



Maine
CHILDREN'S
MENTAL
HEALTH
2006



**MENTAL HEALTH
DATA BOOK
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THIS BOOK WAS PREPARED BY:

G. DEAN CROCKER, MSW
*Executive Vice President
for Programs*

MARY MILAM, MPP
Project Coordinator

SHARON PIENIAK
Graphic Designer
www.bluecatmedia.com

MAINE CHILDREN’S ALLIANCE :: STAFF

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G. DEAN CROCKER, MSW <i>Executive Vice President for Programs</i>	PAULA COOKSON <i>Assistant Ombudsman</i>	

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Executive Summary

The Maine Children's Alliance is pleased to present this report of mental health indicators for Maine's children. The report is made possible by a grant from the Maine Health Access Foundation and by funding from the Maine Department of Health and Human Services. Children's Mental Health presents state-level indicators related to the mental well-being of Maine's children. These indicators are drawn from state survey data, as well as state-level data from the public systems in Maine that ensure that mental health services are available for children.

The state survey data include factors that have an impact on children's mental well-being. Some of these factors have protective qualities, such as peer relationships, while others pose a risk to mental well-being, such as poverty. Also included are indicators of parents' perceptions of their child's social and emotional functional abilities, and adolescents' reports of behavior that reflects their emotional well-being.

The data from the public systems build on work that began in the late 1990s in the areas of access to, utilization of, and expenditures for mental health services for children, as well as efforts to collect data on children involved with other state programs and data on outcomes for children.

Currently, state data are not available from all of the state's public systems or in all of the areas listed above. Recommendations at the end of the report offer suggestions for closing these gaps in the data by integrating and coordinating data collection among the public systems through which children receive mental health services.

The report also recognizes the role of the private healthcare system in serving the mental healthcare needs of Maine's children, as well as the link between children's mental and physical health, and recommends that any efforts to coordinate or integrate data should also consider these two aspects of children's mental health.

We have applied the same standards to the data in this report that we apply to the data in our *Maine KIDS COUNT* data book: data are valid, reliable, and consistent overtime. While current gaps in the data limit analysis, the data that are presented provide a starting point from which to begin to build a comprehensive set of children's mental health indicators.

It is our hope that this report will provide policymakers with the information they need to improve outcomes for Maine's children through the creation of policies that improve access to, utilization of, and expenditures for mental health services for children.



G. Dean Crocker
Project Director

Introduction

While most children are healthy and happy, have successful relationships with family and friends at home and at school, and are able to face life's ups and downs, there are some children for whom this is not the case. For these children, emotional or behavioral issues—often in response to factors outside of their control—frequently require mental health services offered in the public or the private systems that serve children. The public systems in Maine consist of the Departments of Health and Human Services, Education, Labor, and Corrections. The private system includes primary care physicians, pediatricians, mental health professionals, and others who serve children with mental health issues outside of the public systems.

BACKGROUND

In order to better understand the indicators presented in this report, it is necessary to have a basic understanding of the concepts of mental health¹ and mental illness.

For the purpose of this report, *mental health* is defined as “the state of successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.”² It is this state of mental well-being that is considered ideal.

Mental illness will refer collectively to all diagnosable mental disorders. “Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.”³ Mental illness also includes a component of time. Treatments for mental illnesses are intended to bring people as close to a healthy state of mental well-being as is possible for them.

Mental health problems are similar to mental illness but lack the intensity and duration of mental illness.⁴ Treatments for mental health problems are intended to prevent problems from becoming illnesses.

Given these definitions, mental health, mental illness, and mental health problems can be thought of as points along the same continuum.⁵ Over the course of our lives, most of us move along this continuum, settling for periods of time and to varying degrees between and around these points. Frequently, we are unaware of our mental health until a problem arises. As you might expect, as we move along this continuum, some or all of the components of good mental health may be affected. A mental health problem that is left unaddressed can become a mental disorder. Therefore, it is essential that children have access to comprehensive, integrated, quality services — before a mental health problem becomes an illness, and once a mental illness develops.

It is also important to understand that children's mental health is influenced by environmental factors. There are commonly identified environmental risk factors that negatively impact mental health, such as poverty and trauma, as well as protective factors in a child's environment that positively impact mental health, such as early, successful interactions with peers and the mental and emotional health of a child's mother.

1 Behavioral health and behavioral healthcare are frequently used interchangeably with mental health and mental healthcare or mental health services. The Substance Abuse and Mental Health Services Administration defines behavioral healthcare as the “continuum of services for individuals at risk of, or suffering from, mental, addictive, or other behavioral disorders.”

2 U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. www.surgeongeneral.gov

3 Ibid.

4 Ibid.

5 Ibid.

PURPOSE AND LONG-TERM OBJECTIVE

Currently, the public and private systems in which children receive mental health services lack a common set of indicators of children’s mental health, which creates a barrier to improving the access to, effectiveness of, and cost for mental health services for Maine’s children. The purpose of this project is to remove that barrier by identifying a common set of indicators. The long-term objective is to publish, on a regular basis, reports of mental health indicators that provide information about the individuals served, the services received, and the outcomes achieved.

The indicators presented in this report are a starting point from which to begin to build a complete set of data indicators, in order that service providers, advocates, and policymakers will know in which areas policies can improve, and are improving, outcomes for children through access to and delivery of effective mental health services for children.

CRITERIA FOR INDICATORS

At the start of the project, it was determined that the indicator data should meet certain criteria consistent with established standards. The criteria set for the indicator data are the same as those used for the *Maine KIDS COUNT* data book.

The indicator data should:

- Be from a reliable source
- Be consistent over time
- Be understandable to the public
- Reflect an important outcome or measure of children’s well-being
- Represent children of all ages
- Be available at the county-level

For the majority of the indicators, county-level data were not available and so only state-level data are used for this report.

“Data-based advocacy strategies that can generate public support for children and youth...depend on strengthening connections between raw data and final policies, between data and programs that advocate for and serve children, and ultimately, between data and the young people themselves.”

*Data-Based Advocacy:
Part of a Casey Foundation
International Learning
Exchange Series.
The Annie E. Casey
Foundation, 2003*

Child Well-being Indicators

RISK FACTORS

Research has identified a number of experiences that have negative impacts upon children and can increase the risk of developing emotional, social, and cognitive problems. Three of the experiences most often agreed upon, and for which data are regularly collected, are poverty, domestic violence, and child abuse.

Poverty

For young children, growing up in poverty is associated with a variety of negative outcomes, including lower cognitive abilities and school achievement, and impaired health and development. Research indicates that children living in poverty have a greater chance of being exposed to risk factors that may impair brain development and affect social and emotional development. These risk factors include inadequate nutrition, maternal depression, parental substance abuse, trauma and abuse, low quality child care, and exposure to environmental toxins.¹

Domestic Violence

The potential negative effects on children’s emotional, social, and cognitive development from exposure to domestic violence include “aggressive behavior and other conduct problems; depression and anxiety; lower levels of social competence and self-esteem; poor academic performance; and symptoms consistent with posttraumatic stress disorder, such as emotional numbing, increased arousal, and repeated focus on the violent event.”²

Child Abuse

According to the Surgeon General’s 1999 report on mental health, physical abuse is associated with insecure attachment and psychiatric disorders such as post-traumatic stress disorder, conduct disorder, attention deficit hyperactivity disorder, depression, and impaired social functioning with peers. Psychological maltreatment is associated with depression, conduct disorder, and delinquency, and can impair social and cognitive functioning in children.³

- 1 Child Trends DataBank. *Children in Poverty*. www.childtrendsdatabank.org
- 2 U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. www.surgeongeneral.gov
- 3 *The Future of Children*, Winter 1999. “Domestic Violence and Children.” www.futureofchildren.org

RISK FACTORS :: DEFINITIONS AND DATA SOURCES ON PAGE 32

	MAINE NUMBER	RATE OR PERCENT
POVERTY		
Children age 0-17 in poverty, 2003.....	39,896	14.3%
Children under age 5 in poverty, 2003	12,499	18.8%
DOMESTIC VIOLENCE		
Reported domestic assaults, 2004 (rate per 100,000 population)	5,188	397
CHILD ABUSE		
Children in the care or custody of the Department of Health and Human Services, December 2005 (rate per 1,000 children age 0-17)	2,350	8.2
Children who are victims of child abuse and neglect, 2005 (rate per 1,000 children age 0-17).....	3,260	11.4

Rates calculated using population estimates for July 1, 2003 from Maine DHHS, Office of Data, Research and Vital Statistics

PROTECTIVE FACTORS

In addition to the identification of negative experiences that impact children, research also has identified positive experiences that can have a protective influence on children’s emotional and developmental well-being. Two of these experiences for which data have been recently released are indicators related to peer relationships, and the mental and emotional health of children’s mothers.

Peer Relationships

The central task of young children’s play is to establish relationships with other children. In the book, *From Neurons to Neighborhoods*, editors Jack P. Shonkoff and Deborah Phillips point out that the success with which young children establish peer relationships “can affect whether they will walk pathways to competence or deviance as they move into the middle childhood and adolescent years. Learning to play nicely, make friends, and sustain friendships are not easy tasks, and children who do them well tend to have well-structured experiences with peer interactions starting in toddlerhood and preschool, and, in particular, opportunities to play with familiar and compatible peers.” They go on to point out that children who are rejected by their peers are at risk for “an array of subsequent problems ranging from conduct disorders to depression.”⁴

For school-age children, successful interactions with peers are equally important. Research has found that “participation in activities outside of school — such as sports teams, lessons, Scouts, religious groups, or Boys’ or Girls’ Clubs — after school or on the weekends can be an important part of their overall development and can provide enrichment and contribute to their social skills.”⁵

Mothers’ Mental and Emotional Health

The physical and emotional health of a child’s mother can affect her ability to care for her children and can influence the health and well-being of the family as a whole.⁶ The impact of treating depressed parents is not only good for parents but also has a beneficial impact on children. In the report on the STAR*D study of the impact of treating mothers’ depression, the researchers note that “children of depressed parents have high rates of anxiety, disruptive, and depressive disorders that begin early, often continue into adulthood, and are impairing.”⁷ The researchers found that when mothers’ depression was successfully treated, children with a diagnosis at the beginning of the study had a 33% remission rate and children without a diagnosis remained free of a psychiatric diagnosis.⁸

4 Jack P. Shonkoff and Debra A. Phillips (Eds.). *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, D.C.: National Academy Press, 2000).

5 U.S. Department of Health and Human Services. *The Health and Well-Being of Children: A Portrait of States and the Nation 2005*.

6 Ibid.

7 Journal of the American Medical Association. *Remissions in Maternal Depression and Child Psychopathology*. jama.ama-assn.org

8 Ibid.

PROTECTIVE FACTORS :: DEFINITIONS AND DATA SOURCES ON PAGE 32

	MAINE NUMBER	RATE OR PERCENT
PEER RELATIONSHIPS		
Children age 3-5 who attend nursery school, pre-school, or kindergarten, 2003 (as % of children age 3-5)	24,944	59.0%
Children age 6-17 who participate in activities outside of school, 2003 (as % of children age 6-17)	179,136	87.6%
MOTHERS’ MENTAL AND EMOTIONAL HEALTH		
Children whose mothers’ mental and emotional health is excellent, very good, or good, 2003 (as % of children age 0-17)	254,581	94.5%

PARENTS' PERCEPTIONS

When you want to know about a child, you ask the parents, because they are the adults who are most knowledgeable about their child.

Children's Functional Ability

A child's ability to function well with his family and friends and in his community is enhanced by good emotional and behavioral health. This ability to function well leads to satisfying social relationships at home and with peers, and leads to achievement of full academic potential. Any emotional or behavioral difficulties that children may have and that persist throughout a child's development, can lead to lifelong disabilities⁹ that diminish a child's ability to function well.

Parental Concerns

Parents are usually the first to notice when their children are having difficulties in managing their emotions, focusing on tasks, and/or controlling their behavior, which makes parents' concerns crucial to alerting doctors and obtaining mental health services.¹⁰

9 U.S. Department of Health and Human Services. *The Health and Well-Being of Children: A Portrait of States and the Nation 2005*

10 Ibid.

PARENTS' PERCEPTIONS :: DEFINITIONS AND DATA SOURCES ON PAGE 32

	MAINE NUMBER	RATE OR PERCENT
CHILDREN'S FUNCTIONAL ABILITY		
Children age 0-17 with emotional, developmental, or behavioral problems for which they need treatment or counseling, 2003 (as % of children age 0-17)	22,471	7.9%
Children age 3-17 who have moderate or severe difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people, 2003 (as % of children age 3-17) ..	28,825	11.7%
Children age 2-17 who have been told by a doctor that they have:		
ADD or ADHD, 2003 (as % of children age 2-17)	18,566	7.2%
Depression or anxiety, 2003 (as % of children age 2-17)	18,569	7.2%
Behavior or conduct problems, 2003 (as % of children age 2-17)	17,241	6.7%
PARENTAL CONCERNS		
Children age 0-5 whose parents have at least one concern about their child's learning, development, or behavior, 2003 (as % of children age 0-5)	26,957	33.3%
Children age 6-17 whose parents are concerned a lot about:		
How their child copes with stressful things, 2003 (as % of children age 6-17)	48,513	23.8%
Depression and anxiety, 2003 (as % of children age 6-17)	25,482	12.5%
Substance abuse, 2003 (as % of children age 6-17)	14,237	7.0%
Eating disorders, 2003 (as % of children age 6-17)	11,804	5.8%

Lella Gandini
(American early childhood educator and writer)

“All children have preparedness, potential, curiosity and interest in constructing their learning, in engaging in social interaction and in negotiating with everything the environment brings to them.”

ADOLESCENTS' REPORTS

As they grow older, adolescents are able to report on their own behavior, which gives us some insight into the state of their mental well-being.

Depression

Depression in children and adolescents has many clinical features similar to those in adults, such as being sad; losing interest in activities that used to please them; criticizing themselves and feeling that others are criticizing them; and feeling unloved, hopeless, and that life is not worth living, which may be accompanied by thoughts of suicide.¹¹

Suicide

Mood disorders, such as depression, increase the risk of suicide. Although suicide cannot be defined as a mental disorder, there is evidence that over 90 percent of children and adolescents who commit suicide have a mental disorder, making the suicidal behavior of children and adolescents a matter of serious concern for mental health professionals.¹²

Substance Abuse

Emotional and behavioral problems have been linked to alcohol use by adolescents, and illicit drug use has been linked to an increased risk of suicide in adolescents. Adolescents who use alcohol experience emotional and behavioral problems that include withdrawal symptoms, such as being unhappy, sad, or depressed; somatic symptoms, such as feeling overtired, having headaches, feeling nauseous or throwing up; social problems, such as not getting along with other kids; thought problems, such as not being able to get their mind off certain thoughts or doing things others think are strange; attention problems, such as having trouble concentrating, saying their school work is poor, or saying they act without stopping to think; and symptoms of anxiety or depression, such as deliberately trying to hurt or kill themselves or feeling that others are out to get them.¹³

Adolescents who use alcohol or illicit drugs non-medically, such as marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type drugs, are at a higher risk for suicide than adolescents who don't use alcohol or illicit drugs.¹⁴

11 U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. www.surgeongeneral.gov

12 Ibid.

13 Substance Abuse Mental Health Services Administration. March 2000. *Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems*. www.oas.samhsa.gov

14 Substance Abuse Mental Health Services Administration. July 2002. *NHSDA Report: Substance Use and the Risk of Suicide Among Youths*. www.oas.samhsa.gov

ADOLESCENTS' REPORTS :: DEFINITIONS AND DATA SOURCES ON PAGE 33

	PERCENT
DEPRESSION	
High school students reporting feeling so sad or hopeless every day for two weeks or more in a row that they stopped doing some usual activities, 2005	20.6%
SUICIDE	
High school students reporting at least one suicide attempt in the past year, 2005	6.4%
Middle school students reporting having ever attempted suicide, 2005	9.0%
SUBSTANCE ABUSE	
High school students reporting alcohol use within the past 30 days, 2005	43.0%
High school students reporting marijuana use within the past 30 days, 2005	22.2%

Public Systems Indicators

Children receive mental health services in a number of public systems. The Departments of Health and Human Services, Education, Labor, and Corrections all have offices, divisions, or programs that are responsible for ensuring that mental health services are available for children who need them.

In 1999, the Children's Mental Health Benchmarking Project began an effort to identify data sources for indicators of children's mental health. The intent of this nation-wide project was to identify children's mental health indicators that would allow stakeholders and policy-makers to develop standards for system performance. In addition, the data could be used to help evaluate the effectiveness of systems of care for children.

With funding for the project from the Annie E. Casey Foundation, the Center for Health Care Strategies, and the Robert Wood Johnson Foundation, Dougherty Management Associates began the process of identifying data sources for indicators of children's mental health in four areas that are frequently used to assess the performance of healthcare systems: access, utilization and availability, financial performance, and intersystem involvement.¹

1 ACCESS

How many children are receiving mental health services?

Access, which represents the number of individuals receiving services, is one of the measures most frequently collected and reported for both general and behavioral healthcare. However, as Dougherty Management Associates points out, there is no ideal or appropriate standard for access.

2 UTILIZATION

In which settings are children receiving mental health services?

Utilization refers to the appropriateness of the services received. Ideally, children should receive services in the most natural, least restrictive setting, for a time period that meets their needs.²

3 EXPENDITURES

What is the cost for mental health services for children receiving services?

Expenditures demonstrate the level of resources a system dedicates to children receiving services.

4 INTERSYSTEM INVOLVEMENT

In what other systems of care (such as juvenile justice, child protective services, or special education) are children who are receiving mental health services also involved?

One of the guiding philosophies emphasized in community-based systems of care is the "interagency collaboration among the systems that share responsibility for youths [and children] with emotional problems, such as education, child welfare, juvenile justice, public health, mental health, and substance abuse."³

In addition to the areas identified above, "OUTCOME" has been included because it has been identified in the research as an important indicator of the quality and effectiveness of mental healthcare.

5 OUTCOME

What is the status of children when they leave the system where they are receiving mental health services?

1 See Dougherty Management Associates website for more information on the benchmarking project at www.doughertymanagement.com

2 *The Future of Children*, Spring 1998. "Children and Managed Health Care." Available online at www.futureofchildren.org.

3 Ibid.

The Department of Health and Human Services is the largest of the State of Maine’s departments responsible for ensuring that mental health services are available for children. Within the Department, the Office of Child and Family Services has the responsibility of ensuring the availability of children’s mental health services and child welfare services. The Department enters into contracts with community agencies for a variety of mental health services for children in need of mental health and/or child protective services. The source of data for the Division of Children’s Behavioral Health Services is the Office of Integrated Systems Quality Improvement, which analyzes data from the Office of MaineCare Services. Data for the Division of Child Welfare Services are managed within the Division through the State’s automated child welfare information system.

Also within the Department is the Office of Substance Abuse, which has the responsibility of ensuring that substance abuse services are available for the residents of Maine, including children and adolescents. The Office enters into contracts with community providers in order that a variety of substance abuse treatment programs are available. All licensed substance abuse treatment facilities are required to report to the Office through the Treatment Data System.

It should be noted that within the Department of Health and Human Services, the Division of Licensing and Regulatory Services oversees the licensing and regulation of in-patient psychiatric hospitals. Currently, the Department is reviewing the data from hospitals for accuracy; therefore, the data for in-patient psychiatric hospital services are not included in this report.

Figure 1 shows the data that are available and where gaps exist in the data.

FIGURE 1

AVAILABLE DATA IN THE PUBLIC SYSTEMS		
PUBLIC SYSTEMS	ACCESS	UTILIZATION
Maine Department of Health and Human Services (DHHS), Office of Child and Family Services, Division of Children’s Behavioral Health Services	Unduplicated number of children age 0-20 with and without a serious emotional disturbance (SED) receiving mental health services	Unduplicated number of mental health services received by children age 0-20 with and without SED
Maine DHHS, Office of Child and Family Services, Division of Child Welfare Services		
Maine DHHS, Office of Substance Abuse	Unduplicated number of children age 0-20 with and without a secondary DSM-IV diagnosis using substance abuse treatment services	Number of primary substance abuse treatment services used by children age 0-20 with and without a secondary DSM-IV diagnosis
Maine Department of Education, Office of Special Services	Number of children age 3-21 receiving special education services for emotional disability	Number of children age 3-5 receiving special education services for emotional disability in a pre-school setting and number of children age 5-21 receiving special education services for emotional disability in a school-age setting
Maine Department of Labor, Bureau of Rehabilitation Services, Division of Vocational Rehabilitation		Number of vocational rehabilitation services received by children under age 20 with psychosocial or other mental impairments whose case has been closed
Maine Department of Corrections, Division of Juvenile Services		

FIGURE 2

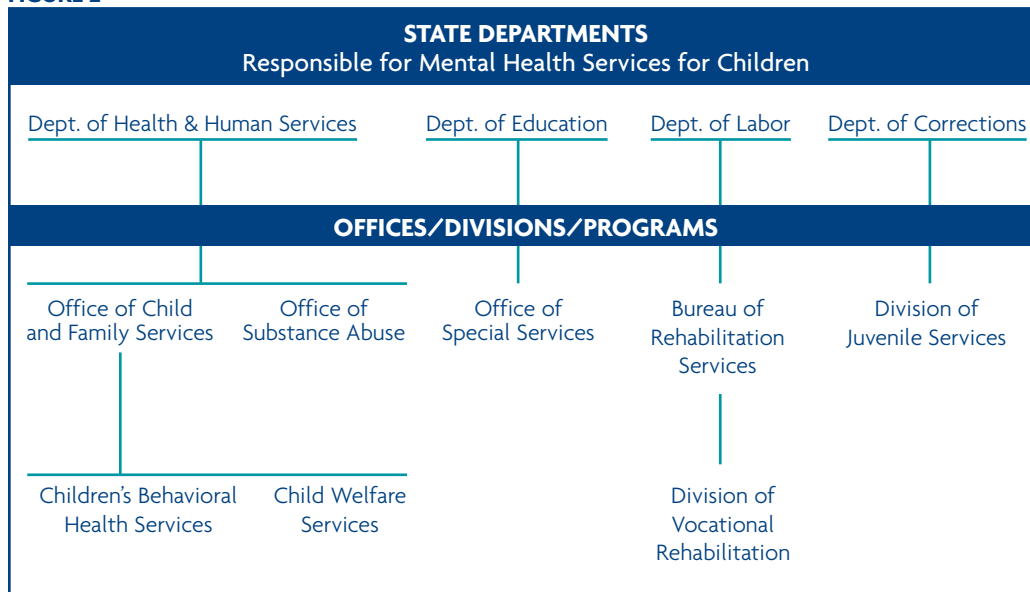


Figure 2 shows the organization of the public systems through which children receive mental health services.

EXPENDITURES

INTERSYSTEM INVOLVEMENT

OUTCOME

Expenditures for mental health services received by children age 0-20 with and without SED

Payer source for children age 0-20 with and without a secondary DSM-IV diagnosis using substance abuse treatment services

Unduplicated number of children age 12 and older referred for substance abuse evaluation by the Division of Juvenile Services or by a Network Identified School Contact

Discharge status of children age 0-20 with and without a secondary DSM-IV diagnosis who used substance abuse treatment services

Exit status of children age 3-21 who received special education services for emotional disability

Expenditures for children under age 20 with psychosocial or other mental impairments whose case has been closed

Closure status of children under age 20 with psychosocial or other mental impairments who received vocational rehabilitation services

The Office of Special Services of the Department of Education is responsible for ensuring that children with disabilities have access to special education and related services. Children identified as having a disability, including an emotional disability, are provided with the services necessary to meet their educational goals through local school administrative units. Data for the Office are managed within the Department.

The Division of Vocational Rehabilitation of the Department of Labor is responsible for ensuring that children in high school and beyond with disabilities, including emotional disabilities, have the vocational services they need to transition to the labor force. Data for the Division are managed within the Department.

The Division of Juvenile Services of the Department of Corrections is responsible for ensuring that juvenile offenders are provided with education, treatment for both physical and mental health, and other necessary services. Data for the Division are managed within the Department.

“The mental health treatment system is a dynamic array of services accessed by patients with different levels of disorder and severity, as well as different social and medical service needs...”

Mental Health: A Report of the Surgeon General.
U.S. Department of Health and Human Services, 1999

“Although historically mental health has been viewed through the lens of mental illness, (e.g. depression, schizophrenia, bipolar disease), we have come to recognize that good mental health is not simply the absence of illness but also the possession of skills necessary to cope with life’s challenges.”

The ABCs of Children’s Mental Health.
National Association of Elementary School Principals, 2002

Maine Department of Health and Human Services
 Office of Child and Family Services
DIVISION OF CHILDREN'S BEHAVIORAL HEALTH SERVICES

The Division of Children's Behavioral Health Services, located in the Office of Child and Family Services, Maine Department of Health and Human Services, has the responsibility of ensuring that mental health services are available for children. Its responsibility extends to those children age 0-5 who have developmental disabilities or severe developmental delays; for children and adolescents age 0-20 who have emotional or behavioral needs, including children with serious emotional disturbance (SED); and for children age 0-20 who have mental retardation, autism or pervasive developmental delay.

The Division enters into contracts with private, non-profit agencies that allow consumers a choice of services and agencies. The Division does not provide direct services but instead provides program oversight, contract monitoring, client enrollment, and quality improvement functions to the agencies with which it contracts for services.

The children included in this section of the report are children who are age 0-20 with and without SED, who are enrolled in MaineCare, and who received MaineCare-covered mental health services. Children with developmental delays, mental retardation, or autism are not included in this section of the report. The Division uses the same definition for SED as the federal government, except that benefits have been extended to children through age 20:

Pursuant to section 1912(c) of the Public Health Service Act "children with a serious emotional disturbance" are persons: (1) from birth up to age 18 and (2) who currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425.¹

Currently, some data are available in the areas of access, utilization, and expenditures. As mentioned above, there are no data included for children receiving in-patient psychiatric hospital services because these data are currently being reviewed by the Department.

Data are also unavailable regarding intersystem involvement and outcome. For children who receive MaineCare-covered mental health services, the data do not show in which other systems they are receiving services. Finally, we do not know the status of these children when they stop receiving mental health services. The recommendations at the end of the report offer strategies for addressing these gaps in the data.

¹ Substance Abuse Mental Health Services Administration, *Mental Health Dictionary*, Serious Emotional Disturbance.
www.mentalhealth.samhsa.gov

ACCESS :: DEFINITIONS AND DATA SOURCES ON PAGE 33

	STATE NUMBER	RATE OR PERCENT
Children receiving mental health services, SFY 2004 (rate per 1,000 children age 0-20)	17,922	52.5
	<i>as % of children receiving services</i>	
Children with SED	13,318	74.3%
Children without SED	4,604	25.7%

Rates calculated using population estimates for July 1, 2003 from Maine DHHS, Office of Data, Research and Vital Statistics

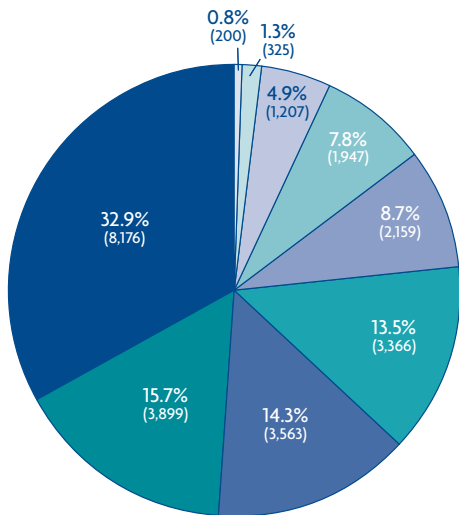
UTILIZATION :: DEFINITIONS AND DATA SOURCES ON PAGE 33

	STATE NUMBER	PERCENT
Mental health services received, SFY 2004	34,382	
	<i>as % of services received</i>	
Outpatient	10,328	30.0%
Targeted Case Management, including Assertive Community Treatment (ACT)	7,121	20.7%
Child and Family Community Support	4,470	13.0%
Medication Management (does not include the cost of medication)	4,395	12.8%
Residential	2,874	8.4%
Crisis Services	2,715	7.9%
Behavioral Health Services	1,765	5.1%
Crisis Residential	392	1.1%
Day Treatment	322	0.9%

MENTAL HEALTH SERVICES RECEIVED

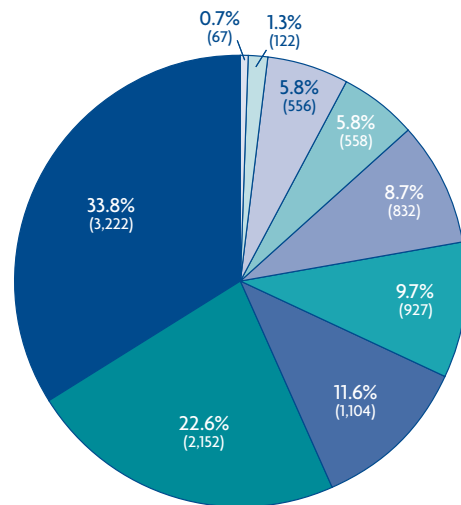
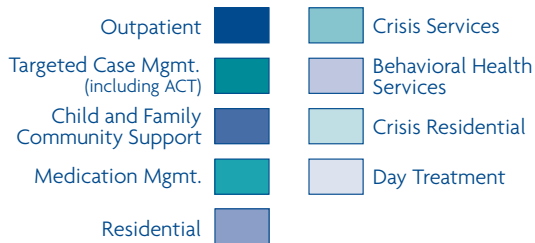
SFY 2004

TOTAL: 34,382



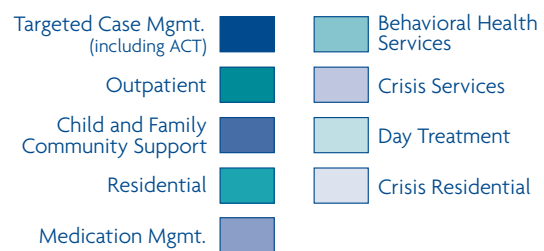
With SED

TOTAL: 24,842



Without SED

TOTAL: 9,540



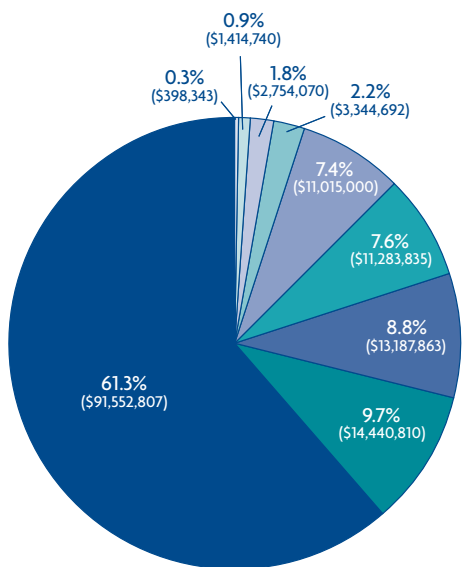
EXPENDITURES :: DEFINITIONS AND DATA SOURCES ON PAGE 34

	STATE NUMBER	PERCENT
Expenditures for mental health services received, SFY 2004	\$209,955,731	
		<i>as % of expenditures</i>
Residential	\$127,069,285	60.5%
Targeted Case Management, including Assertive Community Treatment (ACT)	\$24,950,839	11.9%
Behavioral Health Services	\$17,580,344	8.4%
Outpatient	\$16,299,487	7.8%
Child and Family Community Support	\$14,430,852	6.9%
Medication Management (does not include cost of medication)	\$4,042,284	1.9%
Crisis Services	\$3,282,555	1.6%
Crisis Residential	\$1,667,143	0.8%
Day Treatment	\$632,941	0.3%

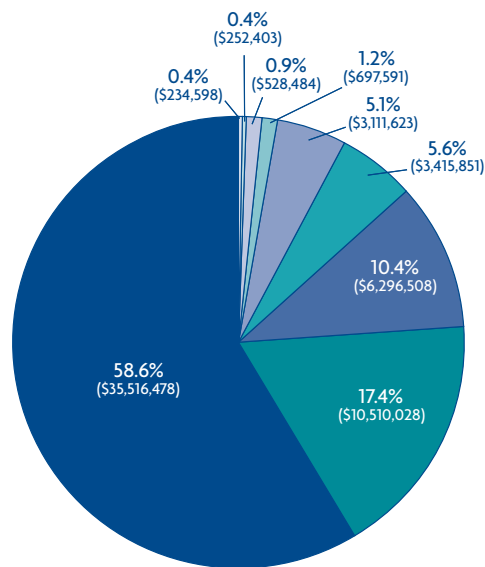
EXPENDITURES FOR MENTAL HEALTH SERVICES RECEIVED

SFY 2004

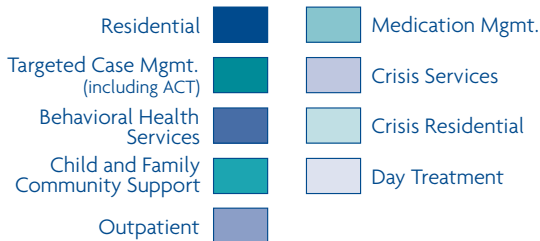
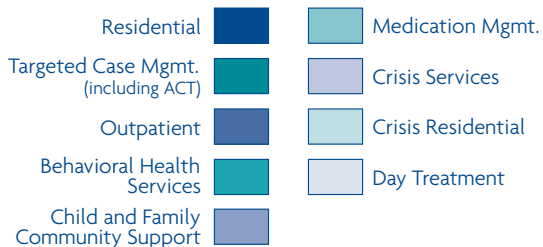
TOTAL: \$209,955,731



With SED
TOTAL: \$149,392,163



Without SED
TOTAL: \$60,563,566



Maine Department of Health and Human Services
 Office of Child and Family Services
DIVISION OF CHILD WELFARE SERVICES

The Division of Child Welfare Services, located in the Office of Child and Family Services, Maine Department of Health and Human Services, is the State’s child welfare agency for children who are in need of services, either as a result of child abuse and neglect or because of the risk of abuse or neglect. The Division also has the responsibility of ensuring that services are available for children who are in the care or custody of the Department as a result of a child abuse or neglect situation that necessitated the removal of the child from his or her family.

Currently, the Division collects data on children’s mental health through the State’s automated child welfare information system known as MACWIS. The MACWIS database functions as a case management tool, and is the electronic case file for children and families receiving child welfare services.

Information on children’s mental health is collected in accordance with federal reporting requirements. Data elements specific to mental health are demographic data that include:

- the child as having been clinically diagnosed as being “emotionally disturbed”
- actions associated with the child’s removal—child’s alcohol abuse; child’s drug abuse; child disability, including emotional disturbance; child’s behavior problem

However, this information is not captured in a way that is usable for this report.

Serious gaps exist in the data for the Division. There are no data for the unduplicated number of children in the Division receiving mental health services, the type of services received, the expenditures for those services, the other public systems in which children are involved, and the outcome at the time children leave the Division. Suggestions for addressing gaps in the data for the Division of Child Welfare Services are included in the Recommendations section at the end of this report.

“More than 80% of children in foster care have developmental, emotional, or behavioral problems. Mental health services are repeatedly identified as their number one health care need...”

*National Fact Sheet 2002.
 Child Welfare League
 of America*

Maine Department of Health and Human Services
OFFICE OF SUBSTANCE ABUSE

According to the website for the Maine Office of Substance Abuse,

“The Maine Office of Substance Abuse is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office provides leadership in substance abuse prevention, intervention, and treatment. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse, and dependency.”¹

The Office funds the Juvenile Treatment Network, a collaborative that includes the Department of Corrections and treatment providers statewide. The goal of the Network is “to expand the capacity of the state to provide substance abuse treatment to juveniles, and to enhance the continuum of care of juveniles.”² Services are provided through the Juvenile Corrections Substance Abuse Treatment Network program and the Substance Abuse Treatment Network for Adolescents program.

In the first program, juvenile offenders are screened for substance abuse issues upon initial contact with the juvenile justice system. Through the second program, adolescents are identified by Network trained schools as being at risk for alcohol or drug abuse before they become involved with the juvenile justice system.

The Office collects, maintains, and publishes data from a variety of sources. The source used for this report is the Office’s Treatment Data System, which collects client information without personal identifiers from substance abuse treatment agencies. The Treatment Data System is able to provide data in each of the focus areas for this report: access, utilization, expenditures, intersystem involvement, and outcome. Additional data that would be useful to policymakers is the expenditure level for substance abuse treatment services, as well as expanded data on intersystem involvement for children receiving services in other state programs.

1 Maine Department of Health and Human Services, Office of Substance Abuse website: www.maine.gov/dhhs/osa
 2 The Juvenile Treatment Network website: www.juveniletreatmentnetwork.org

INTERSYSTEM INVOLVEMENT :: DEFINITIONS AND DATA SOURCES ON PAGE 35

	STATE NUMBER	PERCENT
Adolescents age 12 and older referred for substance abuse screening, SFY 2004	1,367	
	<i>as % of total referred for screening</i>	
Adolescents referred for further evaluation.....	860	63%

ACCESS :: DEFINITIONS AND DATA SOURCES ON PAGE 34

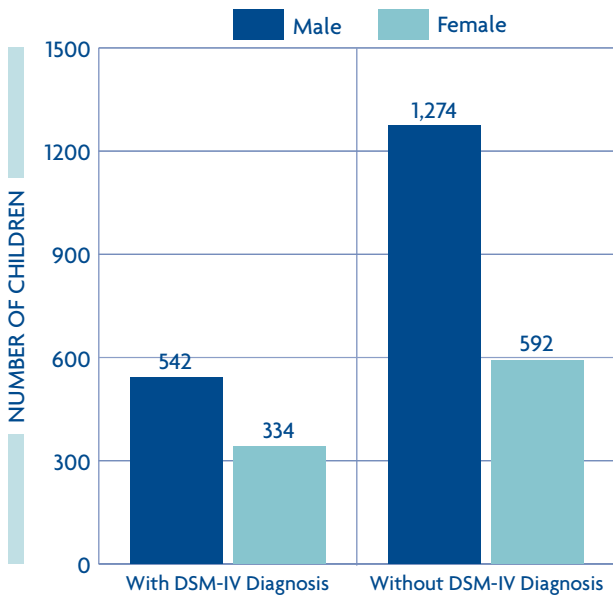
	STATE NUMBER	RATE OR PERCENT
Children and adolescents using substance abuse treatment services, SFY 2004 (rate per 1,000 children age 0-20)	2,742	8.03
	<i>as % of children using services</i>	
Children without a secondary DSM-IV diagnosis	1,866	68.1%
Children with a secondary DSM-IV diagnosis	876	31.9%

Rates calculated using population estimates for July 1, 2003 from Maine DHHS, Office of Data, Research and Vital Statistics

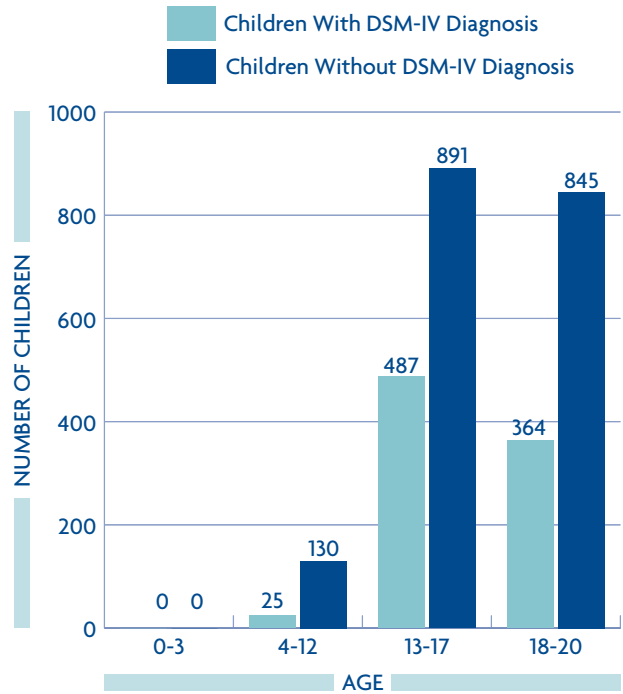
CHILDREN & ADOLESCENTS USING SUBSTANCE ABUSE TREATMENT SERVICES

SFY 2004

TOTAL: 2,742



By GENDER



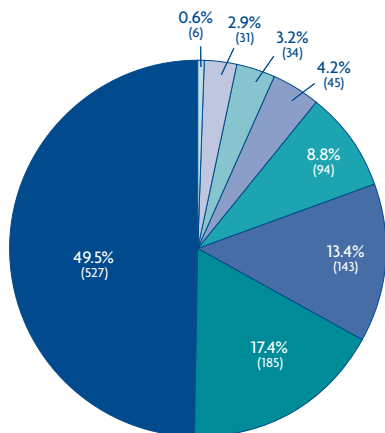
By AGE

UTILIZATION :: DEFINITIONS AND DATA SOURCES ON PAGE 35

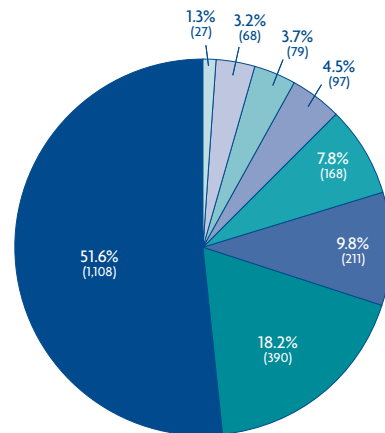
	STATE NUMBER	PERCENT
Primary substance abuse treatment services used, SFY 2004	3,219	
	<i>as % of services used</i>	
Adolescent Outpatient	1,635	50.8%
Non-intensive Outpatient	533	16.6%
Residential Services	353	11.0%
Evaluation	245	7.6%
Adolescent Intensive Outpatient	191	5.9%
Intensive Outpatient	113	3.5%
Methadone Treatment	110	3.4%
Hospital Inpatient	33	1.0%
Missing	6	0.2%
Children and adolescents discharged from substance abuse treatment services, SFY 2004	2,870	
	<i>as % of children discharged</i>	
Children who used crisis intervention services during treatment	368	12.8%
Children who used mental health services assistance during treatment	341	11.9%
Children who received a referral to a mental health professional at discharge	258	9.0%

PRIMARY SUBSTANCE ABUSE TREATMENT SERVICES USED BY CHILDREN & ADOLESCENTS

SFY 2004 TOTAL: 3,219



With a DSM-IV Diagnosis
TOTAL: 1,065



Without a DSM-IV Diagnosis
TOTAL: 2,148

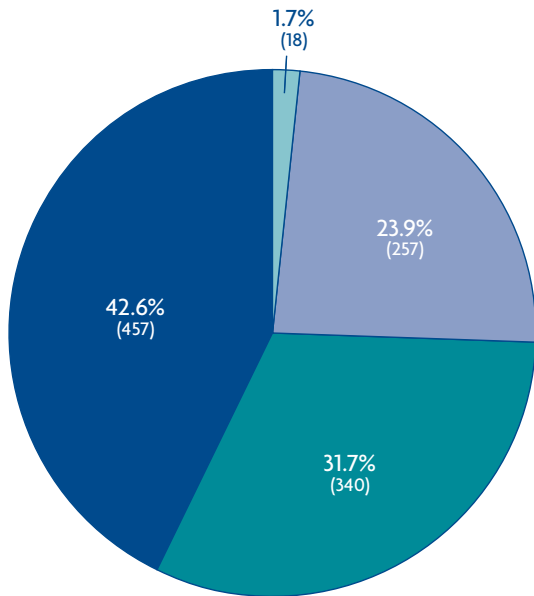


EXPENDITURES :: DEFINITIONS AND DATA SOURCES ON PAGE 35

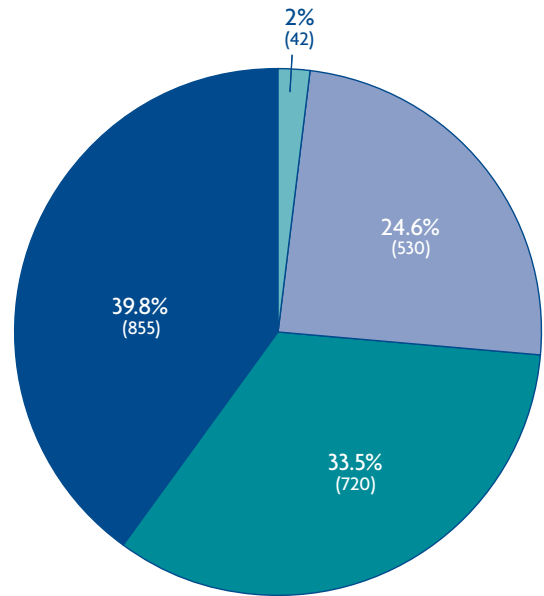
	STATE NUMBER	PERCENT
Primary substance abuse treatment services used, SFY 2004	3,219	
	<i>as % of services used</i>	
Department of Health and Human Services	1,312	40.8%
Other	977	30.3%
Office of Substance Abuse.....	870	27.0%
Department of Corrections.....	60	1.9%

**PAYER SOURCE FOR SUBSTANCE ABUSE TREATMENT SERVICES
USED BY CHILDREN & ADOLESCENTS**

SFY 2004 TOTAL: 3,219



With a DSM-IV Diagnosis
TOTAL: 1,072



Without a DSM-IV Diagnosis
TOTAL: 2,147

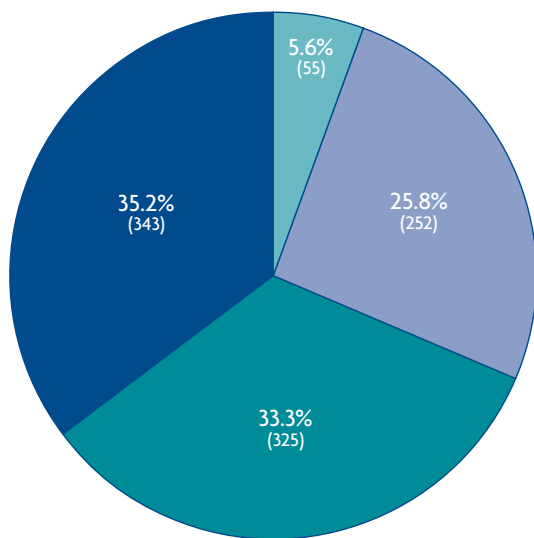


OUTCOME :: DEFINITIONS AND DATA SOURCES ON PAGE 35

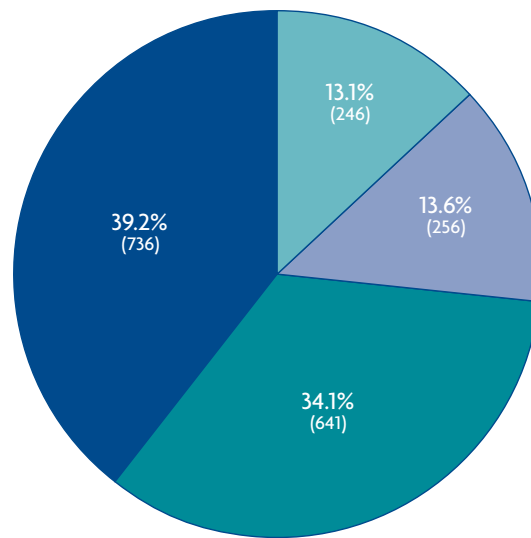
	STATE NUMBER	PERCENT
Children and adolescents with a discharge status from substance abuse treatment services, SFY 2004	2,870	
	<i>as % of children discharged</i>	
Completed Treatment	1,061	37.0%
Did Not Complete Treatment	984	34.3%
Other	498	17.3%
Evaluation Only	311	10.8%
Unknown	16	0.6%

CHILDREN'S & ADOLESCENT'S DISCHARGE STATUS FROM SUBSTANCE ABUSE TREATMENT SERVICES

SFY 2004 TOTAL: 2,870



With a DSM-IV Diagnosis
TOTAL: 975



Without a DSM-IV Diagnosis
TOTAL: 1,879



Maine Department of Education
OFFICE OF SPECIAL SERVICES

The Office of Special Services within the Maine Department of Education is responsible for ensuring that children with disabilities have access to education. Working within federal and state laws and regulations, the Department ensures, through school administrative units, that children with disabilities receive the services identified in their Individual Education Plans (IEP) in order to meet their educational goals and be prepared for post-secondary education, employment, and independent living.

Within the Department, the Office of Special Services oversees special education services to children age 0-21 who have been evaluated and have been found to have at least one of fourteen defined disabilities. These are autism, deaf-blindness, deafness, emotional disability, hearing impairment, mental retardation, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech and language impairment, developmental delay, traumatic brain injury, or visual impairment including blindness.

For the purposes of this report, only data for students age 3-21 with emotional disability will be reported. According to *Maine Special Education Regulations*,¹

“A student with an emotional disability has a condition which exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects the student’s educational performance:

- A. An inability to learn that cannot be explained by intellectual, sensory, or health factors
- B. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers
- C. Inappropriate types of behaviors or feelings under normal circumstances
- D. A general pervasive mood of unhappiness or depression
- E. A tendency to develop physical symptoms or fears associated with personal or school problems

The term includes schizophrenia. The term does not apply to students who are “socially maladjusted,” unless it is determined that they have an emotional disability.”

Currently, the Department is able to provide data in the areas of access, utilization, and outcome but is not able to provide data for expenditures or intersystem involvement. The recommendations at the end of the report provide a suggestion that MaineCare-eligible children receiving education services be identified as such in the MaineCare data.

¹ Maine Department of Education. (11/1/99). *Maine Special Education Regulations*, Chapter 101, Section 3.5, pgs. 10-11. www.maine.gov/education

“Unlike some other educational disabilities, emotional and behavioral disorders are not necessarily lifelong conditions.”

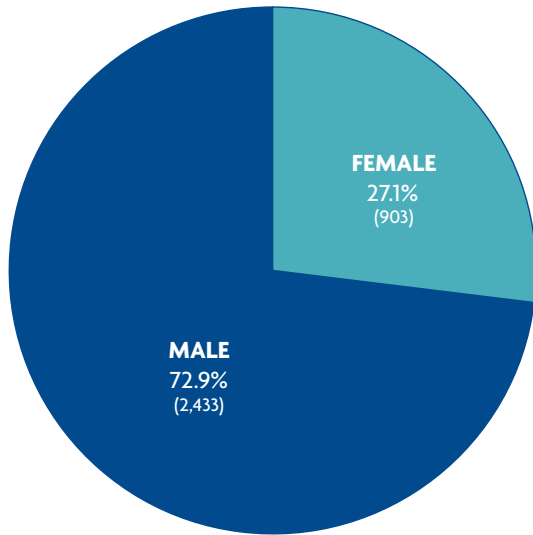
Behavior Disorders/Emotional Disturbance. Council for Exceptional Children, 2005

ACCESS :: DEFINITIONS AND DATA SOURCES ON PAGE 36

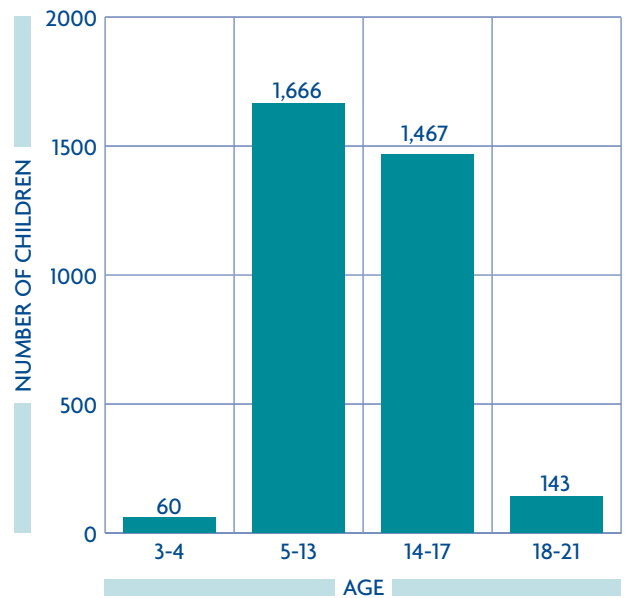
	STATE NUMBER	PERCENT
Children age 3-21 receiving special education services, December 2004	37,573	18.4%
<i>as % of regular education enrollment</i>		
Children age 3-21 receiving special education services for emotional disability, December 2004	3,336	8.9%
<i>as % of children receiving special education services</i>		

CHILDREN RECEIVING SPECIAL EDUCATION SERVICES FOR EMOTIONAL DISABILITY

DECEMBER 2004 TOTAL: 3,336



By GENDER



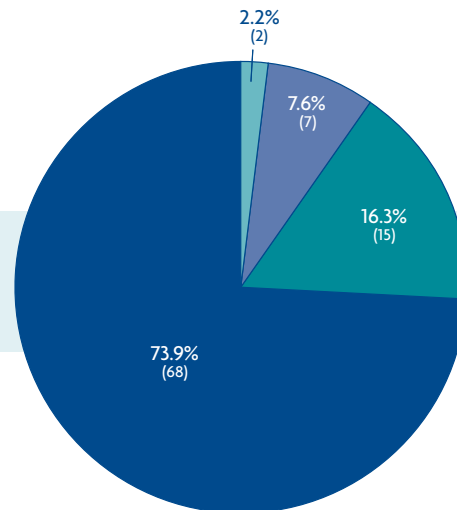
By AGE

UTILIZATION :: DEFINITIONS AND DATA SOURCES ON PAGE 36

	STATE NUMBER	PERCENT
Children age 3-5 receiving special education services for emotional disability in a preschool setting, December 2004	63	
	<i>as % of children receiving services</i>	
Early Childhood Setting	24	38.1%
Early Childhood Special Education Setting	23	36.5%
Part-time Early Childhood/Part-time Early Childhood Special Education	7	11.1%
Separate School	5	7.9%
Home	4	6.3%
Residential Facility	0	0%
Children age 5-21 receiving special education services for emotional disability in a school-age setting, December 2004	3,273	
	<i>as % of children receiving services</i>	
Regular Class Placement	1,165	35.6%
Resource Room Placement	887	27.1%
Self-contained Placement	753	23.0%
Private Separate Day School Placement	225	6.9%
Private Residential Placement	107	3.3%
Public Separate Day School Placement	107	3.3%
Homebound or Hospital Placement	26	0.8%
Public Residential Placement	3	0.1%

“There is always one moment in childhood when the door opens and lets the future in.”

Deepak Chopra



Age 5-13

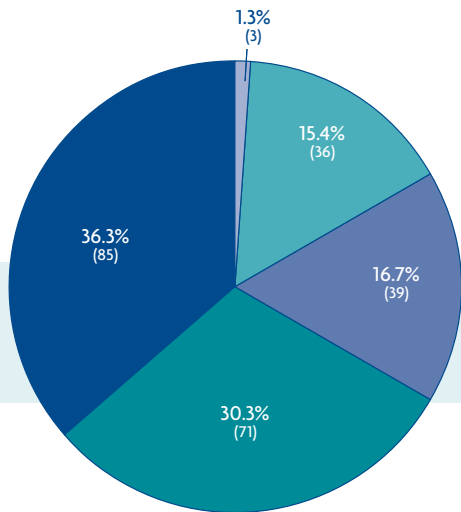
TOTAL: 92



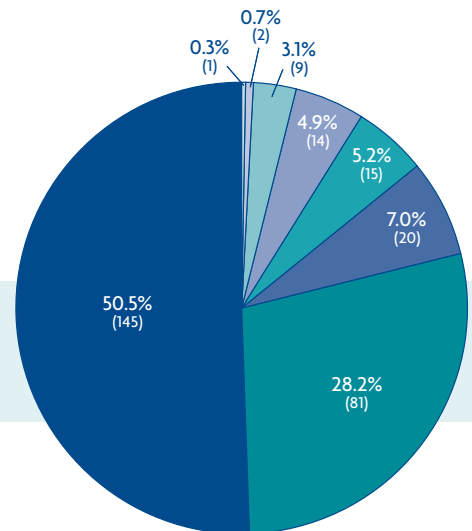
OUTCOME :: DEFINITIONS AND DATA SOURCES ON PAGE 36

	STATE NUMBER	PERCENT
<i>as % of children receiving services for emotional disability</i>		
Children age 3-21 with an exit status from special education services for emotional disability, December 2004	613	18.4%
<i>as % of children with emotional disability exiting special education</i>		
Exited to Regular Education	167	27.2%
Dropped Out	152	24.8%
Graduation with Diploma	148	24.1%
Moved, Not Known to be Continuing	74	12.1%
Status Unknown	58	9.5%
Graduation Through Certificate/Fulfillment of I.E.P Requirement	9	1.5%
Reached Maximum Age	2	0.3%
Parents Refuse Services	2	0.3%
Deceased	1	0.2%

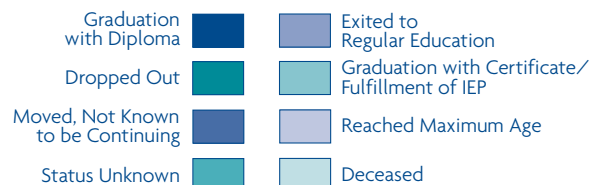
**EXIT STATUS OF CHILDREN WHO RECEIVED
SPECIAL EDUCATION SERVICES FOR EMOTIONAL DISABILITY**
DECEMBER 2004 TOTAL: 613



Age 14-17
TOTAL: 234



Age 18-21
TOTAL: 287



Maine Department of Labor
 Bureau of Rehabilitation Services
DIVISION OF VOCATIONAL REHABILITATION

The Division of Vocational Rehabilitation is a program within the Bureau of Rehabilitation Services in the Maine Department of Labor. The purpose of the Division is to assist “eligible individuals with physical or mental disabilities to prepare for and achieve an employment outcome.”¹ Individuals are eligible for services if they have a physical or mental impairment that is an obstacle to obtaining employment and that requires vocational rehabilitation services to prepare for, secure, retain, or regain employment.

Counselors for the Division work with individuals to develop an individualized plan for employment (IPE) and provide assistance in obtaining services, including some mental health services, as indicated in the plan. The goal of this work is for the individual to obtain full- or part-time employment in a position in a typical employment setting in which they interact with fellow employees to the same extent as non-disabled individuals.

Counselors within the Division also work with the Department of Education in developing individualized education plans for students eligible for vocational rehabilitation services. As part of the transition process of the student from school to employment, the Division must develop an individualized employment plan before the student leaves the school setting.

Data for the Division are maintained by the Department of Labor. The data for this section of the report are based on the outcome of a case at the time the case is closed. These data include children with psychosocial or other mental impairments who at the time they applied to the Division for services were 20 or younger. Children with cognitive disabilities, such as mental retardation or autism, are not included in these data. For this report, data are not available on intersystem involvement.

¹ Maine Department of Labor, Division of Vocational Rehabilitation, Policy Manual.

UTILIZATION :: DEFINITIONS AND DATA SOURCES ON INSIDE BACK COVER

	STATE NUMBER	RATE OR PERCENT
Vocational rehabilitation services received by children with closed cases, FFY 2005	532	
		<i>as % of total</i>
Job Search Assistance, Job Placement Assistance	105	19.7%
Occupational/Vocational Training, On-the-Job Training, Basic Academic Remedial or Literacy Training, Miscellaneous Training	85	16.0%
On-the-Job Supports	77	14.5%
Other Services	56	10.5%
Assessment	50	9.4%
Vocational Rehabilitation and Counseling Guidance	49	9.2%
Transportation Services	36	6.8%
Maintenance	23	4.3%
Diagnosis and Treatment of Impairments	19	3.6%
College or University Training	15	2.8%
Technical Assistance Services	10	1.9%
Job Readiness Training	6	1.1%
Rehabilitative Technology	1	0.2%

OUTCOME :: DEFINITIONS AND DATA SOURCES ON INSIDE BACK COVER

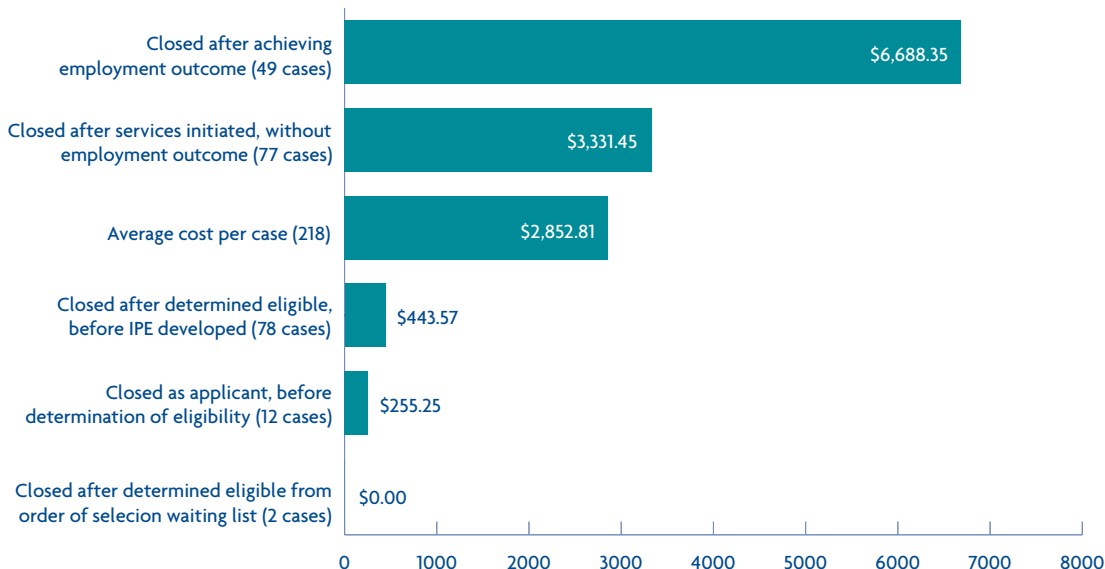
	STATE NUMBER	RATE OR PERCENT
Children age 20 or younger with psychosocial or other mental impairments whose case has been closed, FFY 2005	218	
		<i>as % of total</i>
Closed after determined eligible, before IPE developed	78	35.8%
Closed after services initiated, without employment outcome	77	35.3%
Closed after achieving an employment outcome	49	22.5%
Closed as applicant, before determination of eligibility	12	5.5%
Closed after determined eligible from order of selection waiting list	2	0.9%

EXPENDITURES :: DEFINITIONS AND DATA SOURCES ON INSIDE BACK COVER

	STATE NUMBER	RATE OR PERCENT
Expenditures for vocational rehabilitation services for closed cases, FFY 2005	\$621,912.43	
		<i>as % of total</i>
Closed after achieving an employment outcome	\$327,729.15	52.7%
Closed after services initiated, without employment outcome	\$256,521.65	41.2%
Closed after determined eligible, before IPE developed	\$34,598.63	5.6%
Closed as applicant, before determination of eligibility	\$3,063.00	0.5%
Closed after determined eligible from order of selection waiting list	\$0.00	0.0%

AVERAGE COST PER CASE FOR CLOSED CASES

FFY 2005 TOTAL: \$621,912.43



**Maine Department of Corrections
DIVISION OF JUVENILE SERVICES**

The Division of Juvenile Services is located in the Department of Corrections. The mission of the Division is “to promote public safety by ensuring that juvenile offenders are provided with education, treatment and other services that teach skills and competencies; strengthen prosocial behaviors and require accountability to victims and communities.”¹

As part of its mission to provide treatment and services to youth who are involved with the Division of Juvenile Services, the Department ensures the provision of mental health services to youth whether they are under supervision in the community or in one of the two detention facilities. Youth who are involved with the Division are screened and evaluated for mental health issues and, if necessary, referred for appropriate treatment.

For youth who remain under supervision in the community, mental health coordinators oversee the coordination of mental health services received through contracted community-based service providers. Youth in either of the two detention facilities receive mental health services identified in their individualized intervention plans, which are developed based on a comprehensive mental health assessment upon intake.

In addition to screening and evaluating for mental health issues, the Division in cooperation with the Office of Substance Abuse provides youth with substance abuse screening and referrals to treatment providers.

Currently, the data collected on youth involved with the Division of Juvenile Services are not available in the focus areas of this report: access, utilization, expenditures, intersystem involvement, and outcome. There are no data regarding the number of children receiving mental health services, the types of services being provided, the expenditures for those services, the number of children involved in other public systems, or outcome data for children leaving juvenile justice services. The Division is in the process of implementing national standards with their service contractors, which in the future should produce outcome data. The recommendations at the end of the report provide a suggestion that MaineCare-eligible children receiving juvenile justice services be identified as such in the MaineCare data.

¹ Maine Department of Corrections, Division of Juvenile Services website: www.maine.gov/corrections

“Of the overall youth population [in the Mountain View Youth Development Center], 85 percent have at least one legitimate mental health issue....”

Mountain View Superintendent Eric Hansen as quoted in the Bangor Daily News, Saturday, June 24, 2006

Private System

In addition to the public systems through which children receive mental health services, children also receive mental health services through the private system of primary care physicians, mental health professionals, other professionals, and hospitals. Mental health services received through the private system are primarily funded through private health insurance. The following are two important issues related to data and the private healthcare system.

The first issue is the integration of public and private healthcare data. The two systems use different codes for services, and the private system covers a narrower range of services than do the public systems. Also, the private system does not produce outcome data, which is an important indicator of the quality and effectiveness of mental healthcare. Currently, there is no agreement for uniformity between the information provided by the public and private healthcare systems. Uniformity between the systems would provide a more comprehensive picture of children's mental health.

The second issue is the development of data linking physical and mental healthcare. Available research about the degree to which mental illness increases the risk of other health conditions concludes that there is a clearly elevated risk that an adult with a serious mental illness, such as schizophrenia, will have other health problems.¹ The Department of Health and Human Services is currently undertaking research to determine the degree to which the presence of mental illness in children increases their risk of other health-related conditions.

There appears to be a growing consensus that physical and mental health services should be integrated. The Department's research on the link between physical and mental health, and similar research available nationally, should help to inform public policy discussions.

The recommendations at the end of this report suggest that the best long-term solution to integrating public and private healthcare data and linking physical and mental health services is one uniform data system.

¹ World Federation for Mental Health. *The Relationship Between Physical and Mental Health: Co-Occurring Disorders*. 2004. www.wfmh.org

Report of the Surgeon General's Conference on Mental Health: A National Action Agenda.
U.S. Department of Health and Human Services, 2000

"We must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well-being."

Recommendations

In each of the preceding sections dealing with data from specific state systems, such as children's behavioral health or child welfare, we have identified gaps in the data. Figure 2 on pages 10 and 11 shows where the data are available and where these gaps exist in the data. The first three recommendations focus on how the transition to a new managed care system by the State could be used to address those gaps.

DEVELOPMENT OF A MANAGED CARE SYSTEM

1. The Department of Health and Human Services should use the development of a managed care system for behavioral health services to address gaps and inconsistencies in public and private data about behavioral health care.

The transition of MaineCare's behavioral health services to managed care offers an opportunity to address some of the gaps identified in the sections dealing with specific state programs and their data needs. The Office of Integrated Services Quality Improvement is defining the data needs in the Department of Health and Human Services Request for Proposal (to be released in late 2006 or in 2007) for a managed care organization. The Department can and should use this opportunity to combine MaineCare reporting requirements, and address gaps in behavioral health data and program and licensing requirements, in a single set of data elements to reduce and simplify reporting for provider agencies.

Managed care also offers opportunities to:

- Provide uniform data about services provided by several systems for which program-specific information is currently limited or non-existent;
- Provide integrated data about the extent to which children and their families are served in multiple programs of state government;
- Establish uniformity in demographic data collected about recipients, consistent with research and management needs of state programs; and
- Bring uniformity to public and private reporting requirements.

SUB-POPULATION IDENTIFICATION

2. The Department of Health and Human Services, in its development of the Request for Proposals for a managed care organization, should require the organization to provide comprehensive demographic and services data for sub-populations, such as children receiving child welfare, juvenile justice, or education services. Children receiving child welfare services are almost entirely MaineCare eligible, and children receiving juvenile justice and education services include a substantial portion of children who are MaineCare eligible. Neither the child welfare data system, the juvenile justice system, the education system, nor the MaineCare data system currently offer comprehensive information about children with mental healthcare needs, the services they receive, or the outcomes achieved.
3. The design of data requirements for a managed care organization should recognize that managed care information must complement data collected in other data systems. The result will be comprehensive demographic, service, and outcome information. This information will inform policy-makers about the services provided and the outcomes achieved for children in these systems.

INTEGRATED DATA SYSTEMS

4. The Maine Children's Alliance recommends that the service and provider codes used by the public behavioral health managed care system be used by private health insurance carriers. An alternative may be to develop a data conversion process that translates private healthcare codes into public system codes. Either approach will involve additional work.

The actions necessary to integrate data from public and private systems will require cooperation and collaboration between public and private systems. Private health insurance carriers will have additional work associated with the revision of provider and service codes within the private system. As Maine recognized in the establishment of the Maine Health Data Organization, a clear mandate may be necessary to ensure that data has the same meaning across systems.

5. We recommend that there be one integrated system for physical and mental health data.

This recommendation goes further than the suggestion that data provided by public and private systems be comparable. Several public processes organized over the last three years to provide input about the development of an integrated Department of Health and Human Services have made this recommendation, and we believe it to be sound public policy.

As Maine moves forward to improve integration of physical and mental healthcare, our fragmented and incomplete data systems will become an even more significant barrier to improved access, accountability and integration. Development of an integrated data system should begin now to support the demands of an integrated physical health and mental healthcare system as it develops over the next five to ten years. In order for this to happen, the Executive and Legislative Branches of state government and the Commissioner of the Department of Health and Human Services, in collaboration with commissioners of other state agencies, will need to agree to make it a priority.

Walter P. Bailey.
September 2003.
*Integrated State
Data Systems*

“Integration of data from multiple programs and sources can take the policy-maker far beyond the limited knowledge that originates with data supplied for a single program, both in understanding the underlying problems of the program participants and in evaluating the impact of the services that the program provides.”

Definitions & Data Sources

CHILD WELL-BEING INDICATORS

RISK FACTORS

Children Age 0-17 in Poverty, 2003 is the estimated number and percent of children age 0-17 living in poverty. These estimates are modeled from combined census estimates, current population surveys, and other administrative and economic data. In 2003, the poverty threshold for a typical family of three was \$14,680. SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, 2003. www.census.gov

Children Under Age 5 in Poverty, 2003 is the estimated number and percent of children under age 5 living in poverty. These estimates are modeled from combined census estimates, current population surveys, and other administrative and economic data. In 2003, the poverty threshold for a typical family of three was \$14,680. SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, 2003. www.census.gov

Reported Domestic Assaults, 2004 is the number of assaults reported to the police that were perpetrated by family or household members who are or were married or living together in a romantic relationship, natural parents of the same child (whether or not the couple ever lived together) or other adult family members related by blood or marriage. These are not unduplicated counts and may include numerous assaults affecting the same individuals. Rate per 100,000 population. SOURCE: Maine Department of Public Safety, Uniform Crime Reports, 2004. www.state.gov

Children in the Care or Custody of the Dept. of Health and Human Services, December 2005 is the number of children ordered into the Department of Health and Human Services care or custody as a result of a child protection hearing where the child is found to be in jeopardy, a juvenile hearing where it would be contrary to the child's health and welfare to remain in the care or custody of his parents, or a divorce and/or custody hearing where neither parent has been found able to provide a home in the best interest of the child. Rate per 1,000 children age 0-17. SOURCE: Maine Department of Health and Human Services, Office of Child and Family Services, Division of Child Welfare Services.

Children Who Are Victims of Child Abuse and Neglect, 2005 is the number of individual victims of child abuse and neglect in calendar year 2005 for whom an assessment of their situation led to a finding of a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation or essential needs or lack of protection from these by a person responsible for the child (22 M.R.S.A. §4002). Rate per 1,000 children age 0-17. SOURCE: Maine Department of Health and Human Services, Office of Child and Family Services, Division of Child Welfare Services.

PROTECTIVE FACTORS

Children Age 3-5 Who Attend Nursery School, Pre-School, or Kindergarten, 2003 is the estimated number and percent of children age 3-5 whose parents reported that their children attended preschool, nursery school, Head Start, Early Head Start, or kindergarten in the month prior to responding to the National Survey of Children's Health, 2003. SOURCE: *The Health and Well-Being of Children: A Portrait of States and the Nation 2005*.

Children Age 6-17 Who Participate in Activities Outside of School, 2003 is the estimated number and percent of children aged 6-17 whose parents reported that their children had participated in sports teams, lessons, Scouts, religious groups, or Boys' or Girls' Clubs outside of school in the year prior to responding to the National Survey of Children's Health, 2003. SOURCE: *The Health and Well-Being of Children: A Portrait of States and the Nation 2005*.

Children Whose Mothers' Mental and Emotional Health is Excellent, Very Good, or Good, 2003 is the estimated number and percent of children age 0-17 whose mothers reported that their mental and emotional health is excellent, very good, or good. SOURCE: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

PARENTS' PERCEPTIONS

Children Age 0-17 With Emotional, Developmental, or Behavioral Problems for Which They Need Treatment or Counseling, 2003 is the estimated number and percent of children age 0-17 whose parents report that their child's emotional, developmental, or behavioral problem has lasted or is expected to last more than 12 months, and for which their child receives treatment or counseling. SOURCE: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

Children Age 3-17 Who Have Moderate or Severe Difficulties in One or More of the Following Areas: Emotions, Concentration, Behavior, or Being Able to Get Along with Other People, 2003 is the estimated number and percent of children age 3-17 whose parents describe their child as having moderate or severe difficulties in at least one of the following areas: emotions, concentration, behavior, or being able to get along with other people. SOURCE: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

Children Age 2-17 Who Have Been Told by a Doctor That They Have ADD or ADHD, Depression or Anxiety, or Behavior or Conduct Problems, 2003 is the estimated number and percent of children age 2-17 whose parents report that a doctor or other health professional has told them that their child has attention deficit disorder or attention deficit hyperactivity disorder, depression or anxiety, or behavior or conduct problems. SOURCE: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

Children Age 0-5 Whose Parents Have At Least One Concern About Their Child's Learning, Development, or Behavior, 2003 is the estimated number and percent of children age 0-5 whose parents report having at least one concern that could be about how their child talks and/or makes speech sounds, understands parents, uses hands and fingers to do things, uses arms and legs, behaves, gets along with others, is learning to do things for themselves, or is learning pre-school or school skills. SOURCE: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

Children Age 6-17 Whose Parents Are Concerned A Lot About How Their Child Copes With Stressful Things, Depression and Anxiety, Substance Abuse, and Eating Disorders, 2003 is the estimated number and percent of children age 6-17 whose parents report being concerned a lot about at least one of the following: how their child copes with stressful things, depression and anxiety, substance abuse, and eating disorders. SOURCE: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website. www.childhealthdata.org

ADOLESCENTS' REPORTS

High School Students Reporting Feeling So Sad or Hopeless Every Day for Two Weeks or More in A Row That They Stopped Doing Some Usual Activities, 2005 is the estimated percent of high school students reporting that at some point in the twelve months prior to taking the 2005 Maine Youth Risk Behavior Survey they felt so sad or hopeless every day for two weeks or more in a row that they stopped doing some usual activities. SOURCE: 2005 Maine Youth Risk Behavior Survey. www.maineeshp.com

High School Students Reporting At Least One Suicide Attempt in the Past Year, 2005 is the estimated percent of high school students reporting at least one suicide attempt in the twelve months prior to taking the 2005 Maine Youth Risk Behavior Survey. SOURCE: 2005 Maine Youth Risk Behavior Survey. www.maineeshp.com

Middle School Students Reporting Having Ever Attempted Suicide, 2005 is the estimated percent of middle school students reporting having ever tried to kill themselves. SOURCE: 2005 Maine Youth Risk Behavior Survey. www.maineeshp.com

High School Students Reporting Alcohol Use Within the Past 30 Days, 2005 is the estimated percent of high school students reporting at least one drink of alcohol within 30 days of taking the 2005 Maine Youth Risk Behavior Survey. SOURCE: 2005 Maine Youth Risk Behavior Survey. www.maineeshp.com

High School Students Reporting Marijuana Use Within the Past 30 Days, 2005 is the estimated percent of high school students reporting using marijuana within 30 days of taking the 2005 Maine Youth Risk Behavior Survey. SOURCE: 2005 Maine Youth Risk Behavior Survey. www.maineeshp.com/survey.html

PUBLIC SYSTEMS INDICATORS

Division of Children's Behavioral Health Services

Data analysis for this section was provided by Winston Turner, Ph.D., consultant to the Maine Children's Alliance.

ACCESS

Children Receiving Mental Health Services, SFY 2004 is the unduplicated number of children age 0-20 enrolled in MaineCare who received mental health services from a mental health provider that contracted with the Department. Numbers for children not enrolled in MaineCare were not available. Rate per 1,000 children age 0-20. Data are reported for children with and without serious emotional disturbance (SED) as percent of children served through the Division of Children's Behavioral Health Services. For this project, children were identified as SED based on their diagnosis and from which contracted provider they received mental health services. Children were identified as having SED if they had ever met the definition for SED.

UTILIZATION

Mental Health Services Received, SFY 2004 is the unduplicated number of mental health services received by children age 0-20 enrolled in MaineCare. Services are shown as percentage of services received. Services are also shown as percentage of services

received by children with SED and as percentage of services received by children without SED.

OUTPATIENT services include professional assessment, counseling and therapeutic services to children. Components of service may include diagnosis and assessment, psychometric evaluation, intervention services by psychological examiners, individual, group, family therapy, medication review and chemotherapy and similar professional therapeutic services which must include a direct member encounter. These services may be delivered either in an agency, home, or other community-based setting, such as a school, street, emergency shelter, or drop-in center. (MaineCare Benefits Manual, Chapter II - Section 65)

TARGETED CASE MANAGEMENT (INCLUDING ACT) are targeted case management services provided by a social services or health professional, or other qualified staff, to identify the medical, social, educational and other needs of the eligible member, identify the services necessary to meet those needs, and facilitate access to those services. (MaineCare Benefits Manual, Chapter II - Section 13). Assertive Community Treatment (ACT) is a 24-hour, 7 days a week intensive service provided by multidisciplinary teams which may include psychiatrists, advanced practice psychiatric and mental health nurses, clinical social workers, psychologists, licensed clinical professional counselors, and licensed substance abuse counselors. (MaineCare Benefits Manual, Chapter II - Section 65)

CHILD AND FAMILY COMMUNITY SUPPORT are services provided to persons 20 years of age or younger and include, but are not limited to, supportive counseling or guidance for the child and, if appropriate, family members; discharge planning and placement; outreach; reunification and mediation; crisis management planning; arranging for medication monitoring; medical, special needs, information and referral; assistance in obtaining services, entitlements and benefits, and basic necessities; development of behavior management plans, other skill-building activities; ensuring continuity and consistency of such activities across school, home, and community settings. (MaineCare Benefits Manual, Chapter II - Section 65)

MEDICATION MANAGEMENT services are services that are directly related to the prescription, administration and/or monitoring of medications intended for the treatment and management of mental illness. (MaineCare Benefits Manual, Chapter II - Section 65)

CRISIS SERVICES include crisis resolution services provided by agencies that have a contract with the Department for eligible children ages 20 years or younger that include outreach crisis intervention to home, school, street, emergency shelter or other setting, available on a 24-hour, seven-day a week basis. Crisis services also include emergency services that are immediate, crisis-oriented services provided to a child with an acute problem of disturbed thought, behavior, mood or social relationships. (MaineCare Benefits Manual, Chapter II - Section 65)

RESIDENTIAL SERVICES are services provided to children in Private Non-Medical Institutions (PNMI) that are maintained or operated for the provision of child care services and that are funded and licensed by the Department of Health and Human Services. PNMI's have the responsibility of providing the services identified in each child's individual service plan for treatment and rehabilitation, as well as for the physical needs of the child. (MaineCare Benefits Manual, Chapter II - Section 97)

BEHAVIORAL HEALTH SERVICES are rehabilitative services provided to a child in his/her home or community setting which focus primarily on behavior management, increased skill development, and physical development activities. (MaineCare Benefits Manual, Chapter II - Section 65)

CRISIS RESIDENTIAL is personal supervision services and therapeutic supports provided to a child during a psychiatric emergency and for a time limited post-crisis period during which the child's condition is being stabilized. These services may be provided in the child's home or in a temporary out-of-home setting. (MaineCare Benefits Manual, Chapter II - Section 65)

DAY TREATMENT services are structured developmental or rehabilitative programs designed to improve a child's functioning in daily living and community living. Programs commonly include a mixture of individual, group, and activities therapy, and may also include therapeutic treatment oriented toward developing a child's emotional and physical capability in areas of daily living, community integration and interpersonal functioning. (MaineCare Benefits Manual, Chapter II - Section 65)

EXPENDITURES

Expenditures for Mental Health Services Received, SFY 2004 is the total cost for unduplicated mental health services received by children age 0-20 enrolled in MaineCare. Expenditures are shown as percentage of total expenditures for each type of service received and as percentage of services received by children with SED and as percentage of services received by children without SED.

PUBLIC SYSTEMS INDICATORS Office of Substance Abuse

All sources of data for this section are from the Treatment Data System, Office of Substance Abuse, Maine Department of Health and Human Services, unless otherwise noted. Some data are available online at <http://www.maine.gov/dhhs/osa/>.

ACCESS

Children and Adolescents Using Substance Abuse Treatment Services, SFY 2004 is the number of children age 0-20 using services of Maine alcohol and drug abuse treatment providers. These data represent total clients and include clients with substance abuse, affected others (such as children of parents with substance problems requiring therapy), and clients in for evaluation only. Rate per 1,000 children age 0-20. Children are identified as having a secondary DSM-IV diagnosis, or not, through self-reporting at admission. Data are also reported as the number of children with or without a secondary DSM-IV diagnosis and as a percent of children using services. Data reported by age and gender. Data from TDS admission form.

UTILIZATION

Primary Substance Abuse Treatment Services Used, SFY 2004 is the number of primary substance abuse treatment services used by children age 0-20. Data are also reported as percent of primary substance abuse services used, and as percent of services used by children with a self-reported secondary DSM-IV diagnosis and as percent of services used by children without a self-reported secondary DSM-IV diagnosis. Data from TDS admission form. Primary substance abuse treatment services include:

ADOLESCENT OUTPATIENT SERVICES are provided to children younger than 19 years old at admission and may include individual, group, or family counseling as part of a comprehensive treatment plan. The treatment is less intense and of longer duration than intensive outpatient services. (MaineCare Benefits Manual, Chapter II – Section 111)

ADOLESCENT INTENSIVE OUTPATIENT provides an intensive and structured program of substance abuse assessment, diagnosis, and treatment services to children younger than 19 years old at admission in a setting that does not include an overnight stay. (Office of Substance Abuse Date System TDS Manual, October 2003)

NON-INTENSIVE OUTPATIENT services provide assessment and treatment services. These services may also be provided to affected others whether or not the primary abuser is receiving treatment. (Office of Substance Abuse Date System TDS Manual, October 2003)

INTENSIVE OUTPATIENT provides a relatively intense short-term, treatment experience aimed at persons who are fairly well advanced in the disease of substance abuse, but do not require the more restrictive residential setting for effective treatment. Services may include individual, group, or family counseling as part of a comprehensive treatment plan. (MaineCare Benefits Manual, Chapter II – Section 111)

EVALUATION is the systematic clinical process, performed by licensed individuals within the profession, intended to determine the status of a client's substance use or abuse and to assess the individuals need for treatment, and when treatment is indicated, to outline the modality of treatment. (Office of Substance Abuse Date System TDS Manual, October 2003)

METHADONE TREATMENT provides opiate substitution therapy through daily oral doses of methadone delivered under the direction of a physician. Methadone programs provide case management and treatment services including individual and group counseling. (MaineCare Benefits Manual, Chapter II – Section 111)

RESIDENTIAL SERVICES provide substance abuse treatment services in a 24-hour residential setting in varying degrees of intensity, for varying periods of time, and in conjunction with a variety of other services. Residential settings include adolescent residential rehabilitation transitional, extended shelter, halfway house, shelter, short-term (30 days or less). (Office of Substance Abuse Date System TDS Manual, October 2003)

HOSPITAL INPATIENT services are provided in a hospital setting 24 hours a day. Inpatient hospitalization provides: (1) short-term treatment in cases where a child is in crisis and possibly a danger to himself or herself or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting (SAMHSA.gov)

Children and Adolescents Discharged From Substance Abuse Treatment Services, SFY 2004 is the number of individual children age 0-20 using substance abuse treatment services who were discharged and who during treatment used crisis intervention services and/or mental health services. Also included are children who at discharge received a referral to a mental health professional. Data from TDS discharge form.

EXPENDITURES

Payer Source for Substance Abuse Treatment Services, SFY 2004 is the number of substance abuse treatment services paid for by payer source for children and adolescents age 0-20 using substance abuse treatment services. Data is reported as percent of services paid for by payer source. Data is also reported as percent of services paid by payer source for children who at admission self-reported a secondary DSM-IV diagnosis and as percent by children who did not report a secondary DSM-IV diagnosis. In addition to the Office of Substance Abuse, the other three payers identified are the Maine Department of Health and Human Services (MaineCare, child welfare, adult welfare, behavioral health), the Maine Department of Corrections, and Other (self-pay, town assistance, third party insurance, or any other assistance that is not from the State). Data from TDS admission form.

OUTCOME

Children and Adolescents With a Discharge Status From Substance Abuse Treatment Services, SFY 2004 is the discharge status of children and adolescents age 0-20 from a substance abuse treatment service. Discharge status is broken out by children with and without a secondary DSM-IV diagnosis. Discharge categories include:

COMPLETED TREATMENT (treatment completed for affected other/co-dependency, treatment is complete),

DID NOT COMPLETE TREATMENT (client cannot get to facility for further treatment, client refused service or treatment, non-compliance with rules and regulations, client termination without clinic agreement, termination due to program cut or reduction, treatment not completed for affected other or co-dependency, unable to follow program requirements),

OTHER (client discharged for medical and/or psychological reasons, client incarcerated, client moved out of catchment area, further treatment is not appropriate for client, shelter clients only), and

EVALUATION ONLY.

Note that there are 16 children who were discharged for whom the discharge status is unknown. Data from TDS discharge form.

INTERSYSTEM INVOLVEMENT

Adolescents Age 12 and Older Referred for Substance Abuse Screening, SFY 2004 is the number of adolescents age 12 and older referred for substance abuse screening either by a Juvenile

Community Corrections Officer or by a Network Identified School Contact, and the number and percent of those adolescents who were referred for further evaluation.

SOURCE: Juvenile Automated Substance Abuse Evaluation Data, Office of Substance Abuse, Maine Department of Health and Human Services.

PUBLIC SYSTEMS INDICATORS

Office of Special Services

All sources of data for this section are from the Maine Department of Education, Office of Special Services, unless otherwise noted. Some of the data are available online at <http://www.maine.gov/education/specedata/index.html>.

ACCESS

Children Age 3-21 Receiving Special Education Services, December 2004 is the number of children age 3-21 receiving special education services on December 1, 2004. The percent of children receiving special education services is calculated by dividing the number of students receiving special education services by the number of students age 4-20 enrolled in regular education on October 1, 2004.

Children Age 3-21 Receiving Special Education Services for Emotional Disability, December 2004 is the number and percent of children age 3-21 receiving special education services for emotional disability on December 1, 2004. Data is reported by age and gender.

UTILIZATION

Children Age 3-5 Receiving Special Education Services for Emotional Disability in a Preschool Setting, December 2004 is the number of children age 3-5 counted on December 1, 2004, as receiving special education services for emotional disability. These children are receiving services in the following preschool settings: early childhood settings, early childhood special education settings, part-time early childhood and part-time early childhood special education settings, separate schools, home, and residential facilities. These preschool settings are listed from least restrictive setting to most restrictive to reflect the special education requirement that children be served in the least restrictive environment. "Unless a child's Individualized Family Service Plan or Individualized Education Plan requires some other arrangement, services must be provided to the child in the place or program the child would attend if the child did not have a disability, and supplementary services shall be provided in conjunction with regular class placement, where appropriate."¹

Children Age 5-21 Receiving Special Education Services for Emotional Disability in a School-age Setting, December 2004 is the number of children age 5-21 counted on December 1, 2004, as receiving special education services for emotional disability. These children are receiving services in the following school-age settings (listed from least restrictive setting to most restrictive):

REGULAR CLASSROOM setting is a placement where a student with a disability receives a majority of their educational program with non-disabled students, receiving special education services OUTSIDE THAT CLASSROOM for less than 21 percent of the school day.

RESOURCE ROOM setting is a placement where a student with a disability receives special education and supportive services OUTSIDE THE CLASSROOM for 60 percent or less of the school day and at least 21 percent of the school day.

SELF-CONTAINED setting is a placement where a student with a disability receives special education and supportive services OUTSIDE THE REGULAR CLASSROOM for more than 60 percent of the school day in a self-contained program.

PUBLIC SEPARATE DAY SCHOOL setting is a placement where a student with a disability receives special education and supportive services for greater than 50 percent of the school day in public separate day school facilities.

PRIVATE SEPARATE DAY SCHOOL setting is a placement where a student with a disability receives special education and supportive services for greater than 50 percent of the school day in private separate day school facilities.

PUBLIC RESIDENTIAL setting is a placement where a student with a disability resides and receives special education and supportive services for greater than 50 percent of the school day in public residential facilities.

PRIVATE RESIDENTIAL setting is a placement where a student with a disability resides and receives special education and supportive services for greater than 50 percent of the school day in private residential facilities.

HOMEBOUND OR HOSPITAL setting is a placement where a student with a disability resides and receives special education and supportive services at home or in a medical treatment facility.²

OUTCOME

Children Age 3-21 With an Exit Status From Special Education Services for Emotional Disability, December 2004 is the number of children age 3-21 who were not receiving special education on December 1, 2004, and had been receiving services on December 1, 2003.

1 Maine Department of Education. (5/15/91). *Early Intervention and Special Education for Children Age Birth to Under Age Six*, Chapter 180, Section IX. 5., pg. 8.

2 Maine Department of Education. (11/1/99). *Maine Special Education Regulations*, Chapter 101, Section 11, pgs. 55-58. www.maine.gov/education

PUBLIC SYSTEMS INDICATORS

Division of Vocational Rehabilitation

All sources of data for this section are from Bureau of Rehabilitation Services, Maine Department of Labor, unless otherwise noted.

OUTCOME

Children Age 20 or Younger Whose Case Was Closed, FFY 2005

is the number of children with psychosocial or other mental impairments who at the time they applied to the Division of Vocational Rehabilitation for services were 20 or younger and whose case was closed in federal fiscal year 2005. These children do not include children with cognitive disabilities, such as mental retardation or autism. Data also presented as number and percentage by type of closure for cases closed.

EXPENDITURES

Expenditures for Cases Closed, FFY 2005 is the total cost for services received by children with psychosocial or other mental impairments who at the time they applied to the Division of Vocational Rehabilitation for services were 20 or younger and whose case was closed in federal fiscal year 2005. Data presented as total cost for each type of closure for cases closed and as percentage of total cost of closed cases. Data also presented as average cost per case for each type of type of closure for cases closed.

UTILIZATION

Services Received by Children with Closed Cases, FFY 2005 is the type of vocational rehabilitation services received by children with psychosocial or other mental impairments who at the time they applied to the Division of Vocational Rehabilitation for services were 20 or younger and whose case was closed in federal fiscal year 2005.

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NAME	ORGANIZATION
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**Maine
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303 State Street • Augusta, Maine 04330
Tel : (207) 623-1868 • Fax: (207) 626-3302
MAINEKIDS@mekids.org • www.mekids.org