Upon Work Performance and the Value of Workplace Referral and Treatment Programs. Alcohol and Drug Abuse Planning Committee, Augusta, Maine, 1986.

[40] Policies for the Development of New and Expanded Substance Abuse Services in the State of Maine. Office of Alcoholism and Drug Abuse Prevention, Department of Human Services, Augusta, Maine, 1986.

8. Non-residential Alternatives: There is a need for non-residential alternatives to reduce inappropriate utilization of short-term residential rehabilitation beds.[41]

9. Homeless: There is a need for long-term supportive housing for the late stage alcoholics that are currently living on the streets of our major cities.[42]

10. OUI Offenders: We lack an appropriate program for the second and chronic offenders. There is a need for a more comprehensive OUI prevention/education program which includes informing the public, monitoring the courts, etc.[43]

11. Other Groups: Our island residents are underserved. How do we address what appear to be conflicts in tradition? Our "street persons" are at best underserved. How do we provide basic "lifesaving" services?

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[41]See footnote 40

[42]To Have a Home. Maine Task Force to Study Homelessness, 1986

[43]Drunk Driving is Everyone's Problem. OUI Committee Report, 1986

Overall, the ADPC has made great strides in addressing inequities in the Maine substance abuse prevention, education, and treatment system. There appears to be a more equal geographical balance in the more traditional services and funding. However, as the "knowledge" and attitudes of society change, it is evident that we are just beginning to respond to the special needs of many of Maine's sub-populations. Whereas the ADPC was able to systematically respond to the "knowledge" of the early 1980's, it has shown that it can move forward and lead in establishing new knowledge.

Summary

By statute, the Alcohol and Drug Abuse Planning Committee is required to submit to the Maine State Legislature an assessment of cost related to drug abuse in Maine and the geographical disparities in services and the needs of special populations.

Due to change in the attitudes and "knowledge" of the public, the results of reports/studies, etc., the "known" incidence of substance use/abuse has increased significantly. However, the results of reports/studies also suggest that our increased awareness may not be accompanied by an increase in the number of individuals who actually use/abuse drugs. Further, although all drugs present significant problems, alcohol remains the number one problem drug.

The costs related to substance use/abuse have increased significantly. In addition to inflation we must add the costs related to the needs of populations (e.g., Native Americans and the elderly) that were not included in the original 1982 estimates. Further, there has been a significant increase in costs associated with public service announcements, school program implementation, third party payments, etc. However, the categorical funding has not kept pace with our "known" increase in problems.

Since 1982, Maine's categorical funds for substance abuse prevention, education, and treatment have increased from $4.3 million to $8.2 million while the Federal funds have decreased

from $2.4 million to $1.9 million. However, approximately $1.3 million of the increase in State funding represents a more precise identification of the use of existing funds ($800,000) and the replacement of lost Federal funds ($500,000). Although the initial Premium Fund (1981) served as the basis of new initatives in the Departments of Corrections, Mental Health and Mental Retardation, and Educational and Cultural Services, the funding levels remained relatively consistent until the 112th Maine Legislature increased the Premium Fund, effective FY87.

In order to systematically identify service/program needs, address gaps in the geographical distribution of services, and document the need for additional substance abuse prevention, education, and treatment programs/services, the ADPC initiated a new needs assessment and planning process in 1983. Through the involvement of providers and consumers in local workshops, and working directly with special needs groups, the ADPC was able to identify and document the need for 14 substance abuse prevention, education, and treatment service/program priorities. These were approved for funding by the Maine State Legislature and will be fully implemented in FY88.

The 14 priorities address both the major gaps in services and geographical disparities in funds and services. However, it is evident that the needs of many of the special needs populations have not been met. These include the elderly, Native Americans, early school-age children, etc.

The ADPC has shown that it can systematically respond to "knowledge" as well as lead the way in developing new "knowledge" concerning substance abuse prevention, education, and treatment. It is also clear that we must expand and modify many of the traditional approaches, and introduce new approaches, if we are to address the needs of populations that are not served by our present system.