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CHILDREN'S
MENTAL
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2010

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EXECUTIVE SUMMARY

THE MAINE CHILDREN'S ALLIANCE (MCA) IS PLEASED TO PRESENT this expanded Children's Mental Health 2010 Report made possible by a grant from the Maine Health Access Foundation. This report presents state-level indicators related to the mental well-being of Maine's children. These indicators are drawn from state and national survey data, and from data from the public systems in Maine that provide mental health, child welfare, education, early childhood and related services for children.

The state survey data include factors that have an impact on children's mental well-being and behavioral health. Some of these factors, such as positive peer relationships, have protective qualities while others, such as poverty or domestic violence, pose a risk to mental well-being. 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.

Currently, there is a lack of integrated data to effectively measure and evaluate children's mental health outcomes across systems of care in Maine. The child-serving departments of state government through which children receive mental health and related services appreciate the need for these data. These departments have made significant strides toward integration of data and continue to work towards that end. As a result of this cross-department data integration, we were able to analyze children in state care or custody who were also served through Children's Behavioral Health Services for this report. Recommendations at the end of each data section of the report offer suggestions for filling gaps in the data by integrating and coordinating data collection among public systems, through which children receive mental health and related services.

More integrated data will soon be available as a result of the passage of LD 1356, a new state law allowing the Department of Education to utilize student Social Security numbers to collect longitudinal data beginning in 2011. This effort will make it possible to better track children across systems including Education, Child Welfare and Children's Behavioral Health.

This report highlights many good things that are being done to support children and families in Maine. The Maine Home Visiting Program of the Department of Health and Human Services (DHHS) promotes healthy growth and development for babies and young children by providing support, education, and referrals to first-time and adolescent families. The results of the program are encouraging, as most participating families report making positive changes based on a better understanding of their child's development.

More good news can be found in the data related to children in state care or custody. Kinship care, the placement of a child with relatives on a permanent basis by the court and the child welfare system, is used more often (37.7%) than any other protocol when a child is removed from the home for safety reasons. Kinship placements enable children to live with people they know and trust, creating a sense of stability and continuity.

Before we can chart the best course for our children's future, we must have an understanding of the strengths and challenges present for Maine's families and the systems designed to serve them. Public policies across many systems can provide tools and supports to help families and communities succeed in efforts to ensure that children requiring behavioral health services receive integrated, quality and effective care.



G. Dean Crocker
President/CEO

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 public or private systems that serve children. The public systems in Maine consist of the Departments of Health and Human Services, Education, Labor, and Corrections (see page 10). The private system includes primary care physicians, pediatricians, mental health professionals, and others who serve children with mental health issues outside the public systems.

BACKGROUND

Mental health, mental illness, and mental health problems can be thought of as points along the same continuum.¹ 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. It is essential that children have access to comprehensive, integrated, quality services, either before a mental health problem becomes an illness or once a mental illness develops.

The period from birth to age five serve as the foundation for social, emotional and cognitive development of children. Early experiences determine whether a child's brain architecture will provide a strong or weak foundation for all future learning, behavior, and health.² Prevention of emotional, mental and behavioral health problems begins before birth, starting with early pre-natal care. An expectant mother who is seen by a doctor can be screened for such risk factors as maternal depression, substance abuse or domestic violence, so that these issues can be identified and addressed. Of the 12,370 live births in Maine in 2007, 87.1% were to women whose prenatal care began in the first trimester.

Infants, toddlers and young children need environments where they can explore the world and develop new skills surrounded by nurturing caregivers. As children grow and head off to school, it is often at the kindergarten screening that emotional/behavioral issues are detected in a child, especially for children who did not participate in an early childcare program. Children and adolescents experiencing mental, emotional, behavioral or learning problems are likely to struggle in school. Therefore, it is important for schools to train staff to monitor not just academic progress, but social and emotional progress as well.

Finally, as youth transition into adulthood, it is essential to have programs and supports in place, especially for young people who have been in foster care or have been incarcerated. These supports help Maine youth develop the knowledge, skills, and permanent connections that will promote healthy, productive and secure lives.

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 access to, the effectiveness of, and the cost of mental health services for Maine's children. The purpose of this on-going project is to remove that barrier by continuing to identify a common set of indicators. The long-term objective is to publish on a regular basis mental health indicators that provide information about the individuals served, the services received, and the outcomes achieved in the annual *Maine KIDS COUNT Data Book*.

The indicators presented in this report build upon the information contained in the *2006 Children's Mental Health Report* in order that service providers, advocates, and policymakers

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

2 The Science of Early Childhood Development. (2007) National Scientific Council on the Developing Child. <http://www.developingchild.net>

will know where 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. We have also included information of a one time nature when we believe it may help to achieve better understanding in a policy area. This information may not meet standards for on-going inclusion in this report or KIDS COUNT.

CHILD WELL-BEING

IT IS IMPORTANT TO UNDERSTAND that a child's mental health is influenced by biological/physiological factors as well as environmental factors. There are commonly identified environmental risk factors that negatively affect mental health, such as poverty and trauma, and there are protective factors in a child's environment that positively affect mental health, such as early, successful interactions with peers, and the mental and emotional health of a child's mother.

Mental or Behavioral Development Include Both Biological/Physiological and External Risk Factors

BIOLOGICAL RISK FACTORS	EXTERNAL/PSYCHOSOCIAL RISK FACTORS
Low birthweight infants	Multigenerational poverty
Prematurity (born <37 weeks gestation)	Abuse and neglect
Genetic predisposition to a mental disorder	Parental mental health disorder
Intrauterine exposure to drugs or alcohol	Unsatisfactory relationships
Perinatal trauma	Exposure to trauma
Environmental exposure to lead	
Traumatic brain injury	
Nonspecific forms of mental retardation	
Specific chromosomal syndromes	

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

BIOLOGICAL RISK FACTORS

Birth Outcomes

	MAINE NUMBER	2007 PERCENT	2006 PERCENT	NATIONAL PERCENT
Live births for which prenatal care began in first trimester (as % of live births)	12,295	87.1%	87.4%	n/a
Low birth-weight infants (as % of live births)	892	6.3%	6.9%	8.2%
Preterm births (as % of live births)	1,296	9.2%	9.2%	12.7%

According to the results of the 2006 Maine Pregnancy Risk Assessment Monitoring Survey (PRAMS), 11.9 % of respondents drank at least one alcoholic beverage during the last three months of pregnancy. A much smaller percentage (0.7%) reported binge drinking – consuming four or more drinks in one sitting.

Young children exposed to lead in paint, toys or other environmental contaminants are at risk for long-term health effects including developmental delays, behavior problems, and lower intelligence. Children exposed to lead often show no signs or symptoms of illness. An elevated blood lead level (eBLL) is a blood lead level greater than or equal to 10 micrograms per deciliter of blood. The Maine Center for Disease Control, through the Lead Poisoning Prevention Fund, works with communities across Maine to reduce the instances of lead poisoning among children. In 2008, 135 Maine children under the age of 6 were newly identified as poisoned by lead. This is down from 212 children in 2003, and represents a continuing decline in the number of children poisoned each year.

“Measurements that gauge the health status of pregnant women and infants are a key barometer not only of the health of a family but also of the entire society since so many community factors and support systems contribute toward the health of these two vulnerable populations.”* In 2007, 87.1% of Maine women who gave birth received prenatal care before the first trimester. The percent of low birth-weight infants (6.3%) and preterm births (9.2%) in Maine were lower than the national rates, which were 8.2% and 12.7% respectively.

* Healthy Maine 2010, Chapter 4: Family Planning and Perinatal Health (www.maine.gov)

FOOD INSECURITY, also known as food hardship, is the lack of resources to buy food. When children live in families facing food insecurity and hunger, their brain architecture is damaged, causing harm to their physical, mental, social and emotional health for their entire lives. "But investing in effective public infrastructures to protect young children's nutritional health promotes family stability, and improves their educational achievement, productivity and future earnings."* Maine's food insecurity rate of 13.7% is significantly higher than the national average of 12.2%.** During the 2008-09 school year, 80,478 (43.1%) of Maine school children received subsidized school lunch, an increase of 10.5% from the previous school year.**

* Partnership for America's Economic Success. November 2008, Issue Brief #8. "Reading, Writing and Hungry: The consequences of food insecurity on children, and on our nation's economic success." <http://www.frac.org>

** Maine Department of Education, School Nutrition Program

3 Mather, M. & Adams, D. (2006) A KIDS COUNT/PRB Report on Census 2000: *The Risk of Negative Child Outcomes in Low-Income Families*. www.aecf.org

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

5 *The Future of Children*, Winter 1999. "Domestic Violence and Children." www.futureofchildren.org

ENVIRONMENTAL RISK FACTORS

Chronic stressful conditions in the physical environment, or toxic stress, can disrupt the architecture of a child's developing brain and impair the immune system. Research has identified a number of experiences that have negative impacts upon children and can increase the child's risk of developing emotional, social, and cognitive and health problems later in life.

Poverty

	MAINE NUMBER	CURRENT PERCENT	PREVIOUS PERCENT	NATIONAL PERCENT
Children under age 5 in poverty, 2008 and 2007 (as % of all children in Maine 0-5)	15,077	21.8%	19.40%	21.2%
Children 0-17 in poverty, 2008 and 2007 (as % of all children in Maine 0-17)	43,943	16.5%	15.7%	18.2%
Median income of families with children, 2008 and 2007	n/a	\$54,800	\$54,300	\$58,900
Unemployment, 2009 and 2008	57,792	8.2%	5.4%	9.3%

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, and exposure to environmental toxins.³ For young children, growing up in poverty is associated with a variety of negative outcomes, including lower cognitive abilities and lower school achievement, and impaired health and development.

In 2008, nearly one sixth (16.5%) of Maine children under 18, and over one fifth of children under the age of five (21.8%), were living in poverty. While the rate of poverty in older children in Maine remains below the national average, the rate for our youngest (age birth to 5), now surpasses the national rate of 21.2%.

Domestic Violence and Child Abuse

	MAINE NUMBER	CURRENT RATE	PREVIOUS RATE
Domestic assaults reported to police, 2008 and 2007 (rate per 100,000 of total population)	5,311	403.9	438.9
Children in the care or custody of the Department of Health and Human Services, December 2009 and 2008 (rate per 1,000 children ages 0-17)	1,650	5.8	6.7
Substantiated child abuse and neglect victims, 2008 and 2007 (rate per 1,000 children ages 0-17)	4,085	14.4	14.9

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 post-traumatic stress disorder, such as emotional numbing, increased arousal, and repeated focus on the violent event."⁴ In 2008, there were 5,311 domestic assaults reported to police in Maine, a rate of 403.9 assaults per 100,000 people. The rate is down from 2007, when the rate was 438.9 per 100,000 people.

According to the Surgeon General's 1999 report on mental health, child physical abuse can lead to 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 of children can lead to depression, conduct disorder, and delinquency, and can impair social and cognitive functioning in children.⁵ In 2008, there

were 4,085 substantiated child abuse and/or neglect victims in Maine, a rate of 14.4 victims per 1,000 children ages 0-17.

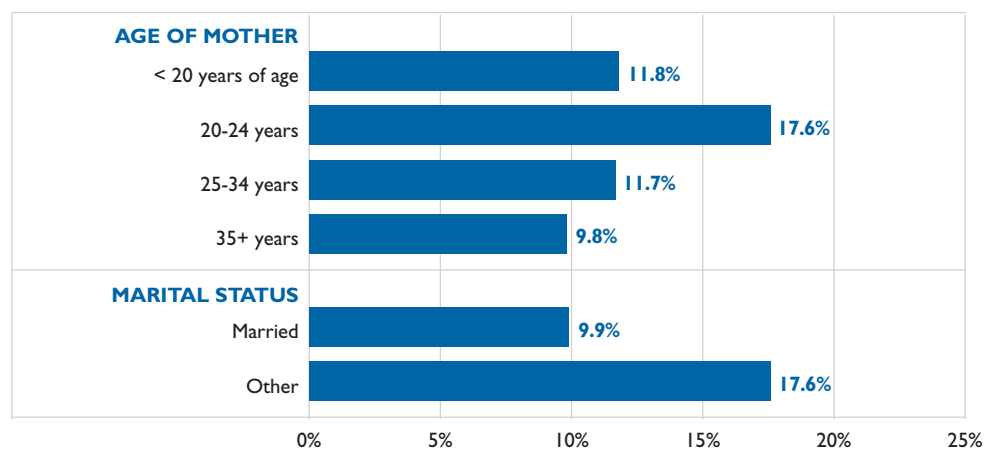
Parents' Mental and Emotional Health

The physical and emotional health of parents can affect the ability to care for children and can influence the health and well-being of the family as a whole.⁶ Treating depressed parents is not only good for parents but also has a beneficial impact on their children. According to the 2007 National Survey of Children's Health (NSCH), most Maine children live with parents whose mental and emotional health is excellent, very good, or good: 95.7% of mothers and 97.0% of fathers.

In the National Institute of Mental Health's Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study, 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 Researchers found that when mothers' depression was successfully treated, it had a positive effect on the mental health of their children.⁸

Children living with a mother suffering with depression are at a greater risk for developing mental health issues. The PRAMS Survey of women who have recently given birth provides information regarding post-partum depression. In 2006, 13% of women giving birth in Maine were told by a doctor, nurse, or health care worker that she had depression.

Post-Partum Depression, 2006



Peer Relationships

	MAINE NUMBER	2007 PERCENT
Children ages 1-5 who play with children of similar age at least four days/week (as % of children ages 1-5)	47,924	66%
Children ages 6-17 who participate in activities outside of school (as % of children ages 6-17)	172,419	87.3%

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

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

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

8 Ibid.

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.”⁹

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.”¹⁰

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. The 2007 National Survey of Children’s Health (www.nschdata.org) includes indicators regarding the concerns that parents have about their child’s functional ability, learning, development and behavior.

Children’s Functional Ability

	MAINE NUMBER	2007 PERCENT	2003 PERCENT	NATIONAL PERCENT
Children age 0-5 who have moderate or severe risk for developmental, behavioral or social delays (as % of children 1-5)	15,550	18.6%	20.7%	26.4%
Children age 0-17 with emotional, developmental, or behavioral problems for which they need treatment or counseling (as % of children 0-17)	20,562	7.2%	7.9%	5.9%
Children age 2-17 who have been told by a doctor that they have:				
ADD or ADHD (as % of children 2-17)	16,390	6.5%	7.2%	5.9%
Depression, (as % of children 2-17)	13,497	5.3%	n/a	3.7%
Anxiety, (as % of children 2-17)	20,419	8.0%	n/a	4.5%
Behavior or conduct problems	10,694	4.2%	n/a	4.4%

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 disabilities that diminish a child’s ability to function well.

Parental Concerns

	MAINE NUMBER	2007 PERCENT	2003 PERCENT	NATIONAL PERCENT
Children age 0-5 whose parents have at least one concern about their child’s learning, development or behavior (as % of children 0-5)	26,975	32.2%	33.3%	40.1%
Children age 6-17 whose parents report child sometimes exhibits problematic behavior (arguing too much; bullying or cruelty to others; disobedient; sullen, stubborn or irritable)	20,951	10.6%	7.8%	8.8%

Parents are usually the first to notice when their children are having difficulties managing their emotions, focusing on tasks, and/or controlling their behavior. This makes parents’ concerns crucial to alerting doctors and obtaining mental health services.¹¹

9 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)

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

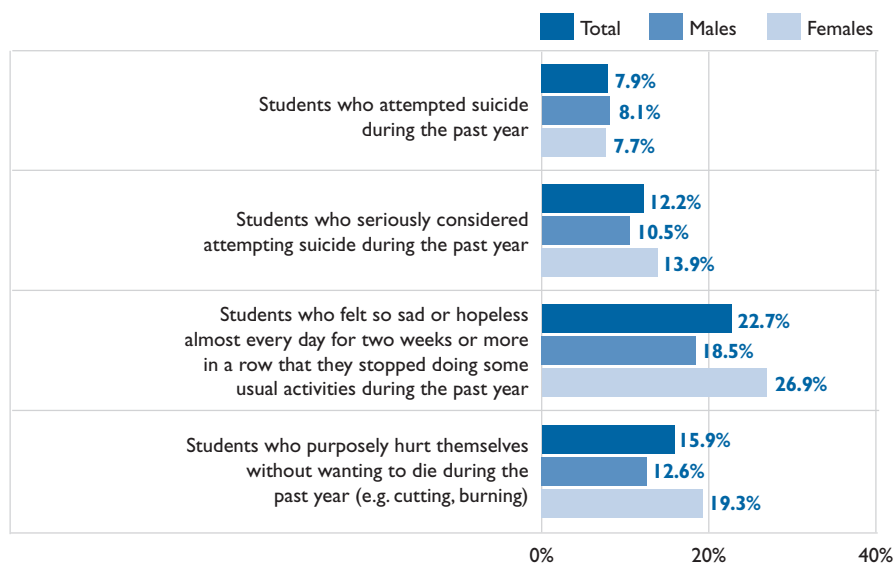
11 U.S. Department of Health and Human Services. *The Health and Well-Being of Children: A Portrait of States and the Nation, 2005.*

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** 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.¹²
- **SUICIDE:** Mood disorders, such as depression, increase the risk of suicide. Although suicide cannot be defined as a mental disorder, there is evidence that more than 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.¹³
- **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.^{14,15}

Suicide: Maine High School Students by Gender, 2009



Source: 2009 Youth Risk Behavior Survey

CHILDHOOD OBESITY is a rising concern in Maine and across the nation. According to the 2007 National Survey of Children's Health, 12.9% of Maine children ages 10-17 were obese, with a Body Mass Index (BMI) at or above the 95th percentile. In addition, 15.3% of Maine children in the same age category were overweight, with a BMI between the 85th and 94th percentile.* Physical health disorders that have been related to childhood obesity include hypertension, type 2 diabetes and asthma. Further, childhood obesity has been linked to psychosocial problems, including depression, difficult peer and family relationships and impaired quality of life.**

* National Survey of Children's Health, 2007

** Daniels, S. "The Consequences of Childhood Overweight and Obesity" From *The Future of Children*, a publication of The Woodrow Wilson School of Public and International Affairs at Princeton University and the Brookings Institute. Volume 16, No. 1, Spring 2006.

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

13 Ibid.

14 Substance Abuse Mental Health Services Administration. March 2000. *Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems*.

15 Substance Abuse Mental Health Services Administration. July 2002. *NHSDA Report: Substance Use and the Risk of Suicide Among Youths*.

PUBLIC SYSTEMS

MAINE CHILDREN RECEIVE MENTAL HEALTH services in a number of public systems. 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.

Also within the Department is the Office of Substance Abuse, which has the responsibility of ensuring that substance abuse services are available for state residents, including children and adolescents. The Office enters into contracts with community providers so that a variety of substance abuse treatment programs are available.

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.

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.

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

THE OFFICE OF CHILD AND FAMILY SERVICES (OCFS) serves Maine's children and their families through the Children's Behavioral Health, Division of Child Welfare, Division of Early Childhood and Public Service Management.

CHILDREN'S BEHAVIORAL HEALTH SERVICES (CBHS) provides information and referrals for children to their 21st birthday with developmental disabilities/delays, mental retardation, pervasive developmental disorder (PDD)/autism and mental health disorders.

CHILD WELFARE seeks safety, well-being and permanent homes for children.

EARLY CHILDHOOD is responsible for child care and Head Start programs, coordination of child care licensing, technical assistance, training and employer incentives.

THE OFFICE OF INTEGRATED ACCESS AND SUPPORT is responsible for determining eligibility for a number of programs, including MaineCare, Temporary Assistance to Needy Families (TANF), Supplemental Nutritional Assistance Program (SNAP, formerly Food Stamps), and for administering programs such as Child Support.

MAINECARE SERVICES (Maine's Medicaid Program) administers the DHHS' major health care financing programs and health care benefits. Programs include MaineCare, Maine Eye Care, Maine Rx Plus, the Katie Beckett Option, and Drugs for the Elderly and Disabled. The Katie Beckett Option is a MaineCare benefit for children with serious health conditions. Children with Katie Beckett coverage get full MaineCare benefits, the same benefits that all other MaineCare children get.

MAINE CENTER FOR DISEASE CONTROL develops and delivers services to preserve, protect and promote the health and well-being of Maine citizens.

OFFICE OF SUBSTANCE ABUSE (OSA) is responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services

DEPARTMENT OF EDUCATION (DOE)

THE CHILD DEVELOPMENT SERVICES (CDS) system is an Intermediate Educational Unit that provides both Early Intervention (birth-2 years) and Free Appropriate Public Education (FAPE for ages 3-5 years) under the supervision of the Maine Department of Education.

SPECIAL SERVICES supports students with disabilities, kindergarten through graduation, in their quest to achieve academically.

DEPARTMENT OF CORRECTIONS (DOC)

DIVISION OF JUVENILE SERVICES promotes public safety by ensuring that juveniles under Department of Correction's jurisdiction are provided with risk-focused intervention, treatment, and other services that teach skills and competencies, strengthen social behaviors to reduce the likelihood of re-offending and require accountability to victims and communities.

DEPARTMENT OF LABOR (DOL)

THE DIVISION OF VOCATIONAL REHABILITATION (VR) is a program that helps people who have physical, mental or emotional disabilities to get and keep a job.

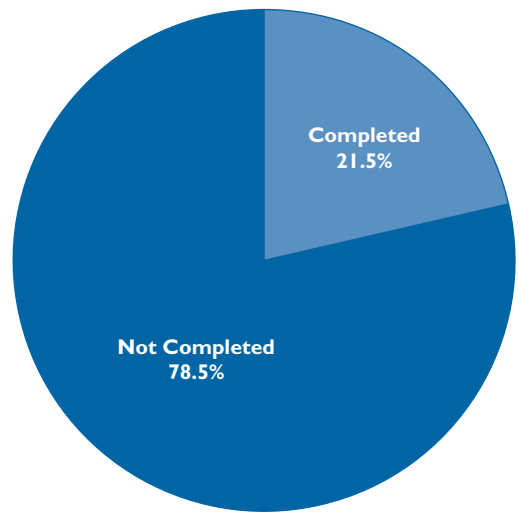
According to a report released by the U.S. Department of Health and Human Services Office of Inspector General, three out of four children in nine selected states did not receive all required medical, vision, and hearing screenings through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). In these nine states (Arkansas, Florida, Idaho, Illinois, Missouri, North Carolina, North Dakota, Texas, Vermont, and West Virginia), 76% of children, or 2.7 million children, did not receive one or more of the required Medicaid screenings. Forty-one percent of children did not receive any required medical screenings. Officials from the nine states identified one of three main strategies to improve beneficiary participation in EPSDT: direct communication to eligible families, outreach, and incentives.

Source: Most Medicaid Children in Nine States Are Not Receiving All Required Preventative Screening Services. U.S. Department of Health and Human Services, Office of Inspector General, May 2010.

EARLY IDENTIFICATION OF DEVELOPMENTAL DELAYS and behavioral problems can lead to timely interventions that best support a child's development and decrease parental stress. Trying to change behavior or learn new skills on a foundation of brain circuits that were not initially wired properly requires more work and is less effective than early identification.

According to the most recent National Survey of Children's Health, not enough Maine children between the ages of ten months and 5 years are receiving developmental and behavioral screenings at well-child visits. In addition, 32.2% of parents had at least one concern about their young child's learning, development or behavior, yet only 21.5% were screened.

Developmental and Behavioral Screening Completed at Well-Child Visit, 2007

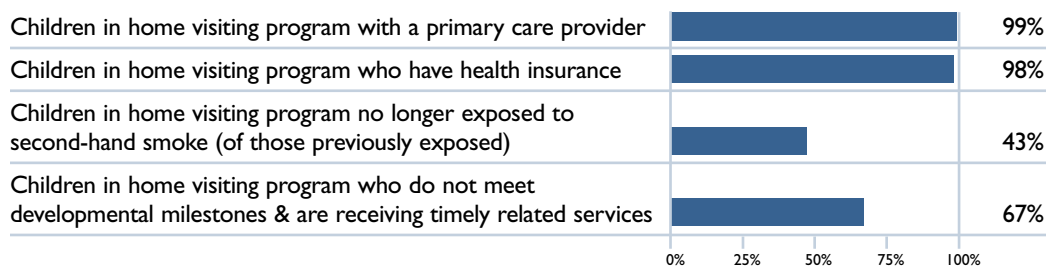


Source: 2007 National Survey of Children's Health

MAINE'S HOME VISITING PROGRAM

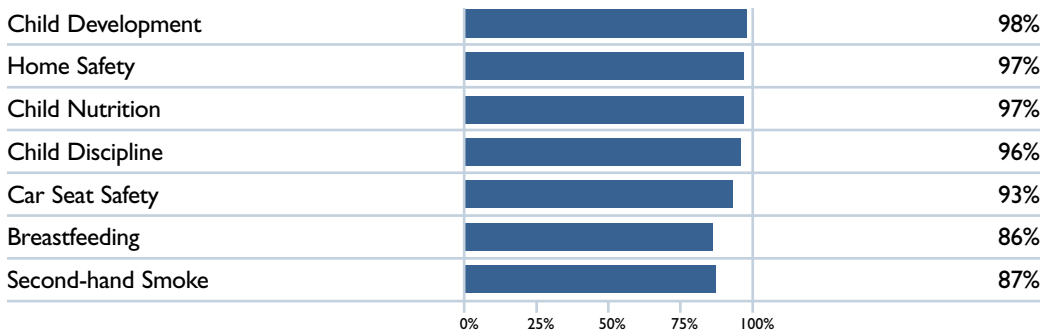
The societal costs of less-than-optimal early childhood health and development are enormous, both in human and economic terms. The Department of Health and Human Service's Maine Home Visiting Program promotes healthy growth and development for babies and young children. Home visiting is offered to first-time families and expectant teens on a universal basis. The decision to receive services is voluntary. In SFY 2009, well-trained professionals worked with 5,000 first-time and adolescent families. Of these, 2,702 families received 20,341 home visits, while the remaining families accessed other services such as educational parent groups or play-groups, developmental information by mail and resource referral. The families who received home visits were largely young, with 45% younger than age 22 at their child's birth, and single, with 61% unmarried. Ninety-one percent of home visiting parents report a moderate-to-great increase in confidence in their parenting skills.

Maine Home Visiting Program Child Health and Development Results, SFY 2009



Source: Department of Health and Human Services, Office of Child & Family Services, Early Childhood Division

Maine Home Visiting Parents' Report of Positive Changes as a Result of Participation, 2009

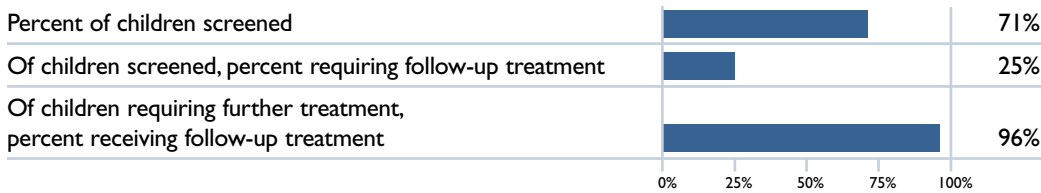


Source: Department of Health and Human Services, Office of Child & Family Services, Early Childhood Division

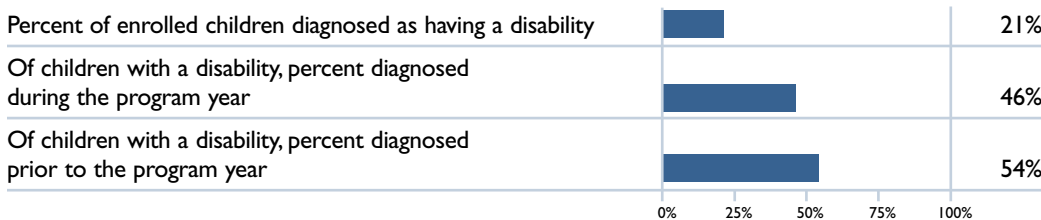
MAINE HEAD START

Head Start provides early care and education, health, nutrition, mental health, social and family support services to low-income families with prenatal to five-year-old children. In Maine, 11 Head Start grantees are funded through the Federal Office of Head Start. Three Head Start programs are funded by the Tribal Office of Head Start. Head Start programs provide mental health services and referrals to community providers.

Head Start Medical Screenings Results, 2008



Head Start Disability Services, 2008



Source: Maine Head Start Program Information Report (PIR), 2008

Access to Medical Services for Head Start Children in Maine, 2008



Source: Maine Head Start Program Information Report (PIR), 2008

Over the course of the last decade, approximately two-thirds of children eligible for Head Start have not enrolled in the program. In 2009, there were 15,077 eligible children. The total actual enrollment of individual children in Head Start was only 4,452 because of limited funding.

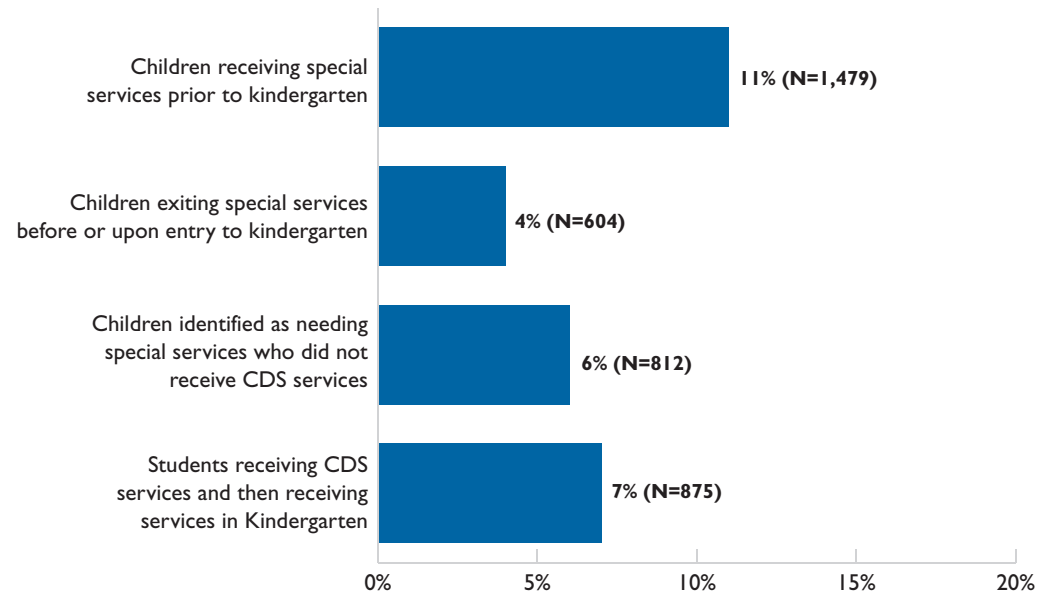
In 2008-09, 71% of the children enrolled in Head Start had received a medical screening. This figure includes those children who dropped out of a program prior to 45 days, the time frame during which Head Start programs are required to provide such screenings.

SCHOOL READINESS

Early identification of developmental delays and access to the appropriate therapies are key elements of any successful early childhood system. Assuring that schools are well prepared for the students entering kindergarten requires access to good information about each individual child. The Child Development Services (CDS) system is an Intermediate Educational Unit that provides both Early Intervention (birth-two years) and Free Appropriate Public Education (FAPE, for ages 3-5 years) under the supervision of the Maine Department of Education. The CDS system ensures compliance with federal and state special education rules and regulations through contractual or grant relationships between the Department of Education and each regional site.

In the 2008-09 school year, 14,074 children entered kindergarten. Eleven percent (1,479) of the children entering kindergarten had received Child Development Services (CDS) prior to kindergarten entry. Of the 1,687 children receiving special services in kindergarten in 2008, 48% (812) did not receive services prior to kindergarten entry. Finally, of the 57 children receiving special services for an emotional disability upon kindergarten entry, 34 (59.6%) had received CDS services.

Children with Special Needs as Percent of Total Kindergarten Population, 2008-09



CHILD PROTECTIVE SERVICES

Young children exposed to abuse or neglect can have lifelong difficulties in the areas of learning, memory and self-regulation. As adults, their risk of developing chronic health conditions such as diabetes, obesity and heart disease is higher. A more in-depth analysis of child protective services and child welfare data can be found in the School Age and Adolescence Section of this report.

In 2008, the Department of Health and Human Services received almost 19,000 referrals for Child Protective Services intervention in a family situation. From these initial reports, 6,178 (involving 12,141 children) were assigned to a caseworker for a Child Protective Assessment. Of the reports assigned to a caseworker for assessment, 4,929 (80%) involved a children under five years of age. Assessments completed in 2008 with findings of substantiated child abuse and neglect included 2,173 instances of abuse for children under age 5.

Type of Child Abuse & Neglect Found in Assessments for Children Under Age 5, 2008

	NUMBER
Sexual Abuse	72
Physical Abuse	282
Neglect	1,306
Emotional Abuse	513
Total	2,173

Source: Maine Department of Human Services, Office of Child and Family Services, Child Protective Services, Annual Report on Referrals 2008

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Children's Behavioral Health Services (CBHS) contracts with many agencies throughout the state to offer a broad range of services for children 20 and under if they have treatment needs related to mental health, mental retardation, pervasive developmental disorders, or developmental disability. In 2008, of the 18,877 children served through CBHS, 1,730 (9.2%) were ages 0-5. A more in-depth analysis of CBHS service use can be found on page 17 in the School Age and Adolescence Section of this report.

RECOMMENDATIONS

1. Anecdotally we have learned that early childcare providers have seen an increase in violent, disruptive behaviors in preschool settings among the 3-5 year old population. There is no valid or reliable data source that captures preschool suspension or expulsion rates in a systematic manner. Better understanding of these issues through the collection of data will help communities and schools better understand where and how frequently such events are happening.
2. We do not have data that indicate the number of children who arrive in Maine schools unprepared. The current kindergarten screening process is not consistent across school districts. A common screening tool, linked to the MEDMS data system, would accurately track the number of students who come into the system unprepared.
3. The following recommendation appeared in a special KIDS COUNT report released by the Annie E Casey Foundation entitled, "Early Warning: Why Reading by Third Grade Matters"

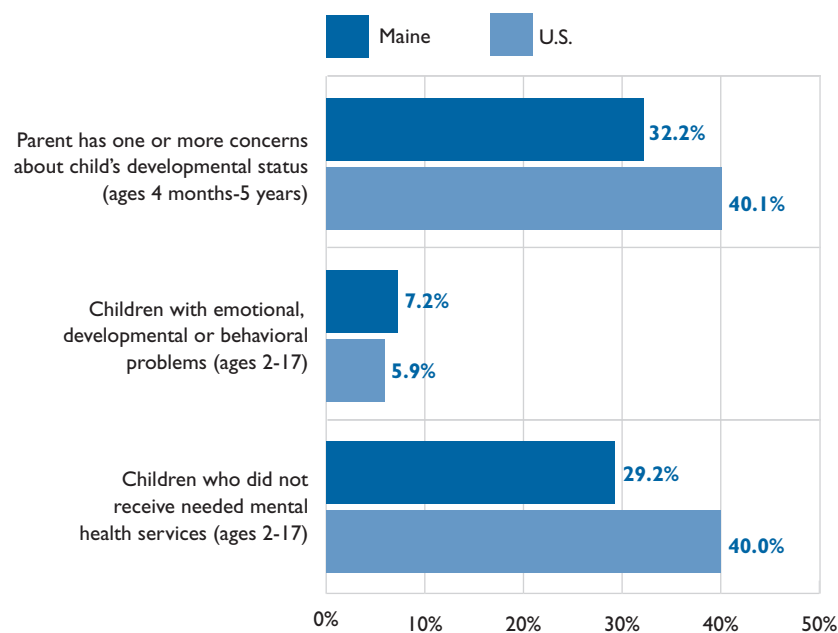
Develop a coherent system of early care and education that aligns, integrates, and coordinates what happens from birth through grade 3 so children are ready to take on the learning tasks associated with fourth grade and beyond.

The Maine Children's Alliance strongly supports this recommendation and believes it is critical to the mental health of children. A system built upon early care will identify and address behavioral health issues at an early age, when interventions are more timely and cost effective.

FOR CHILDREN AND ADOLESCENTS, good mental health is the achievement of developmental cognitive, social, and emotional milestones that result in secure attachments, satisfying social relationships, and effective coping skills. Children's behavior at home and school, their academic performance, and their ability to participate in community life is directly influenced by their mental health.¹

According to the 2007 National Survey of Children's Health (NSCH), 20,562 children (7.2%) in Maine ages 0-17 had an emotional, developmental or behavioral problem for which they needed treatment or counseling. More than 29% of Maine children (and 40% of U.S. children) with mental health issues did not receive needed mental health services.

Children's Mental Health, 2007



Source: 2007 National Survey of Children's Health

Children experiencing mental, emotional, behavioral or learning problems often struggle socially or academically. Additional pressures and stressors come into play as a child grows into adolescence. While school-based supports identify and address emotional and mental health problems, other key supports for healthy social and emotional development include specialized supports such as behavioral health services, after school substance abuse treatment programs, community-based recreation programs, and teen health services.²

DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Child and Family Services

Children's Behavioral Health Services

Children's Behavioral Health Services provides leadership in the development of a comprehensive system of care that ensures that each child develops to his/her full potential. The system of care strengthens the capacity of families, promotes natural helping networks, and develops community resources to meet behavioral, developmental, and treatment needs of children.

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

2 Report of the Surgeon General's Conference on Children's Mental Health: A National Agenda (2000). Washington, DC: Department of Human Services.

Maine Care Data Source: For this report, the DHHS’ Office of Integrated Services & Quality Improvement provided 2008 Fiscal Year paid claims data. The extract was based on the data developed for the Substance Abuse and Mental Health Service Administration (SAMHSA) Mental Health Data Infrastructure Grant (DIG). Individuals are identified as having a mental health condition if they receive an ICD-9 diagnosis between the range 290 to 314.9 (excluding 291, 292, 303-306.9) and receive at least one mental health treatment or support service during the year (services are defined in DIG extract). Individuals with exclusive developmental disabilities are not included in this data set. However, children with a pervasive developmental (PPD) and a co-occurring mental health diagnosis were included in the analysis. The inclusion of PPD spectrum children accounts for the higher percentage of 0-5 children with a diagnosis of “other psychotic.” This data set includes a child welfare field, allowing comparisons across systems.

The MaineCare data include the following services:

- Outpatient: service units measured in ¼ hours
- Home and Community Based Services: service units measured in ¼ hours
- Day Treatment: service units measured in days
- Targeted Case Management: service units measured in months
- Residential Placement/Treatment: service units measured in days
- Medication Assessment and Treatment Services: service units measured in ¼ hours
- Crisis Intervention and Resolution Services: service units measured in ¼ hours
- Psychological/Neurological Testing-Evaluation: service units measured in ¼ hours
- Children’s Assertive Community Treatment (ACT): service units measured in months
- Inpatient: no service units measurement available

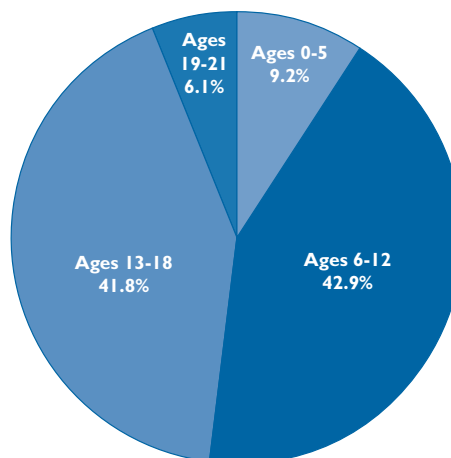
For a detailed explanation of services, see page 55.

Children Receiving Mental Health Services, 2008

	MAINE NUMBER	PERCENT
Children receiving mental health services, SFY 2008 (as percent of children age 0-21)	18,877	5.4%
Ages 0-5 (as percent of children age 0-5)	1,730	2.0%
Ages 6-12 (as percent of children age 6-12)	8,106	7.6%
Ages 13-18 (as percent of children age 13-18)	7,887	7.3%
Ages 19-21 (as percent of children age 19-21)	1,154	2.3%

In 2008, 18,877 children 21 years or younger, and who were covered by MaineCare, received services through Children’s Behavioral Health.

**Age of Children Receiving
Children’s Behavioral Health Services, 2008**
as % of children receiving mental health services



Mental Health Services Received, 2008

	MAINE NUMBER	AS % OF SERVICES RECEIVED	AVERAGE UNITS
Outpatient	13,524	39.0%	3.4 hrs.
Targeted Case Management	7,161	20.6%	7.6 mos.
Medication Assessment and Treatment Services	4,628	13.3%	1.5 hrs.
Home and Community Based Services	2,745	7.9%	8.6 hrs.
Residential Placement/Treatment	1,934	5.6%	25.7 days
Crisis Intervention and Resolution Services	1,590	4.6%	1.0 hrs.
Inpatient	1,462	4.2%	N/A*
Day Treatment	653	1.9%	48.6 days
Psychological/Neurological Testing-Evaluation	591	1.7%	1.2 hrs.
Children's Assertive Community Treatment (ACT)	395	1.1%	3.5 mos.
TOTAL SERVICES	34,683	100%	

*Inpatient service units (# of stays in the hospital) could not be calculated. See Psychiatric Hospital Visits data on page 25.

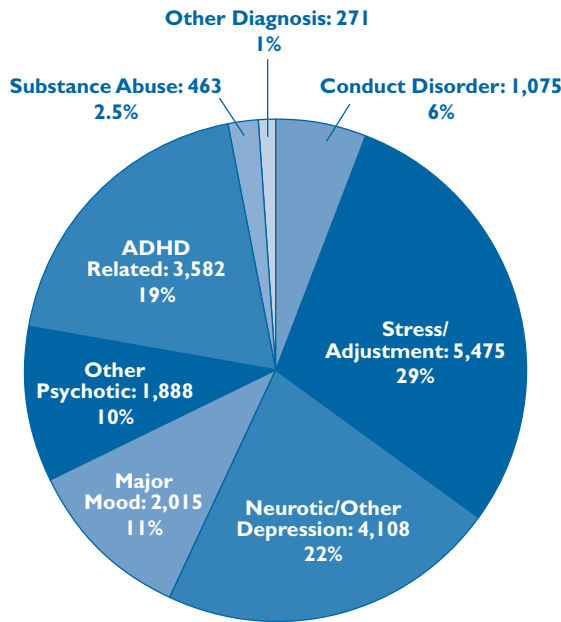
Service units are subject to variation across services. That is, mental health services can be measured in ¼ hours, days, or months. The table above details the services received and the average units of those services. The 18,877 children receiving mental health services received 34,683 units of service in 2008. Accounting for the majority of mental health service received were outpatient services (39%), targeted case management (20.6%) and medication assessment and treatment (13.3%). Children receiving outpatient services averaged 3.38 hours of treatment. Children in residential placement/treatment averaged 25.7 days of that service. Finally, more males than females received day treatment services than females.

The MaineCare data include the following diagnoses:

- Conduct Disorder includes oppositional defiance disorder, disruptive behavior disorder, reactive and attachment disorder.
- Stress/Adjustment includes adjustment disorders, separation anxiety, post-traumatic stress disorder, eating disorders, and acute stress disorders.
- Neurotic/Other Depression includes generalized anxiety disorder, phobias, dissociative disorders, panic disorders, personality disorders, and obsessive compulsive disorder.
- Major Mood Disorder includes bipolar disorders, major depressive disorders and other mood disorders.
- Other Psychotic includes schizophrenia (disorganized, catatonic & paranoid), schizophreniform disorder, and schizoaffective disorder.
- ADD/ADHD includes attention deficit/hyperactivity disorders
- Substance Abuse includes alcohol dependence or abuse, drug dependence or abuse, nicotine dependence or abuse, inhalant abuse, and other substance abuse.
- Other Diagnosis includes other disorders not captured in the other diagnostic categories.

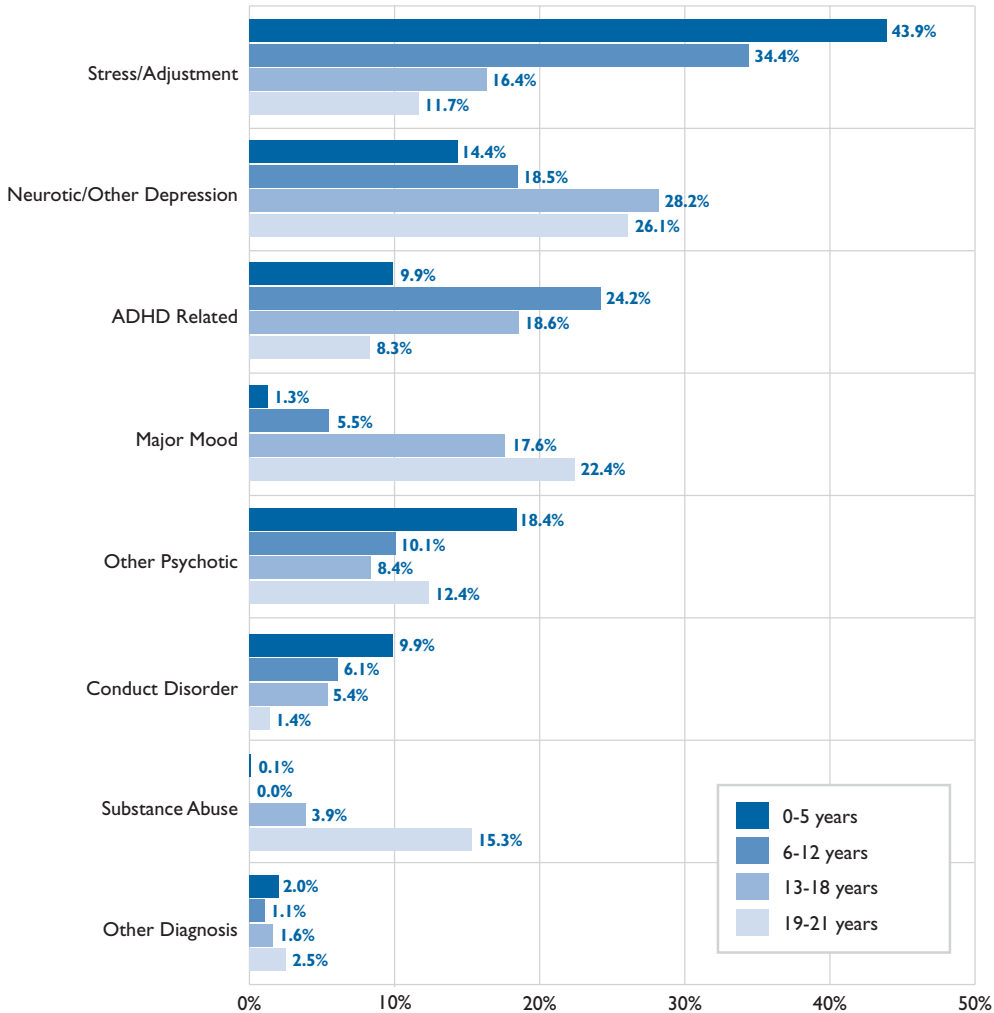
Diagnosis of Children, 2008

as % of children ages 0-21 receiving mental health services



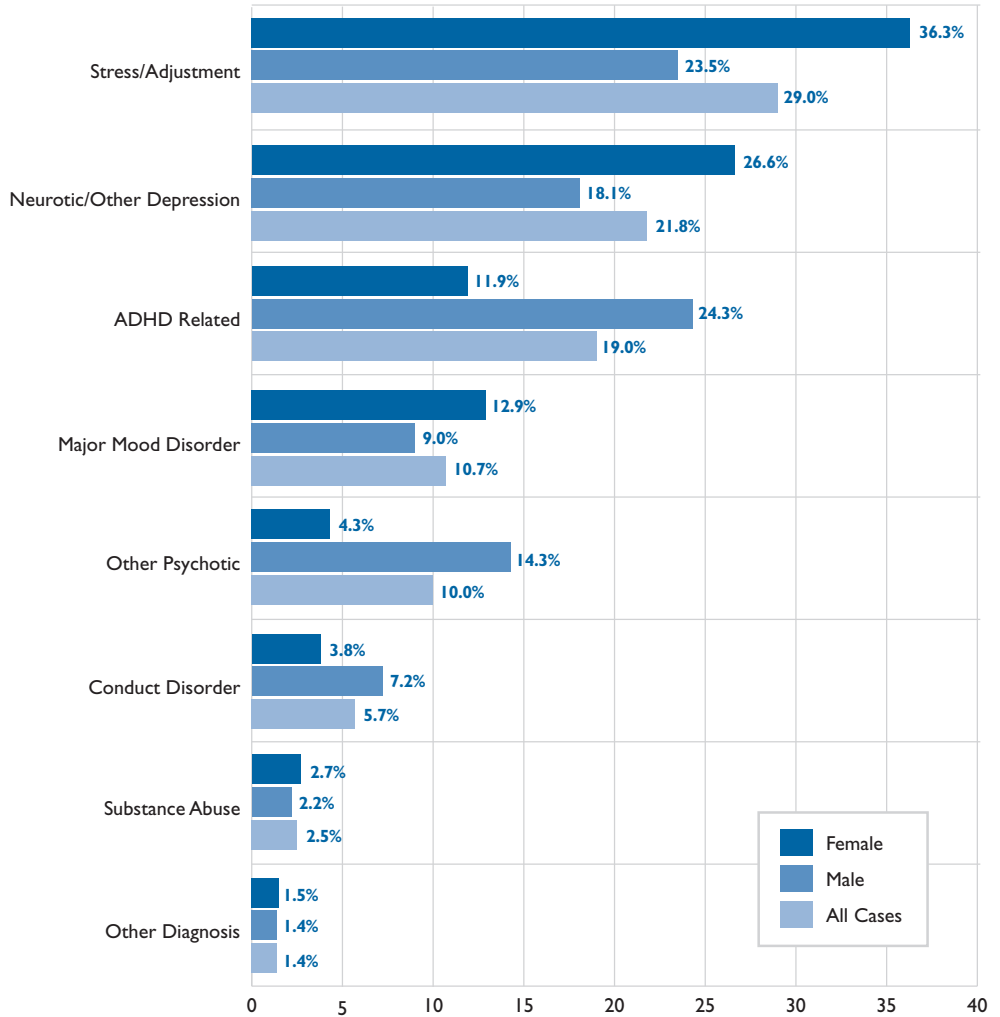
Diagnosis by Age Group, 2008

as % of children receiving mental health services



Accounting for the majority of the diagnosis given to children ages 0-21 receiving mental health services were Stress Adjustment (29%), Neurotic/Other Depression (22%) and ADHD Related (19%). Within the 0-5 age group, Stress Adjustment (43.9%), Other Psychotic (18.4%), Neurotic/Other Depression (14.4%), and Conduct Disorder (9.9%) accounted for the majority of diagnosis. Within the 6-12 year olds, most were diagnosed with Stress Adjustment (34.4%), ADHD Related (24.2%), or Neurotic/Other Depression (18.5%). The majority of diagnosis for the adolescent age group included Neurotic/Other Depression (28.2%), ADHD Related (18.6%), Major Mood Disorder (17.6%) and Stress Adjustment (16.4%). For the older adolescents over age 18, Neurotic/Other Depression (26.1%), Major Mood (22.4%), Substance Abuse (15.3%) and Other Psychotic (12.4%) were diagnosed most often.

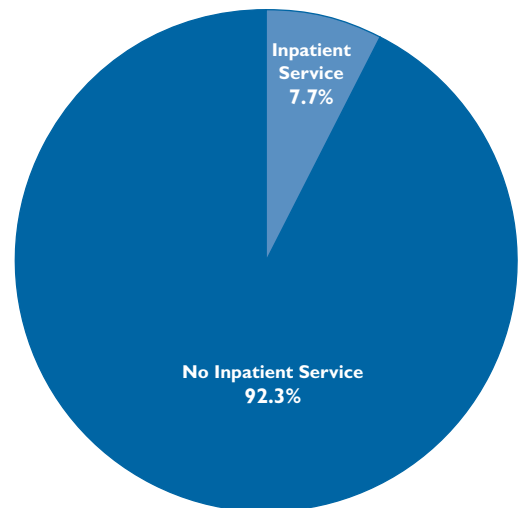
Diagnosis by Gender, 2008
as % of children receiving mental health services



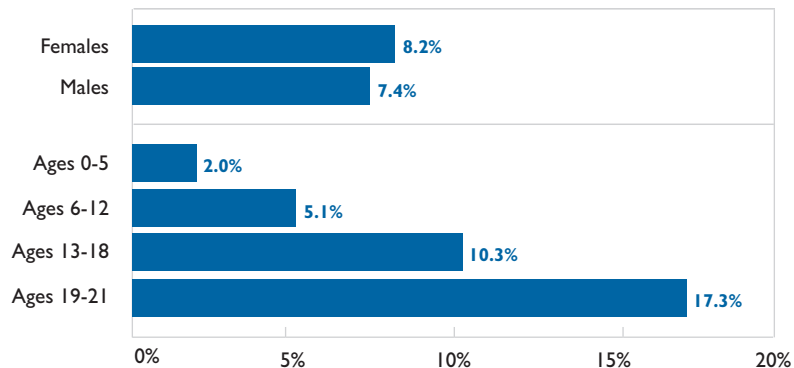
A majority of the 8,154 females receiving children’s mental health services were diagnosed with Stress Adjustment (36.3%), Neurotic/Other Depression (26.6%), and Major Mood Disorder (12.9%). For the 10,723 males receiving mental health services, a majority were diagnosed with ADHD Related (24.3%), Stress/Adjustment (23.5%), Neurotic/Other Depression (18.1%) or Other Psychotic (14.3%).

Children Receiving Inpatient Services, 2008

Some children with mental health issues require placement in a hospital setting. Of the 18,877 children receiving services in 2008, 7.7% had at least one inpatient placement. Females had a slightly higher percentage of inpatient episodes (8.2%) than did males (7.4%).

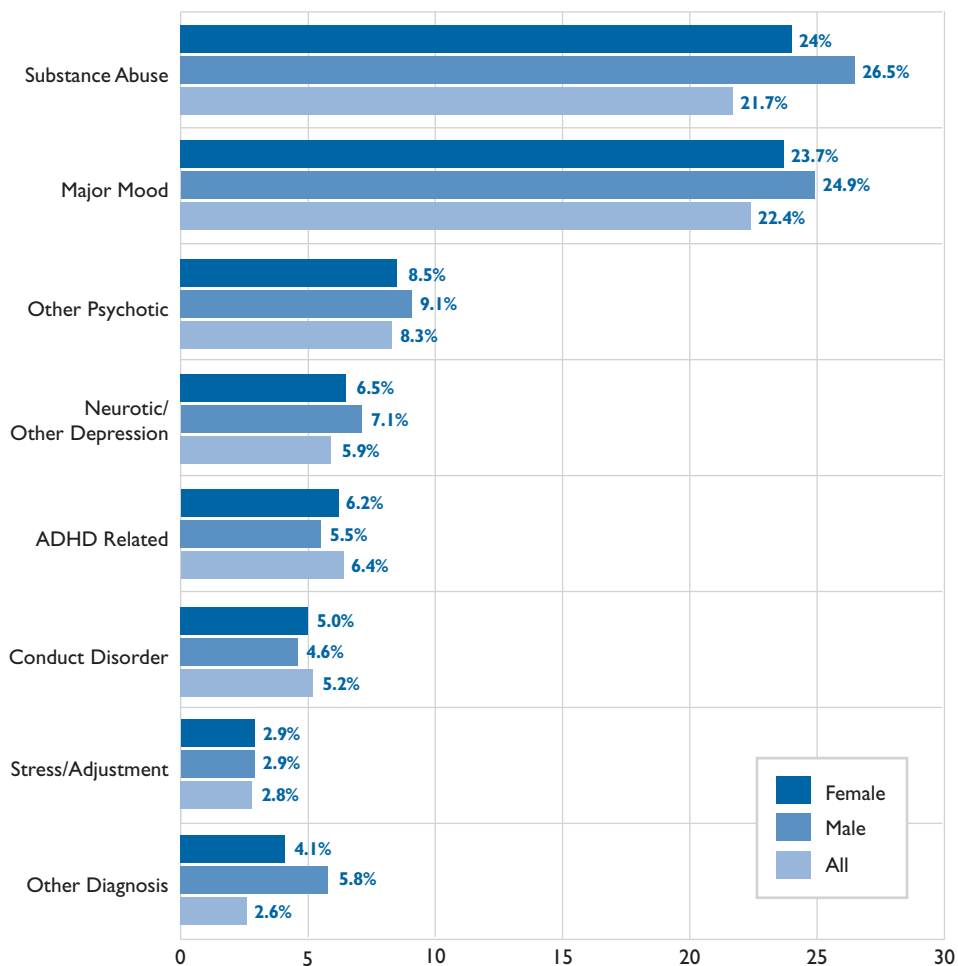


Inpatient Service by Gender and Age, 2008
as % of children receiving mental health services



Older children had higher percentages of inpatient service than did younger children. Two percent of the 1,730 children ages 0-5 receiving mental health services had at least one inpatient service. In addition, more females than males had an inpatient service. Because females tend to come into the mental health system at an older age, this might explain their slightly higher inpatient rate.

Inpatient Service by Diagnosis, 2008
as % of children receiving mental health services



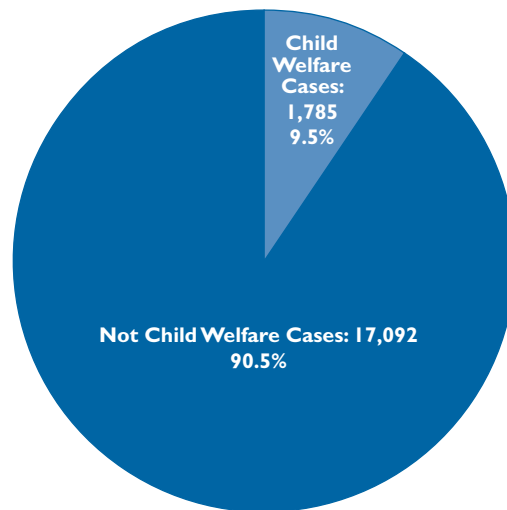
Almost one quarter of children with a diagnosis of major mood and substance abuse experienced an inpatient service. Less than 10% of children with other diagnoses experienced an inpatient service.

Inpatient service was more likely with a diagnosis of Substance Abuse or Major Mood Disorder. As indicated earlier, females experienced more inpatient service than males across diagnoses. However, slightly more males than females with a diagnosis of Conduct Disorder and ADHD had an inpatient service.

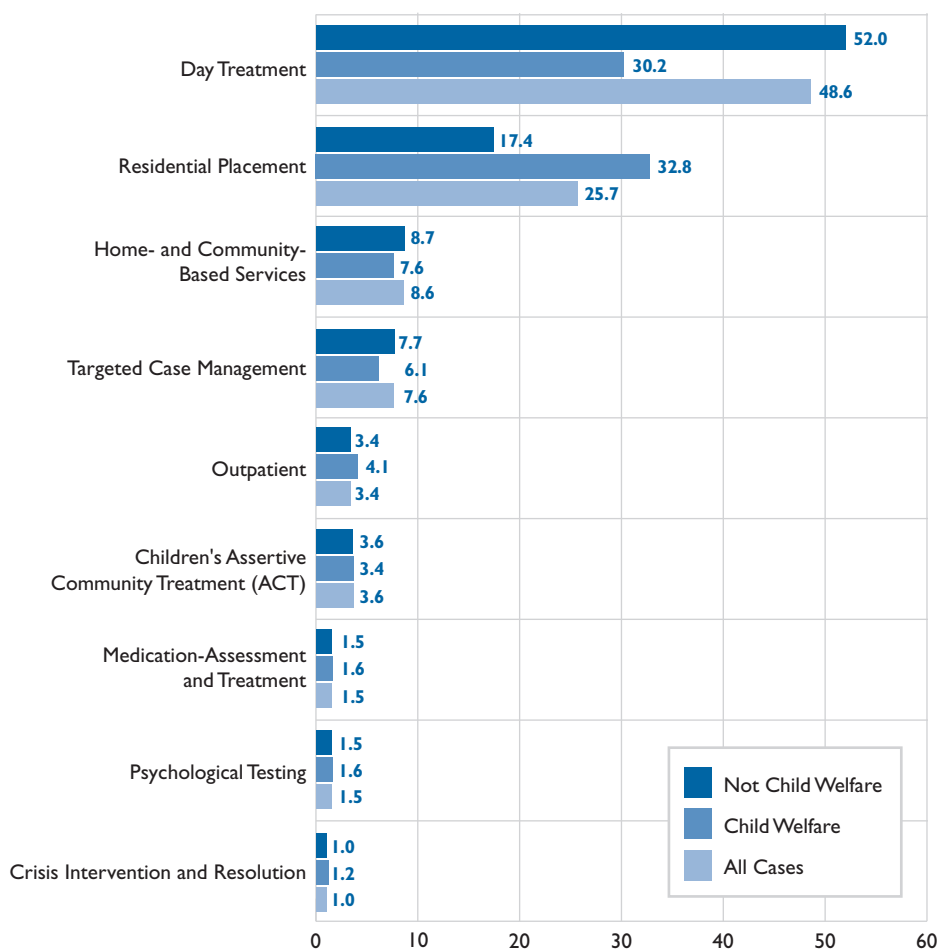
Child Welfare and Mental Health Services

Of the 18,877 children receiving mental health services in 2008, 1,785 (9.5%) were also receiving services through Child Welfare. For reference, there were 1,850 children in the DHHS care or custody in December, 2008. Thus, most kids in custody receive mental health services.

Child Welfare Cases, 2008
as % of children receiving mental health services

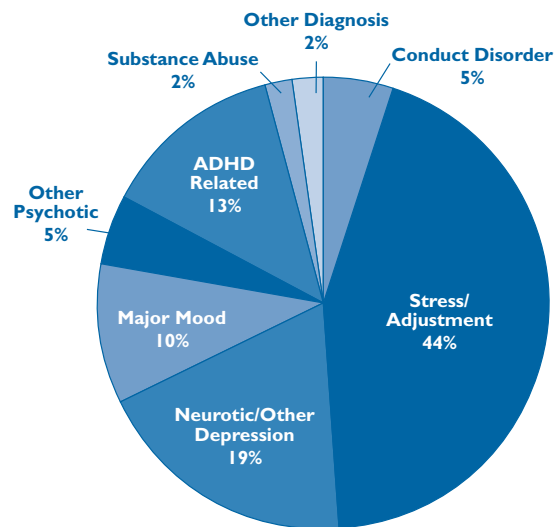


Units of Mental Health Services By Child Welfare Status, 2008



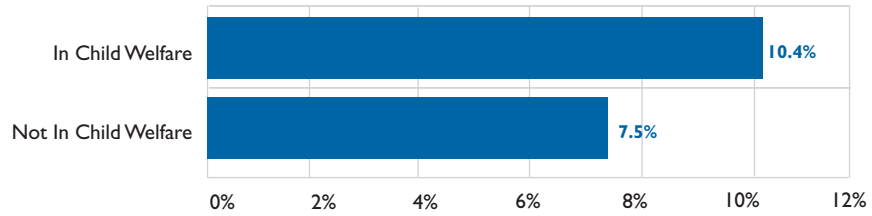
More children in state care or custody (Child Welfare) received a residential placement than children who were not in state care or custody. Children who were not in Child Welfare received day treatment services at a higher rate than kids in state care or custody.

Mental Health Diagnosis of Child Welfare Cases, 2008
as % of children receiving mental health services



More children in state care or custody were diagnosed with Stress/Adjustment than children not in state care or custody (44% vs. 28%).

Inpatient Service by Child Welfare Status, 2008
as % of children receiving mental health services



A higher percentage of the children in Child Welfare had an inpatient service than the children not in Child Welfare (10.4% vs. 7.5%). More than 32% of Child Welfare children with a Major Mood Disorder diagnosis had an inpatient service compared to 22.9% of non-Child Welfare children with the same diagnosis. More than 21% of children in Child Welfare with a diagnosis of Other Psychotic had an inpatient service. For children not in Child Welfare with a diagnosis of Other Psychotic, only 7.8% had an inpatient service. Substance Abuse was the only diagnosis where non-Child Welfare children had a higher percentage of inpatient service than children in Child Welfare (24.2% vs. 20.6%).

PSYCHIATRIC HOSPITAL VISITS

APS Healthcare was awarded the contract with the State of Maine’s Department of Health and Human Services to provide a Behavioral Health Utilization Management System for services currently purchased through the State’s Office of Maine Care Services and administered by the Adult Mental Health Services, Children’s Behavioral Health Services, and the Office of Substance Abuse. Using APS data allows for a closer look at inpatient services.

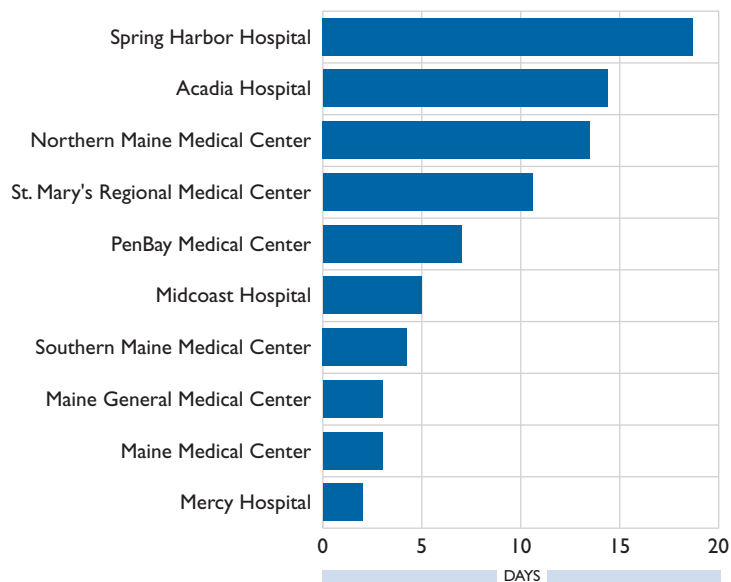
The average length of stay in a child psychiatric hospital was 8.15 days, ranging from two days at Mercy to 18.7 days at Spring Harbor. The community hospitals (PenBay, Midcoast, SMMC, ME Gen, ME Medical Center & Mercy) had lower lengths of stays because many of their patients transfer to Spring Harbor, Acadia, Northern ME Medical or St. Mary’s.

The hospital readmission rate is a key healthcare quality measure that is used nationally to measure the effectiveness of healthcare systems. The 30 day readmission rate (readmission to a hospital within 30 days of discharge) is the most widely used version. This report shows the MaineCare-funded child psychiatric hospital readmission rate for Maine hospitals.

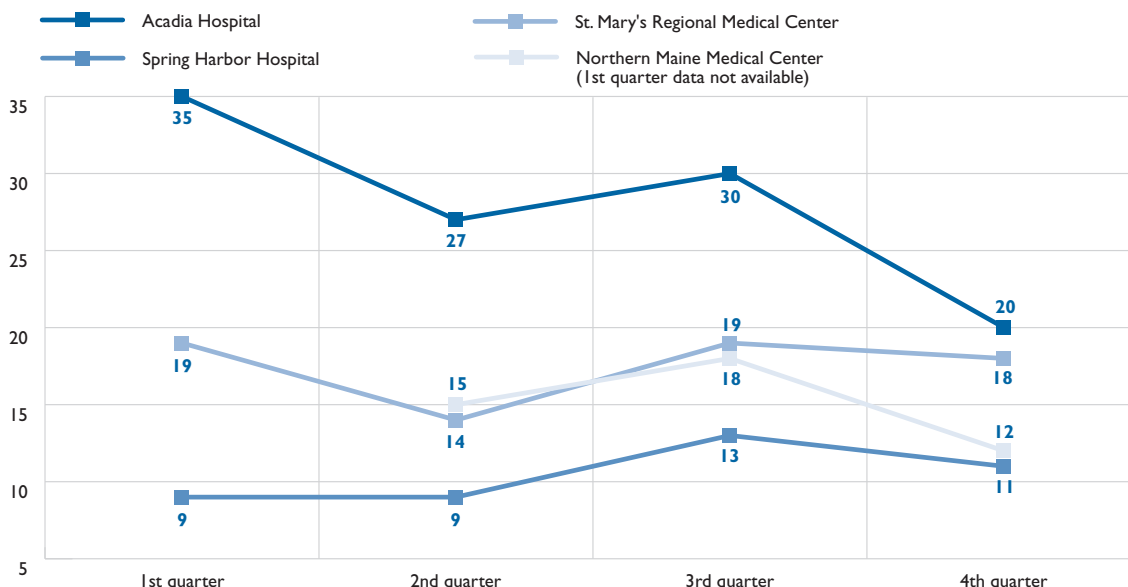
Below are highlights from a recent APS report, *MaineCare-Funded Child Psychiatric Hospital Readmission Report: FY2009*.

- In FY 2009, out of 1,791 discharges statewide, 18% (321) had a readmission within 30 days.
- 79% (252 of 321) of readmissions were to the original admitting facility; 11% (69 of 321) were readmitted to a different facility.
- There are differences in 30 day readmission rates among the hospitals and through the course of the year.
- Changes from quarter to quarter may be due to normal seasonal change. Starting in FY2010, this report will compare change from year to year and within the year.

Average Length of Stay in Psychiatric Hospital, 2008



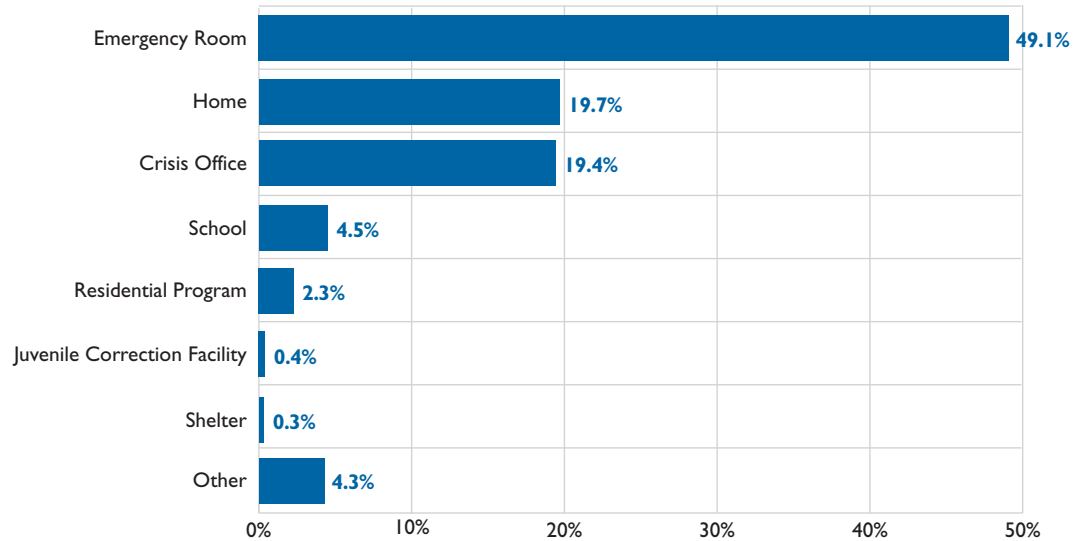
30 Day Readmissions per 100 Discharges, 2008



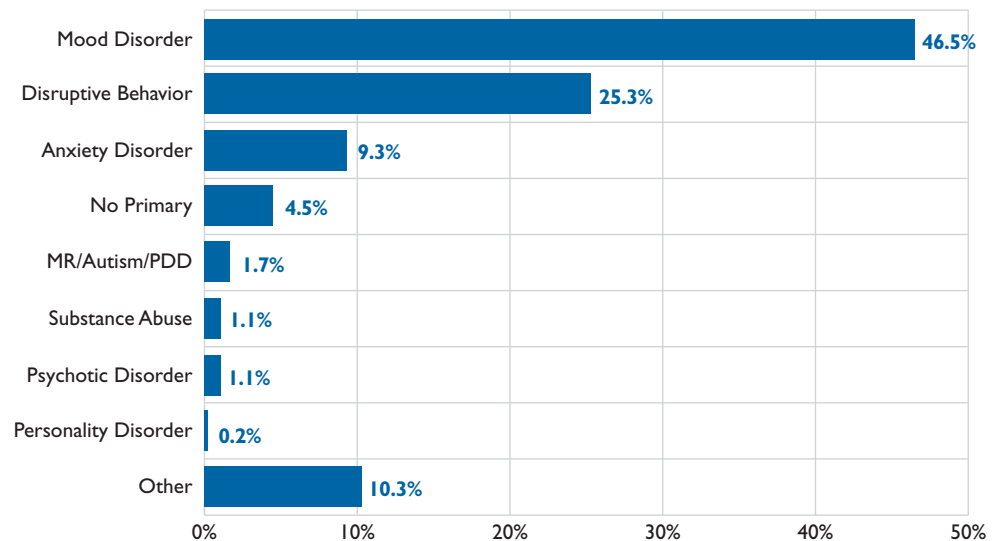
Crisis Services

A crisis is a time when a parent or caregiver is worried for their child’s safety and need help dealing with the child’s behaviors or dangerous thoughts. Children’s Behavioral Health Services provides crisis intervention and reports this data on a monthly basis. The following is a summary of the crisis reports from January to December, 2008.

Location of Crisis Intervention Assessments, 2008



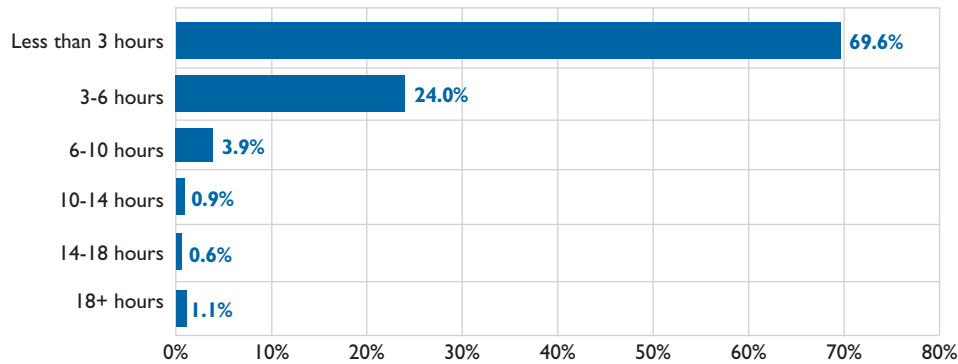
Presenting Concern in Crisis Intervention Assessment, 2008



The “presenting concerns” listed above do not correspond with the diagnostic categories used earlier in the analysis of CBHS MaineCare claims data.

A majority of children receiving crisis intervention lived with their parents (83.7%), while 10% were in state care or custody. More than half the children in crisis received an assessment in less than 4 hours after referral.

Time Between Assessment and Resolution of Crisis Intervention, 2008



ADVERSE CHILDHOOD EXPERIENCES

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations into traumatic stressors in childhood and how those experiences relate to health and well-being later in life. The ACE Study calculates an ACE Score, which is a count of the total number of ACE reported by participants. The ACE Study findings suggest that as the number of ACE increase, the risk for the following health problems increases in cumulative fashion:

- Alcoholism and alcohol abuse
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies

The ACE Study also found that childhood trauma is related to health-related behaviors and outcomes during childhood and adolescence. That is, study participants with a high ACE score reported early initiation of smoking, sexual activity, illicit drug use, adolescent pregnancies, and suicide attempts. Finally, as the number of ACE increases the number of co-occurring conditions increases.³

TRAUMA-INFORMED CARE

The THRIVE System of Care Initiative in Maine helps providers and community organizations in Androscoggin, Franklin and Oxford counties transform the way services are delivered to children, families of children, and to youth who are affected by serious emotional and behavioral challenges. THRIVE's trauma-informed trainings and technical assistance, its committees and activities are family-driven, youth-guided and culturally and linguistically competent. Rather than working with a child and asking "What's wrong?" trauma-informed care asks "What has happened?" This approach recognizes a "problem" behavior as a way of coping with or adapting to painful current circumstances or as a stress response related to past trauma.

In a study of 60 THRIVE participants and their caregivers, Hornby Zeller and Associates examined the intergenerational effects of trauma on child and family outcomes.⁴ Eighty-eight percent of caregivers reported having experienced at least one trauma event before the age of 18, and 63% reported experiencing three or more trauma events before age 18. On average, caregivers reported having experienced 7.6 trauma events in their lifetime. For the youth in the study, 41 of the 60 participants (68%) reported experiencing three or more trauma events, with an average being four events.

The study also examined symptoms and outcomes among children who were both experiencing trauma AND living with a caregiver who also had an extensive trauma history. The analysis revealed that caregivers who experienced three or more trauma events and who also had a child/youth who had experienced three or more trauma events reported higher stress levels than caregivers who had not experienced three or more events. In addition, youth in this group exhibited significantly higher scores for depression, anger, sexual concerns, and rates of residential treatment than their peers who had fewer trauma events. The results of this study support the need for family-centered care that addresses both youth and family experiences.

3 Department of Health and Human Services, Center for Disease Control and Prevention. Adverse Childhood Experiences Study. <http://www.cdc.gov>

4 H. Hornby and S. Goan. "First Look: The Intergenerational Effects of Trauma on Child and Family Outcomes." March 2, 2009.

Child Protective Services

Within the Office of Child and Family Services, Child Protective Services (CPS) is mandated to respond to reports of suspected child abuse and neglect. When risk is found to be severe, supervisors assign a child protective caseworker from Child and Family Services to do a safety assessment, looking specifically at whether each child in the home is safe and, if not, what must be done to keep each child safe.

Each year DHHS provides a summary of the number of referrals to CPS, the number of inappropriate referrals that were screened out, and a series of detailed reports on the characteristics of the referrals that were assigned to caseworkers for assessment. In 2008 there were 6,168 reports of child abuse and neglect. Within those reports, there were a total of 10,543 family stress factors identified. Many families had more than one identified stress factor.

Sources of Child Protective Services Reports, 2008

	MAINE NUMBER	PERCENT
School Personnel	966	15.6%
Law Enforcement Personnel	958	15.5%
Social Services Personnel	771	12.5%
Medical Personnel	658	10.7%
Anonymous	611	9.9%
Mental Health Personnel	489	7.9%
Relative	489	7.9%
Self/Family	486	7.9%
Neighbor/Friend	456	7.4%
Child Care Personnel	100	1.6%
Other	194	3.1%
TOTAL	6,178	100.0%

Family Stress Factors Identified During Assessment, 2008

	MAINE NUMBER	PERCENT
Mental/Physical Health Problem	3,501	33.2%
Alcohol/Drug Misuse by Parent/Caretaker	2,066	19.6%
Family Violence	1,352	12.8%
School Problems	767	7.3%
Severe Parent/Child Conflict	740	7.0%
Severe Acting Out Behavior of Child	668	6.3%
Divorce Conflict	597	5.7%
Emotionally Disturbed Child	545	5.2%
Alcohol/Drug Misuse by Child	183	1.7%
Runaway	92	0.9%
Failure To Thrive Child	32	0.3%
TOTAL	10,543	100.0%

Child Abuse and Neglect Victims by Age and Gender, 2008

	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
MALE				
Ages 0-4	30	163	673	245
Ages 5-17	70	208	698	559
Total	100	371	1371	804
FEMALE				
Ages 0-4	42	119	633	268
Ages 5-17	167	196	704	508
Total	209	315	1337	776
ALL CHILDREN				
Ages 0-4	72	282	1306	513
Ages 5-17	237	404	1402	1067
Total	309	686	2708	1580

Child Welfare Services

The Division of Child Welfare 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 DHHS as a result of a child abuse or neglect situation that necessitated the removal of the child from his or her family.

Currently, Child Welfare Services collects data on children’s mental health through the state’s 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 include:

- Whether the child has 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.

Child Welfare Services Reports, 2008

Total Referred	18,478
Substantiated	4,582
Screened Out	9,975
Opened for CPS Service	6,178
Referred to Contract Agency	2,325

Child Welfare Services Assessments, 2008

Indicated (low-moderate abuse)	2,494
Substantiated (moderate-severe abuse)	2,065
Unsubstantiated (no abuse found)	23
TOTAL	4,582

CHILD WELFARE DEFINITIONS:

TOTAL REFERRED:The number of referrals for Child Protective Services (CPS) intervention in a family situation.

SUBSTANTIATED:The child protective caseworker makes a determination, based on a preponderance of the evidence, that child abuse or neglect has occurred or is threatened to occur.

SCREENED OUT:A report that does not meet the statutory definition of child abuse and/or neglect and does not meet the “Appropriate to Accept for Assessment Criteria.”

OPENED FOR CPS SERVICE: When risk to a child is severe, child protective supervisors assign a child protective caseworker from Child and Family Services. Caseworkers do a safety assessment, looking specifically at whether each child in the home is safe and, if not, what must be done to keep each child safe.

REFERRED TO CONTRACT AGENCY: Child protective supervisors can refer the report to a Community Intervention Agency. These private agencies are contracted to offer services or coordinate services designed to reduce the risk of child abuse or neglect, such as counseling, substance abuse treatment or parenting education.

An **INDICATED** finding means that, by a preponderance of the evidence, a parent(s)/caregiver(s) has caused and/or is likely to cause low/moderate severity child abuse. Signs of risk may also be present.

A **SUBSTANTIATED** finding means that, by a preponderance of the evidence, a parent(s)/ caregiver(s) has caused and/or is likely to cause high severity child abuse and neglect. This person is considered a danger to children.

An **UNSUBSTANTIATED** finding means that, by a preponderance of the evidence, a parent(s)/ caregiver(s) did not abuse or neglect a child. However, signs of risk may be present.

INITIAL PLACEMENT OF CHILDREN REMOVED FROM HOME DEFINITIONS:

KINSHIP CARE: Family foster care provided to children in the care or custody of DHHS who are related by blood, marriage, or adoption to the caretakers. Kinship care is a preferred placement.

FOSTER CARE: Parental care and supervision which is provided within a family setting in a private dwelling on a regular, 24-hour a day basis by qualified foster parent(s). The foster parents hold a license as a family foster home for children required by state law.

THERAPEUTIC CARE: Family foster care utilizes the foster home setting and the foster parents as primary agents in improving the behavioral and emotional functioning of foster children.

UNLICENSED CARE: A placement that occurs when (a.) a relative is identified and immediate placement is recommended, (b.) when a child places himself in an unlicensed home and that placement is being considered, or (c.) a previous relationship exists between a child and an unlicensed family with indications that it would be in the child's best interest to be placed in that home,

CONGREGATE CARE: Care that occurs in a homeless shelter, emergency facility, or children's residential facility.

BRIDGE HOME: This is a transitional placement geared to stabilize behavior in preparation for a less restrictive, community-based placement.

OTHER CARE: Care not covered in the above descriptions, including semi-independent living, professional parent model, and intermediate care facility.

Child Welfare Substantiated Reports, 2008

	MAINE NUMBER	PERCENT
<2 years of age	1,001	21.8%
5 years of age	1,252	27.3%
6-9 years of age	989	21.6%
10-13 years of age	786	17.2%
14-17 years of age	551	12.0%
18+ years of age	3	0.1%
Total	4,582	100%

Of the substantiated reports, 50% were females and 50% were males.

Child Welfare Prior Report of Abuse, 2008

	MAINE NUMBER	PERCENT
Yes	2,722	59.4%
No	1,860	40.6%
Total	4,582	100.0%

Child Welfare Type of Abuse Indicated, 2008

	MAINE NUMBER	PERCENT
Emotional Abuse	3,409	55.7%
Neglect	1,191	19.5%
Physical Abuse	1,022	16.7%
Sexual Abuse	493	8.1%
Total*	6,115	100.0%

* Total is greater than the number of cases because some children had more than one type of abuse.

Initial Placement of Children Removed from Home, 2008

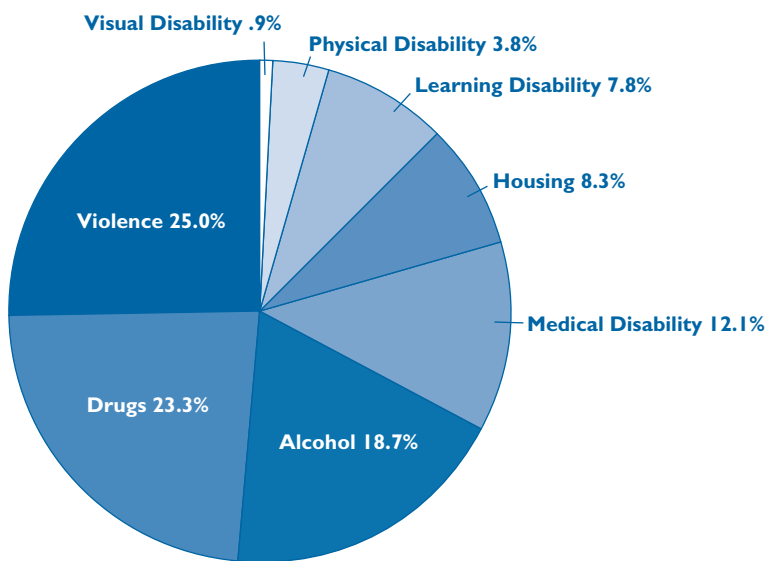
	MAINE NUMBER	PERCENT
Kinship Care	308	37.7%
Foster Care	270	33.0%
Therapeutic Care	96	11.7%
Unlicensed Care	50	6.1%
Congregate Care	37	4.5%
Bridge Home	5	0.6%
Other Care	52	6.4%
Total	818	100.0%

Of Those Removed From Home, Number of Removals, 2008

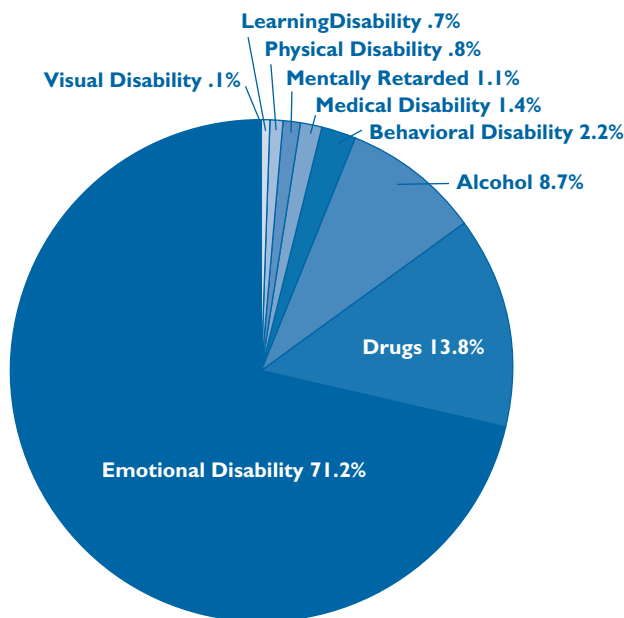
	MAINE NUMBER	PERCENT
One Removal	739	90.3%
Two Removals	71	8.7%
Three Removals	8	1.0%
Total	818	100.0%

Of the 818 children removed from their home during 2008, 79 children had two or three prior removals between October 1, 2005 and September 30, 008.

Child Welfare Family Risk Factors, 2006-2008



Child Welfare Children's Risk Factors, 2006-2008



KINSHIP CARE is the placement of a child with relatives on a permanent basis by the court and the child welfare system. While it appears that 308 children were formally placed in Kinship Care in 2008, what is not known is how many children were placed with a relative without court involvement. Kinship caregivers under an informal placement may not receive financial or health benefits for the child that would be provided to kinship caregivers under a formal placement. The collection of data pertaining to informal kinship placements would allow for a better understanding of the scope of this practice and the children and kinship families needing services.

Child Welfare Services Received, 2008

	MAINE NUMBER	PERCENT
Foster Care*	860	21.2%
Court Appointed Representative	843	20.7%
Post Investigation	645	15.9%
Other	613	15.1%
Juvenile Court Petition	367	9.0%
Day Care	253	6.2%
Transportation	273	6.7%
Family Preservation	72	1.8%
Counseling	44	1.1%
Respite	23	0.6%
Legal	24	0.6%
Health	15	0.4%
Substance Abuse	14	0.3%
Pregnancy/Parenting	7	0.2%
Housing	5	0.1%
Education	2	0.0%
Employment	1	0.0%
Family Support	1	0.0%
Home-based	1	0.0%
Social Security Disability	1	0.0%
Total	4,064	100.0%

*This figure represents foster care services provided during SFY 2008 and is greater than the number of children removed from the home in SFY 2008 (page 30). The above figure includes foster care services provided to children who were removed from the home prior to 2008.

Child Welfare Case Removals by Type of Abuse, 2008

	MAINE NUMBER	PERCENT
EARLY CHILDHOOD (UNDER 5)	516	100.0%
Neglect	280	54.3%
Emotional Abuse	137	26.6%
Physical Abuse	88	17.1%
Sexual Abuse	11	2.1%
SCHOOL AGE (5-17)	592	100.0%
Neglect	268	45.3%
Emotional Abuse	214	36.1%
Physical Abuse	80	13.5%
Sexual Abuse	30	5.1%
ALL AGES	1,108	100.0%
Neglect	548	49.5%
Emotional Abuse	351	31.7%
Physical Abuse	168	15.2%
Sexual Abuse	41	3.7%

Child Welfare Cases With More Than One Removal Who Re-enter DHHS Custody Within Six and Twelve Months, 2008

	MAINE NUMBER	PERCENT
EARLY CHILDHOOD (UNDER 5)	31	100.0%
Return within 6 months	8	25.8%
Return within 12 months	4	12.9%
Return after 12 months	19	61.3%
SCHOOL AGE (5-17)	62	100.0%
Return within 6 months	5	8.1%
Return within 12 months	9	14.5%
Return after 12 months	48	77.4%
ALL AGES	93	100.0%
Return within 6 months	13	14.0%
Return within 12 months	13	14.0%
Return after 12 months	67	72.0%

In 2008, 93 children re-entered into DHHS state care or custody. Most of these returns occurred after being out of state custody for more than twelve months.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Substance Abuse (OSA)

“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.”

– *Maine Office of Substance Abuse website*

The OSA collects, maintains, and publishes data from a variety of sources. The sources for this report are the Treatment Data System (TDS) and the Maine Youth Drug and Alcohol Use Survey (MYDAUS). The TDS collects data on clients who are receiving substance abuse treatment from OSA contracted providers or from methadone treatment providers, or who are involved in the Driver Education and Evaluation Program (DEEP). These data are used for state and federal reporting requirements, and for monitoring substance abuse trends, and for evaluating the effectiveness of contracted providers. Data are also used for needs assessment planning and workforce development.

The purpose of the MYDAUS is to quantify the use of alcohol, tobacco and other substances among middle and high school students in Maine, and to identify the risk and protective factors that influence a student’s choice of whether or not to engage in these and related harmful behaviors. These influences are found in the different domains of the student’s social environment: peer group, family, school, and community. Identification of specific populations in which the risk factors are high and the protective factors are low permits the targeting of interventions where they are most needed.

“RISK FACTORS are characteristics of school, community, and family environments, as well as characteristics of students and their peer groups that are known to predict increased likelihood of drug use, delinquency, and violent behaviors among youth. For example, children who live in disorganized, crime-ridden neighborhoods are more likely to become involved in crime and drug use than children who live in safer neighborhoods.”

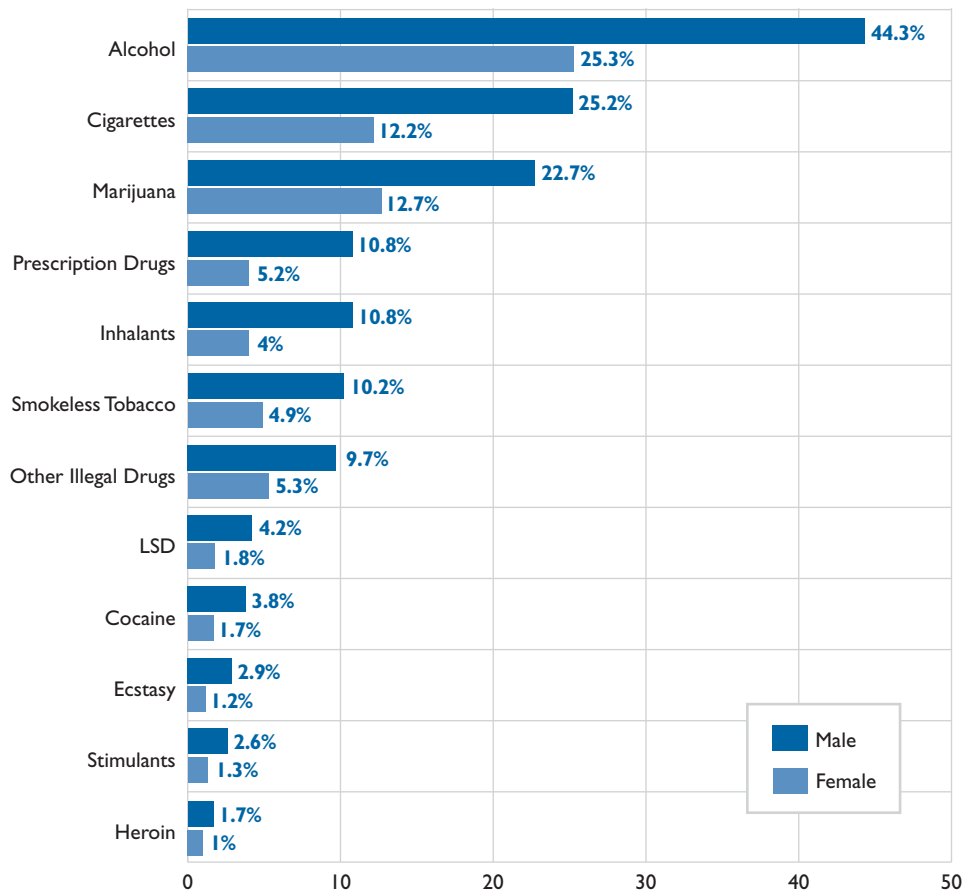
– from 2008 MYDAUS Report

Maine Youth Drug and Alcohol Use Survey (MYDAUS)

As indicated previously, the purpose of the MYDAUS is to identify patterns of alcohol, tobacco, and other drug use among middle and high school students in Maine, and to measure the prevalence of the underlying characteristics of a student’s social environment that influence his/her decision whether or not to use substances or engage in other prohibited behaviors. These risk and protective factors are found at all social levels (domains): peer group, family, school and the greater community.

The 2008 MYDAUS results were based on surveys from 74,953 students from 340 schools in 141 districts. All 16 counties were represented. Approximately 70% of all eligible students (grades 6-12) participated.

Prevalance of Lifetime and Past Month Substance Use, 2008

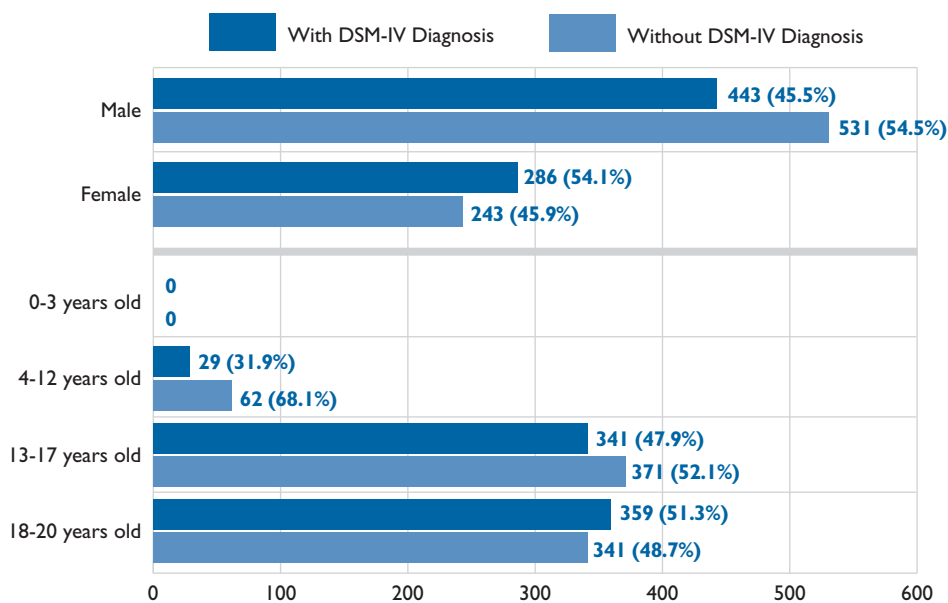


Substance Abuse Treatment Data System, 2009

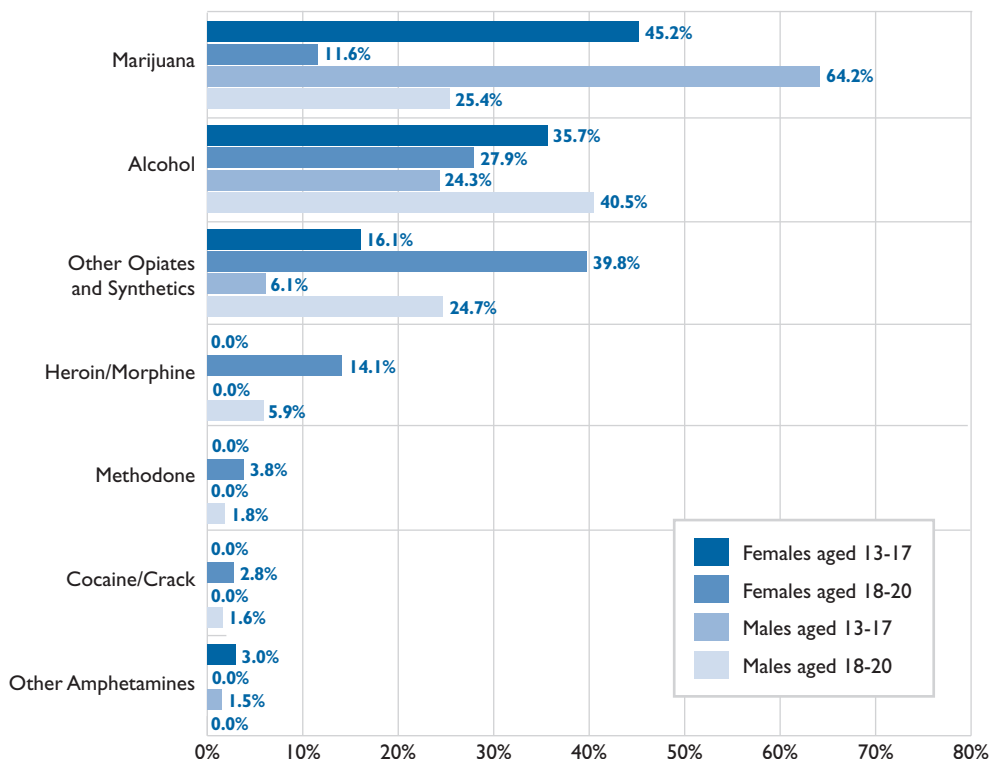
Substance Abuse Treatment, 2009

	MAINE NUMBER	RATE/ PERCENT
Children and adolescents admitted in substance abuse treatment services, SFY 2009 (rate per 1,000 children age 0-20)	1,503	4.49
without a secondary DSM-IV diagnosis	774	51.5%
with a secondary DSM-IV diagnosis	729	48.5%

Children and Adolescents Using Substance Abuse Treatment Services, 2009



Primary Drug Used by Children and Adolescents in Substance Abuse Treatment Services, 2009



Pregnant women risk harm to their unborn babies when they abuse drugs or alcohol. Babies exposed to alcohol and illegal drugs such as heroin, methamphetamine, or crack/cocaine often are low birthweight and suffer from extreme irritability. Long-term health consequences include motor skill delays, poor socialization, and behavioral health issues. In 2009, 451 babies in Maine were reported to be born drug addicted, up from 274 babies in 2007 and 343 in 2008**.

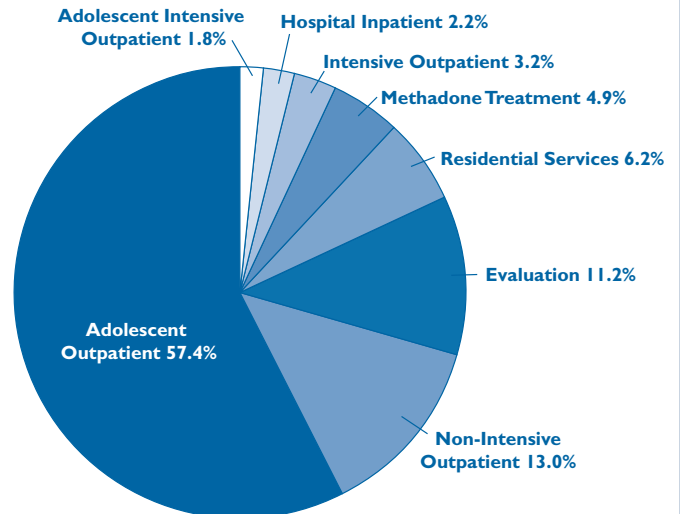
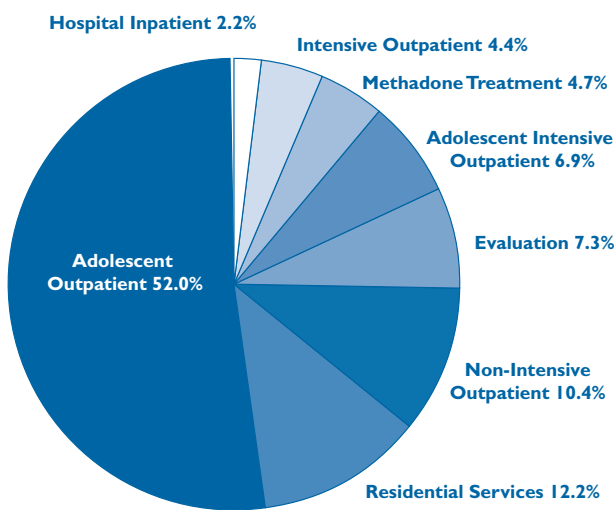
According to Dr. Mark Publicker at Mercy Hospital's Recovery Center in Portland, successful addiction services provided to young, pregnant addicted women include daily treatment, prenatal care, weekly group meetings, weekly drug screenings, breastfeeding promotion, and peer mentoring for new mothers. Providing such treatment for addicted, expectant women can lower preterm deliveries and sustain abstinence.

** Source: DHHS, Office of Child & Family Services, Division of Child Welfare

Primary Substance Abuse Treatment Services Used, 2009

	MAINE NUMBER	RATE/ PERCENT
Adolescent Outpatient	823	54.8%
Non-Intensive Outpatient	177	11.8%
Residential Services	137	9.1%
Evaluation	140	9.3%
Methadone Treatment	72	4.8%
Intensive Outpatient	57	3.8%
Adolescent Intensive Outpatient	64	4.3%
Hospital Inpatient	33	2.2%
Total	1,503	100%

Primary Substance Abuse Treatment Services Used by DSM-IV Diagnosis, 2009



Substance Abuse Treatment Discharge Status, 2009

	MAINE NUMBER	PERCENT
Children and adolescents discharged from substance abuse treatment services, SFY 2009	1,344	
Children who used crisis intervention services during treatment	222	16.5%
Children who used mental health services assistance during treatment	198	14.7%
Children who received a referral to MH professional at discharge	122	9.1%
Children and adolescents discharged from substance abuse treatment services, SFY 2009	1,344	100%
Completed Treatment	524	39.0%
Did Not Complete Treatment	508	37.8%
Other	155	11.5%
Evaluation Only	157	11.7%

**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.

In this report, only data for students age 3-21 with emotional disability will be reported. According to Maine Special Education Regulations:⁵

“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:

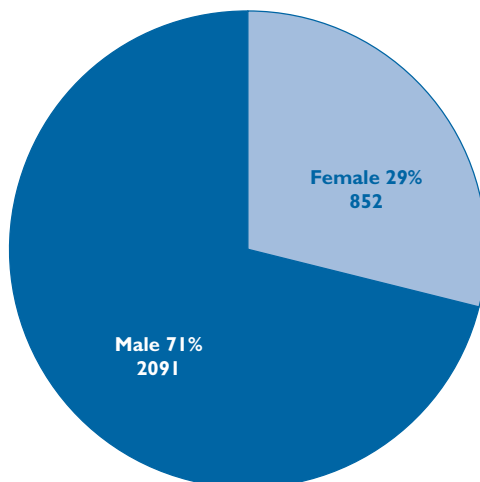
- An inability to learn that cannot be explained by intellectual, sensory, or health factors
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers
- Inappropriate types of behaviors or feelings under normal circumstances
- A general pervasive mood of unhappiness or depression
- 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.”

During the 2007-08 school year, 34,425 of Maine’s 198,094 school students (17.4%) received special education services. Of the students receiving special education services, 2,943, or 8.5%, were receiving special education services because of an emotional disability.

Students with Disabilities, 2008

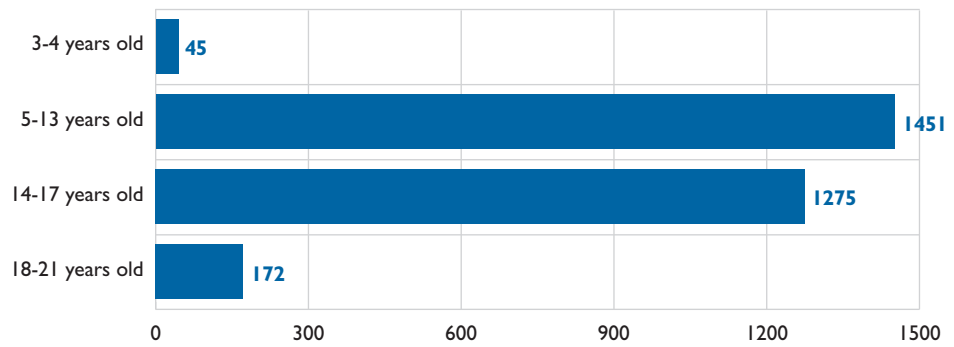
	MAINE NUMBER	PERCENT
Children age 3-21 receiving special education services, 2007- 2008 (as % of regular education enrollment)	34,425	17.4%
Children age 3-21 receiving special education services for emotional disability, 2007-08 (as % of children receiving special education enrollment)	2,943	8.5%

Students with Emotional Disability, by Gender, 2007-08



5 Maine Department of Education (5/8/2010). Maine Special Education Regulations, Chapter 101, Section 2, page 70.

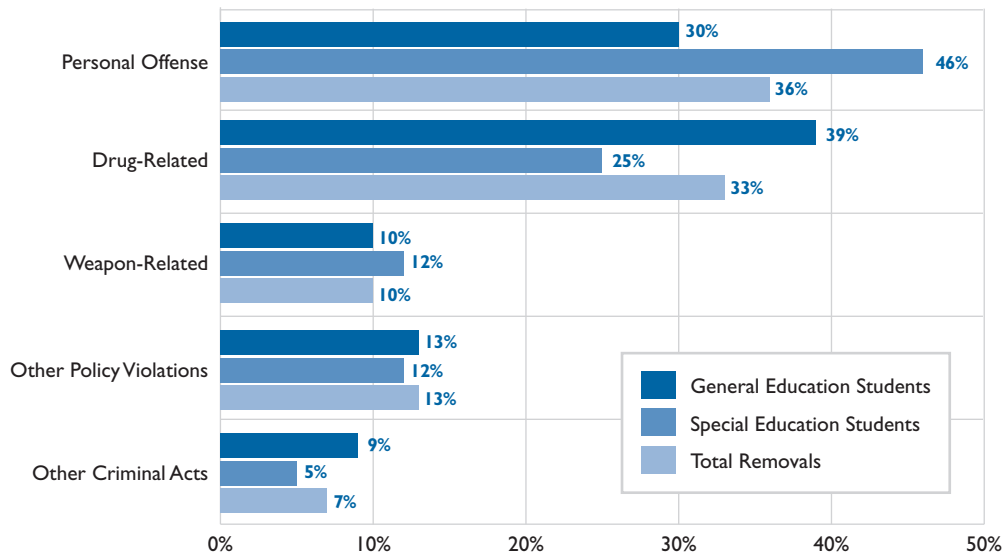
Students with Emotional Disability by Age Group, 2007-08



Students with Emotional Disability, 2008

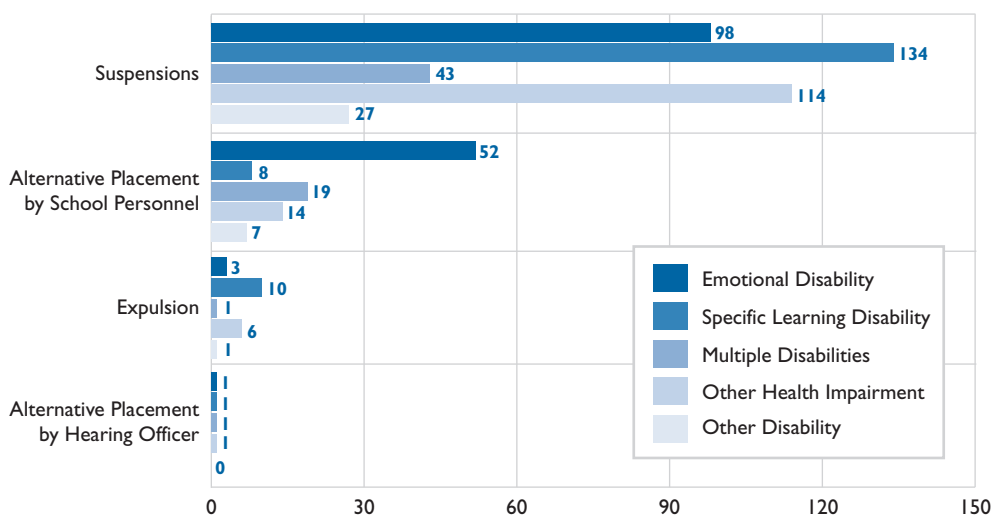
	MAINE NUMBER	PERCENT
Children age 3-5 receiving special education services for emotional disability in a preschool setting, 2007-2008	92	100%
Early Childhood Setting	35	38.0%
Early Childhood Special Education Setting	33	35.9%
Separate School	13	14.1%
Home/Service Provider/Separate Class	11	12.0%
Children age 6-21 receiving special education services for emotional disability in a school-age setting, 2007-2008	2,851	100%
Resource Room Placement	1,284	45.0%
Regular Class Placement	1,128	39.6%
Public Separate Day School Placement	328	11.5%
Public Residential Facility	91	3.2%
Homebound or Hospital Placement	14	0.5%
Private Separate Day School Placement/Correctional Facility	6	0.2%
Children age 3-21 with an exit status from special education services for emotional disability, 2007-2008	549	100%
Exited to Regular Education	194	35.3%
Graduation with Diploma	167	30.4%
Dropped Out	104	18.9%
Moved, Not Known to be Continuing	26	4.7%
Exited to School Age Special Education Services	15	2.7%
Deceased/Graduation through Certificat/Fulfillment of IEP Requirement/Reached Maximum Age	12	2.2%
Status Unknown	31	5.6%

School Removals by Type of Offense, 2007-08



Source: The Maine Lobster Report

Type of Removals of Special Education Students, 2007-08



Source: The Maine Lobster Report

**DEPARTMENT OF CORRECTIONS
Division of Juvenile Services**

The Division of Juvenile Services is organizationally located within the Department of Corrections. The mission of the Division is “to promote public safety by ensuring that juveniles under Department of Correction’s jurisdiction are provided with risk-focused intervention, quality treatment, and other services that teach skills and competencies; strengthen pro-social behaviors to reduce the likelihood of re-offending and require accountability to victims and communities.”

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 Youth Development Centers. Committed youth are screened and evaluated for mental health issues

According to a recent report released by the Annie E. Casey Foundation, some children don’t develop the social and emotional skills needed to function in a structured environment such as school before they reach school age. The ability to control emotions, follow directions, take turns, and manage executive function tasks greatly affects school readiness and future learning. A child entering school with behavioral health issues may fall behind academically if not given proper supports and services. The report also addresses how chronic absenteeism can result in underachievement in school. Succeeding in school requires being in school, thus finding alternatives to out of school suspension would be beneficial to students, particularly those already struggling academically.

Source: Early Warning: Why Reading By The End of Third Grade Matters. A KIDS COUNT Special Report from the Annie E. Casey Foundation. May 2010.

and, if necessary, provided treatment through a contracted service provider, the Centers' psychological services staff, or contracted psychiatrists.

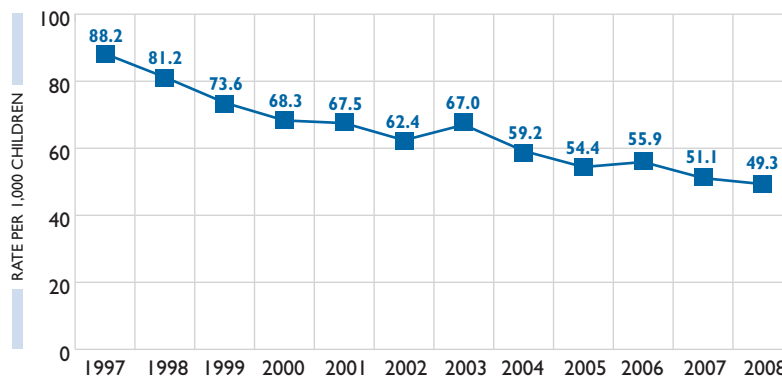
For youth who remain under supervision in the community, Children's Behavioral Health Services Mental Health Program coordinators consult with Division of Juvenile Services staff to assist with referrals and coordination of mental health services received through contracted community-based service providers. 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.

Arrests

There are many risk factors that increase the likelihood that a young person will become involved with the juvenile justice system. A few of these risk factors are poor cognitive development, a lack of treatment for mental health disorders, associating with deviant peers, parental antisocial or criminal behavior, and poverty.⁶

Between 1997 and 2008, the overall annual arrest rate of children ages 10-17 decreased 44%, from 88.2 arrests per 1,000 children ages 10-17 to 49.3 arrests.

Arrests of Children Ages 10-17, 1997-2008



Source: Maine Department of Public Safety, Uniform Crime Reports

Of the 6,842 arrests in 2008, 30.1% were females and 69.9% were males. In the past three fiscal years (July 1 through June 30) the number of detention admissions to the Division's two juvenile correctional facilities dropped by more than a third. Admissions, as shown in the table below, included youth admitted as a result of a court order, Juvenile Community Corrections Officer (JCCO), or Prosecutor authorization to hold. The table does not include admissions for drug court sanctions, shock sentences (determinate sentences of 30 days or less), interstate compact cases, federal detentions, or indeterminate sentences. Youth may be admitted more than once during a given year; the unduplicated count of youth admitted to detention is shown in the table below.

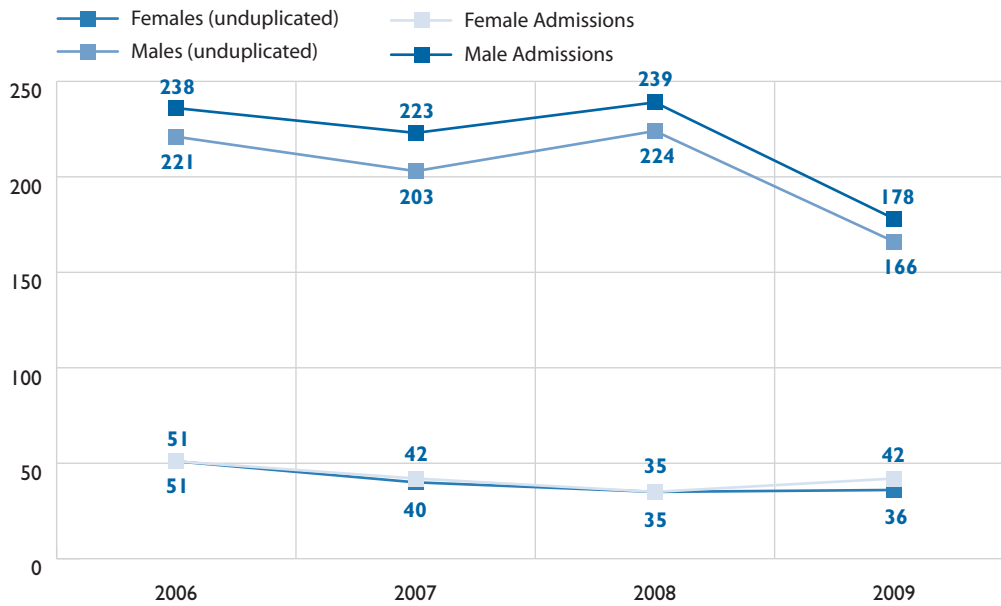
Juvenile Services Detention Admissions, 2007-09

	FY 07		FY 08		FY 09		% change 07-09	
	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES
Admissions	1,045	297	824	218	651	191	-38%	-36%
Youth	653	182	543	143	419	121	-36%	-34%
Average number of admissions per youth	1.60	1.63	1.52	1.52	1.55	1.58		

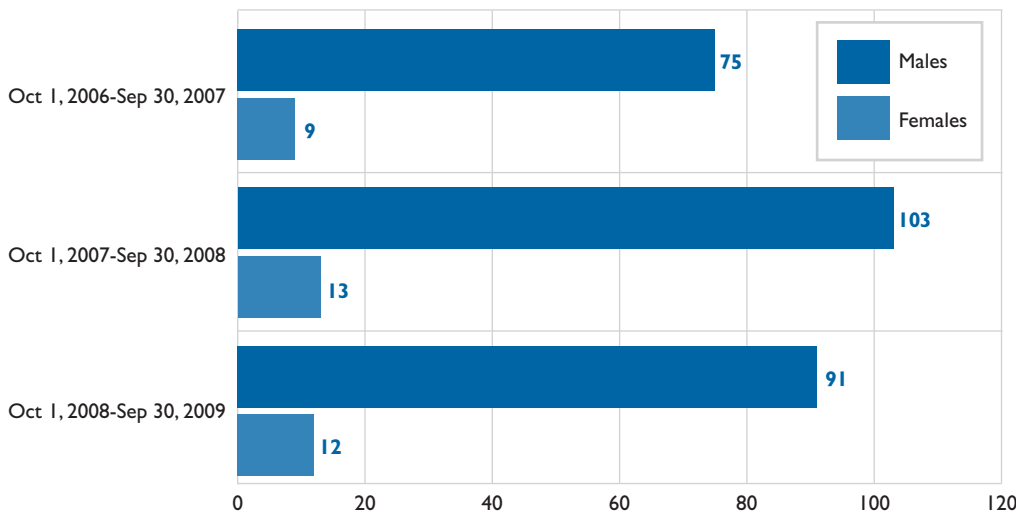
6 U.S. Department of Justice. April 2003. Risk and Protective Factors of Child Delinquency. Available at <http://www.ncjrs.gov>

Youth judged to have committed an offense might be given a determinate sentence, as allowed by the Juvenile Code, of no more than 30 days. These dispositions are commonly referred to as “Shock Sentences,” the assumption being that once youth face the reality of being detained, they will change their ways and commit no more offenses. Because of the short-term nature of the sentence, these youth serve their sentences in the detention unit. Because some youth may receive more than one “shock” sentence within a year, the number of sentences exceeds the number of youth.

Shock Sentence Admissions by Gender, 2006-09



Commitments to Youth Development Centers by Gender, 2007-09



The number of committed youth residing in the two facilities rose from 120 on January 1, 2006 to 170 on July 1st 2009 for a 42% increase. The number of girls committed increased by 70%. Further analysis could more adequately explain this increase, but most likely it is some combination of an increase in the number of commitments, longer lengths of stay, and or returns from community reintegration.

Count of Committed Youth in Residence, 2006-09

	MALES	FEMALES	TOTAL
January, 2006	110	10	120
April, 2006	115	13	128
July, 2006	117	9	126
October, 2006	125	11	136
January, 2007	113	12	125
April, 2007	140	13	153
July, 2007	138	12	150
October, 2007	128	11	139
January, 2008	112	10	122
April, 2008	127	7	134
July, 2008	130	14	144
October, 2008	123	15	138
January, 2009	126	17	143
April, 2009	135	17	152
July, 2009	153	17	170

While youth reside in the facilities, they are expected to complete a program of treatment, which is individually developed to address the assessed risks and needs. Progress for each youth is monitored through a series of reviews conducted by facility and community staff as well as the youth and his or her parents. The youth's rate of progress in achieving his or her case plan goals determines the youth's length of stay in the program. Ideally, the youth should be able to reach case plan goals within 9 to 12 months.

Once youth are deemed to have completed their programs they may be released to the community under supervision of a JCCO in a status called community reintegration. While under supervision in the community in this status, a youth may be returned to the facility for a number of reasons. Some may be unable to comply with the community plan, some experience programmatic failures, others may be charged with new offenses.

Youth Level of Service/Case Management Inventory

The Youth Level of Service/Case Management Inventory (YLS/CMI) is a quantitative screening survey of attributes of juvenile offenders and their situations relevant to decisions regarding level of service, supervision, and programming. The YLS/CMI collects data on the following risk categories: offense, family, education/employment, peer relationships, substance/alcohol abuse, leisure activities, personality and attitude.

In 2008, 2,983 youth, ages 9-21, were assessed using the YLS/CMI. The average age was 16.5 years. More males were assessed than females (2,208 (74%) vs. 775 (26%) and 177 (6%) of those assessed were minority.

In exploring the relationships between the types of crimes committed over a three year period (2006 to 2008) and assessment results, males tended to have higher mean scores than females in the number of offenses committed and on the assessment scores related to education, substance abuse and attitude. Minority youth scored higher than caucasian youth in every risk category.

The number of felonies a youth commits was best predicted most by the number of overall offenses he/she committed. That is, the more offenses committed the more likely one of those offenses was a felony. For misdemeanors, predictors included the number of offenses as well as

the personality score and gender (males were more likely to commit misdemeanors than females.) Civil crimes were most strongly linked to a youth's substance abuse score and a youth's substance abuse score was closely linked to whether the crime was drug/alcohol related. Personal crimes were committed by youth with higher personality scores (more difficult personality type) and a higher number of offenses. Finally, property crimes appeared to be linked to peer issues.

RECOMMENDATIONS

1. The Maine Children's Alliance supports a proposed in-depth study of Maine's children in state care or custody (Child Welfare) compared to children not in state care or custody. In addition to the differences shown in this report, the need to do this stems from a recent national study of the over prescribing of anti-psychotic medications to child welfare children. Because of the complicated nature of the data, we were not able to address this issue in this report. However, the DHHS Office of Integrated Service & Quality Improvement has the capacity to produce a study that will tell us how medication is being used in the treatment of child welfare kids and how this differs from other children.
2. With the increase in the use of kinship care in child protective cases, there is little data on those children who are removed from the home and placed in the custody of a family member through the use of a safety plan. We urge DHHS to collect such data so that there is a better understanding of how many children are being removed to live with family members. In addition, we urge that these extended families be eligible for services similar to those families who gain custody through Child Welfare kinship placements.

THE TRANSITION FROM ADOLESCENCE TO ADULTHOOD is drawn out over a span of nearly a decade and consists of small steps rather than a giant leap. During this important time, young people who have been dependent on their families move towards financial, residential, and emotional independence. In addition, they take on new roles as worker, citizen, spouse and parent.¹ For young people who drop out of high school, get involved in the criminal justice system, become parents at a young age, or have been in and out of foster care, the transition to adulthood can be extremely difficult. “If the transition to adulthood is likely to be smooth for college-bound middle class youth, but is often rough sledding for working-class, non-college-bound youth, then it can be a minefield for such vulnerable populations.”²

DISCONNECTED YOUTH

Teens who are neither in school nor employed are disconnected from the roles and relationships that help young people transition to adulthood. These young people tend to have a harder time connecting to the job market as young adults, which increases the risk that they will have lower earnings and a less stable employment history than their peers who stayed in school or found jobs.³

In 2008, eight percent of Maine teens ages 16-19 were neither in school nor employed. The percentage of disconnected youth in Maine was equal to the national rate. More than half of Maine’s disconnected youth (56%) did not graduate from high school. Of these youth who had not graduated, 62% were not in the labor force, while 38% were unemployed.

Disconnected Youth Demographics, 2008

	MALE	FEMALE	TOTAL
Total Population, ages 16-19	36,044	33,933	69,977
TOTAL DISCONNECTED YOUTH	3,071	2,394	5,465
% of total population	9%	7%	8%
% of all disconnected youth	56%	44%	100%
HIGH SCHOOL GRADUATES	48%	46%	48%
Unemployed*	48%	57%	52%
Not in labor force**	52%	43%	48%
NOT HIGH SCHOOL GRADUATES	52%	54%	52%
Unemployed*	38%	55%	46%
Not in labor force**	62%	45%	54%

* not working and currently looking for work
 ** neither working nor looking for work

Source: 2008 American Community Survey

1 S. Jekielek and B. Brown. “The Transition to Adulthood: Characteristics of Young Adults Ages 18 to 24 in America”. A KIDS COUNT/Child Trends Report on Census 2000. May 2005.

2 D. Ostood, E. Foster, & M. Courtney. “Vulnerable Populations and the Transition to Adulthood.” The Future of Children, Volume 20, No. 1, Spring 2010.

3 Shore, R. July 2005. KIDS COUNT Indicator Brief: Reducing the Number of Disconnected Youth. Available at www.aecf.org

Labor Statistics: Unemployment Claims By Age Groups, 2006 - 2008

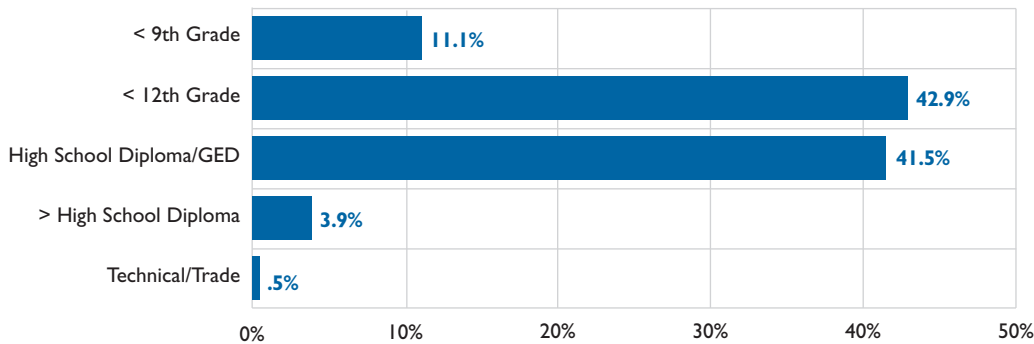
	2006	2007	2008
Under 16	21	13	14
16-19	954	990	1,186
20-24	5,615	5,573	7,153
25-64	35,522	36,494	46,352
65 & Up	825	907	1,271
Grand Total	42,937	43,977	55,976

Note: Data above represent claimants filing an initial claim for a new regular benefit year period and were found monetarily eligible to receive benefits. This does not mean that all claimants received a benefit payment.

Source: *Maine Department of Labor, Center for Workforce Research and Information.*

Of the 1,840 adult prisoners in Maine on November 1, 2008, more than half (54%) did not complete high school and less than 5% had more than a high school diploma.

Education Level of Maine Prisoners as of November 1, 2008



Source: *Maine Crime and Justice Data Book, 2008* <http://muskie.usm.maine.edu>

**DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Child & Family Services**

Child Welfare

According to the Adoption and Foster Care Analysis and Reporting System (AFCARS), 202 Maine youth aged out of foster care without a permanent, legal family in 2007. Research shows that many of these youth will face significant obstacles in the future, including homelessness, unemployment, depression and substance abuse.

For those youth who do not find a family, Maine provides support to help them make the transition to independent living and post-secondary education. Any youth in DHHS custody who reaches age 18 is automatically dismissed from custody and achieves full adult rights and responsibilities. However, the DHHS caseworker and the youth may negotiate a written agreement (V9) for continued care for the following reasons:

- Obtaining a high school diploma or general equivalency diploma, or going on to a post-secondary educational program or a specialized post-secondary education certification program
- Participation in an employment skills support program
- Mental health or other counseling support
- Specialized placement needs
- Pregnancy and parenting support needs
- Medical and special health conditions, or needs

“Numerous public policy reforms can raise the employment and incomes of today’s young adults and increase the educational attainment, and hence, the labor market success of the next generation.” Policy reforms that could improve the labor market prospects of young adults and facilitate successful transition to adulthood include making work pay for low-wage workers, expanding employment for less-educated workers, and raising high school graduation rates and skills by investing in education and training across the lifespan.*

* D. Sheldon and D. Ratner: “Labor market Outcomes and the Transition to Adulthood.” *The Future of Children*, Volume 20, No. 1 Spring 2010.

Youth in Foster Care, 2008

	MAINE NUMBER	PERCENT
Total Youth in Care (Ages 15-21)	698	100.0%
Ages 15-17	548	78.5%
Ages 18-21 (V-9 Agreement)	150	21.5%
V-9 Post-Secondary Education	88	58.7%
V-9 Other	62	41.3%
Youth Who Aged Out	52	

Source: DHHS Office of Child & Family Services

DEPARTMENT OF EDUCATION
Office of Special Services

When a student graduates and receives a regular high school diploma, he/she is no longer eligible for special education services. Students who have not reached the age of 20 before the start of the school year (July 1st) may be entitled to receive a public school education through their 20th year, if deemed appropriate (20-A M.R.S.A. Chapters 301 and 303).

Transition refers to activities meant to prepare students with disabilities for adult life. This can include developing postsecondary education and career goals, getting work experience while still in school, setting up linkages with adult service providers such as the vocational rehabilitation agency—whatever is appropriate for the student, given his or her interests, preferences, skills, and needs. Statements about the student’s transition needs must be included in the IEP after the student reaches a certain age:

- **TRANSITION PLANNING**, for students beginning at age 14 (and sometimes younger)—helps the student plan his or her courses of study (such as advanced placement or vocational education) so that the classes the student takes will lead to his or her post-school goals.
- **TRANSITION SERVICES**, for students beginning at age 16 (and sometimes younger)—provides the student with a coordinated set of services to help the student move from school to adult life. Services focus on the student’s needs or interest in such areas as higher education or training, employment, adult services, independent living, and taking part in the community.

During the 2007-08 school year, 11,703 students ages 14 to 21 received special education services. These students received 10,395 units of independent living, postsecondary education, vocational training/ job placement, and employment related services.

Special Education Anticipated Transition Services, 2007-08

AGE AS OF DATA COLLECTION DATE:	14	15	16	17	18	19	20	21	TOTAL
Independent Living Services	123	182	209	204	114	40	13	0	885
Postsecondary Education	866	923	946	861	386	41	4	0	4,027
Vocational Training and Job Placement	699	874	828	815	426	96	19	0	3,757
Employment Related Services	320	374	420	372	182	48	10	0	1,726
TOTAL	2,008	2,353	2,403	2,252	1,108	225	46	0	10,395

Source: Department of Education, Special Services, State Totals Report by Anticipated Services and Age, 2007-08
<http://www.maine.gov/>

DEPARTMENT OF LABOR
Bureau of Rehabilitation Services

Division of Vocational Rehabilitation

The Bureau of Rehabilitation Services (BRS) is a US Department of Education program within the Maine Department of Labor that works to bring about full access to employment, independence and community integration for people with disabilities. The Division of Vocational Rehabilitation (VR), has a primary goal of assisting interested individuals who have disabilities to get and keep a job. VR helps people who have physical, mental, or emotional disabilities and can assist students with disabilities in coordinating information and resources as they transition from high school to adult life.

To be eligible for VR services, a student must have a documented disability that creates a barrier to getting or keeping a job, and VR services are required for the individual to find or keep a job. A referral of a student while in high school allows time for students and their VR counselors to start working towards the students' employment goals prior to graduation.

The Vocational Rehabilitation counselor will work with the student and other people involved with the student's planning to assist through the process of making informed choices about future jobs and careers. The planning includes consideration of the skills and abilities a person has, the types of jobs an individual wants to consider, where the student is willing to work and live, and what transportation is available. The student and VR counselor work together to develop a plan that will lead to a job.

The data for this section of the report are based on the outcome of cases 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 age 20 or younger. Children with cognitive disabilities, such as mental retardation or autism, are not included in these data. The chart for services received includes only services that were purchased by VR, and does not include counseling and guidance provided by the counselor.

Closed Cases, 2008

	MAINE NUMBER	PERCENT
Vocational Rehabilitation Services Purchased for Clients with Mental Illness	2,235	100%
Job Search Assistance, Job Placement Assistance	694	31%
Transportation Services	340	15%
College or University Training	219	10%
On-The-Job Supports	233	10%
Occupational/Vocational Training, On-the-Job Training, Basic Academic Remedial or Literacy Training, Misc. Training	174	8%
Assessment	149	7%
Maintenance	144	6%
Disability Related Services	68	3%
Diagnosis & Treatment of Impairments	50	2%
Rehabilitation Technology	32	1%
Job Readiness Training	29	1%
Technical Assistance Services	2	0%
Other Services	101	5%

Closed Cases by the Division of Vocational Rehabilitation, 2008

	MAINE NUMBER	PERCENT
Number of clients under age 21 served by DVR in FFY 2008	339	100%
Closed after determined eligible, but before an IPE* was developed	180	53%
Closed after services were initiated, without employment outcome	78	23%
Closed after achieving an employment outcome	49	14%
Closed as applicant, but before a determination of eligibility	19	6%
Closed after determined eligible, from an order of selection waiting list	7	2%
Closed after determined eligible, but before services under IPE were initiated	5	1%
Closed as applicant, but during or after a TWP**/extended eval and before determination of eligibility	1	0%

* Individualized Plan for Employment

** Transitional Work Program

RECOMMENDATION:

1. The Maine Department of Education (DOE) has created the Maine Education Data Management System (MEDMS), a statewide project targeted to deliver an information management system that links the agency with schools around the state. MEDMS allows DOE to communicate with local school administration districts and cooperatively manage their data for state and federal regulatory and assessment compliance, while managing the department's internal database and information flow. Related to MEDMS is the State Longitudinal Data System (SLDS). The SLDS, among other things, will include a Data Warehouse serving as a repository of data for ages PreK through 20. The data collected from department databases will be used to support data driven decision making, timely and complete state and federal reporting, as well as research and analysis of the effectiveness of intervention programs across state systems. With the collection of social security numbers beginning in 2011, DOE will be able to track students across data systems and across years, which the Maine Children's Alliance strongly supports.

CONCLUSION

FINAL RECOMMENDATIONS

1. Children who live in chronic stressful situations, such as domestic violence, extreme poverty, abuse or neglect experience what neurologists term “toxic stress.” The quality of a child’s environment and experiences at the early stages of development are crucial in determining the strength or weakness of the brain’s architecture, which, in turn, determines how well a child is able to regulate emotions. Intensive interventions can reverse the impact of toxic stress, provided the interventions are timely and occur in the early years of life. Remedial education, clinical treatment and other professional interventions are more costly and produce less desirable outcomes than the provision of nurturing, protective relationships and appropriate learning experiences earlier in life. We recommend that data systems track socioeconomic status and other toxic stress situations so that a child’s well-being is understood within a more complete context.
2. Behavioral health services need to be “trauma informed,” grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans.* Counselors, police, teachers, doctors, and others providing services to children and families need training in this area to better understand the impact that adverse childhood experiences have, both immediately and across the lifespan of a child. Programs such as the community-based THRIVE System of Care Initiative would benefit all communities in Maine.
3. The Maine Quality Forum (MQF), part of the Office of Healthcare Policy and Finance, was established by the Governor and Legislature in 2003 to improve the quality of healthcare in Maine. MQF has been charged with collecting research, promoting best practices, collecting and publishing comparative quality data, promoting electronic technology, promoting healthy lifestyles and reporting to consumers and the Legislature. In addition, through the “Quality Counts” organization, foundation funding has been received to appropriately involve and empower consumers in assuring quality healthcare.

The Departments of Education and Health and Human Services have also developed impressive programs to involve consumers and their families in the development of quality educational, behavioral health and healthcare services. Unfortunately the contributions of consumers and their families are not captured in a way that supports the consistent reporting of this critical information. We suggest that the two departments that support this activity develop consistent reporting methodology to capture consumer and family opinion about the services they receive. This effort should become a formal and coordinated part of the MQF’s effort to improve the quality of healthcare.

The systematic collection of data regarding child outcomes across systems is good public policy. The State’s implementation of managed care, healthcare reform and the CHIPRA improvement project all offer opportunities to improve data collection across systems of care. Data collection and integration should be a clear agenda item for these policy initiatives. This report establishes a process that will enable us to generate an annual report on children’s mental health care that can be disseminated to policymakers, the Maine Legislature, mental health professionals, child advocates, and the public. Based on our experience with this Children’s Mental Health Data Project, we expect our collaboration with the state’s child-serving departments, and their collaboration with each other, will bolster integration within and among the divisions and offices of DHHS and the other child serving departments of state government, and will ultimately benefit the children and families served by the state.

* Jennings, A. (2004). The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning.

DATA SOURCES

MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Child & Family Services, Division of Child Welfare Services

DATABASE	Maine Automated Child Welfare Information System (MACWIS)
WHAT DATA ARE COLLECTED	Demographic, service related information
WHO INPUTS DATA	Caseworkers, outside contractors
WHAT ARE THE REGULARLY PRODUCED REPORTS	Federal reports (AFCARS & NCANDS), on demand, managerial and ad hoc reports.
WHO RECEIVES REPORTS	Federal agencies, supervisors, legislature and decision makers

MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Substance Abuse

DATABASE	Treatment Data System (TDS)
WHAT DATA ARE COLLECTED	Demographic, life circumstances, substance use, treatment
WHO INPUTS DATA	Treatment providers
WHAT ARE THE REGULARLY PRODUCED REPORTS	Monthly treatment reports for the federal government, aggregate reports on trends and patterns in substance abuse, effectiveness reports for contracted agencies
WHO RECEIVES REPORTS	Federal agencies, contracted agencies, legislature and decision makers. Data access to the last ten years of data in the TDS is available at http://www.maine.gov/dhhs/osa

MAINE DEPARTMENT OF EDUCATION

DATABASE	Maine Education Data Management System (MEDMS)
WHAT DATA ARE COLLECTED	Demographic, enrollment, academic information, special services, prohibited behaviors (types & resulting actions taken), prevention programs (types, hours of participation) , finance
WHO INPUTS DATA	Data are entered into the database by school staff
WHAT ARE THE REGULARLY PRODUCED REPORTS	Enrollment, student demographics, attendance, special services, high school graduation, truancy/drop out, retention and expulsions, finance
WHO RECEIVES REPORTS	Federal reports, state legislature and decision makers, school administrative units. Public reports can be found at http://www.maine.gov/education/datalist.htm

MAINE DEPARTMENT OF LABOR: Division of Vocational Rehabilitation

Office of Rehabilitation Services

DATABASE	Office of Rehabilitation Services Information System (ORSIS)
WHAT DATA ARE COLLECTED	Demographic, case information, services
WHO INPUTS DATA	Supervisors, counselors and support staff
WHAT ARE THE REGULARLY PRODUCED REPORTS	The data elements collected meet the requirements to complete federal reporting to the Rehabilitation Services Administration (RSA). Ad hoc reports are also produced.
WHO RECEIVES REPORTS	Federal agency, state legislature and decision makers.

Child Well-Being

BIRTH OUTCOMES

Live births for which prenatal care began in the first trimester is the number and percent of live births for which the mother began receiving prenatal care during the first three months of pregnancy. These data represent calendar years 2007 and 2006.

Source: Maine Department of Health and Human Services, Office of Data, Research and Vital Statistics.

Low birth-weight infants is the number and percent of live births in which the newborn weighed less than 2500 grams, (5.5 pounds). These data represent calendar years 2007 and 2006.

Source: Maine Department of Health and Human Services, Office of Data, Research and Vital Statistics; 2007 national rate from Centers for Disease Control, National Center for Health Statistics Report, Vol. 57, No. 12, "Births: Preliminary Data for 2007."

Pre-term births is the number and percent of pre-term births in which the newborn was born at less than 37 weeks gestation. These data represent calendar years 2007 and 2006.

Source: Maine Department of Health and Human Services, Office of Data, Research and Vital Statistics; 2007 national rate from Centers for Disease Control, National Center for Health Statistics Report, Vol. 57, No. 12, "Births: Preliminary Data for 2007."

POVERTY

Children under age 5 in poverty is the estimated number and percent of children under age 5 living in poverty in 2008 and 2007. The estimates are modeled from combined census estimates, the American Community Survey, and other administrative and economic data. In 2008, which represents the current rate, the poverty threshold for a typical family of three was \$17,346. These data represent calendar years.

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates, 2008.

Children under age 18 in poverty is the estimated number and percent of children under age 18 living in poverty in 2008 and 2007. The estimates are modeled from combined census estimates, the American Community Survey, and other administrative and economic data. In 2008, which represents the current rate, the poverty threshold for a typical family of three was \$17,346.

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates, 2008.

Median income of families with children is the estimated median annual income for families with related children under age 18 living in the household. "Related children" include the householder's (head of household) children by birth, marriage, or adoption; as well as other persons under age 18 (such as nieces and nephews) who are related to the householder and living in the household. The median income is the dollar amount that divides the income distribution into two equal groups – half with income above the median and half with income below it. These data represent December 2008 and 2007.

Source: U.S. Census Bureau, American Community Survey, 2008 and 2007.

Unemployment is the estimated annual monthly average number and percent of people in the civilian labor force who are unemployed. The unemployment rate is calculated by dividing the average number of unemployed people by the average number of people in the civilian labor force. These data represent calendar years 2008 and 2007.

Source: Maine Department of Labor, Bureau of Employment Security, Division of Labor Market Information Services, Local Area Unemployment Statistics Program (LAUS). Civilian Labor Force Estimates for Maine and Maine Counties, By Month and Annual Average, 2009, and Civilian Labor Force Estimates for Maine and Maine Counties, By Month and Annual Average, 2008.

DOMESTIC VIOLENCE AND CHILD ABUSE

Domestic assaults reported to police is the number and rate of assaults reported to police that were perpetrated by family or household members including couples who are married or living together in a romantic relationship, who are the natural parents of the same child or other adult family members related by blood or marriage. The rate is per 100,000 of the population. These are not unduplicated counts and may include numerous assaults affecting the same individuals. These data represent calendar years 2008 and 2007.

Source: *Maine Department of Public Safety, Crime in Maine Reports.*

Children in Department of Health and Human Services care or custody is the number and rate of children ages 0-17 in the care or custody of the Department of Health and Human Services (DHHS) in December 2009 and 2008. The rate is per 1,000 children ages 0-17. These children were ordered into DHHS custody as a result of a child protection hearing where the child is found to be in jeopardy, a juvenile hearing that found that it would be contrary to the child's health and welfare to remain in the care or custody of the parents, or a divorce and/or custody hearing where neither parent had been found able to provide a home in the best interest of the child.

Source: *Maine Department of Health and Human Services, Office of Child and Family Services, Division of Child Welfare Services.*

Substantiated child abuse and neglect victims is the number and rate of individual victims of child abuse and neglect ages 0-17 for whom assessment 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 of essential needs or lack of protection from these by a person responsible for the child (22 MRSA §4002). The rate is per 1,000 children ages 0-17. These data represent calendar years 2008 and 2007.

Source: *Maine Department of Health and Human Services, Office of Child and Family Services, Division of Child Welfare Services.*

PARENT'S MENTAL AND EMOTIONAL HEALTH

Children whose mothers'/fathers' have good mental and emotional health is the estimated number and percent of children age 0-17 whose mothers/fathers reported that their mental and emotional health was excellent, very good, or good. These data are from the National Survey of Children's Health 2007.

Source: *National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website.*

Mothers with post-partum depression, 2006 is the estimated percent of mothers who gave birth in Maine who were told by a doctor, nurse or health care worker, since giving birth, that she had depression. These data are from the Pregnancy Risk Assessment Monitoring System (PRAMS), 2006. Population is Maine women giving birth in 2006.

Source: *Pregnancy Risk Assessment Monitoring System (PRAMS), Maine Department of Health and Human Services, Center for Disease Control, Office of Data, Research and Vital Statistics.*

PEER RELATIONSHIPS

Children ages 1-5 who play with children of similar age at least 4 days/week is the estimated number and percent of children ages 1-5 whose parents reported that their child played with children similar to their own age at least 4 days/week in the month prior to the survey. These data are from the National Survey of Children's Health 2007.

Source: *Child and Adolescent Health Measurement Initiative. National Survey of Children's Health. Data Resource Center on Child and Adolescent Health website.*

Children ages 6-17 who participate in activities outside of school is the estimated number and percent of children ages 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 survey. These data are from the National Survey of Children's Health 2007.

Source: *Child and Adolescent Health Measurement Initiative. National Survey of Children's Health. Data Resource Center on Child and Adolescent Health website.*

CHILDREN'S FUNCTIONAL ABILITY

Children age 0-5 who have moderate or severe risk for developmental, behavioral or social delays, 2007 is the estimated number and percent of children age 0-5 whose parents report that they had moderate or severe concerns about their child's risk for developmental, behavioral or social delays.

Source: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website.

Children age 0-17 with emotional, developmental, or behavioral problems for which they need treatment or counseling, 2007 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.

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, 2007 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.

PARENTAL CONCERN

Children age 0-5 whose parents have at least one concern about their child's learning, development, or behavior, 2007 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.

Children age 6-17 whose parents report child sometimes exhibits problematic behavior, 2007 is the estimated number and percent of children age 6-17 whose parents report that their child exhibits one of the following problematic behaviors: arguing too much; bullying or cruelty to others; disobedient; sullen, stubborn or irritable.

Source: National Survey of Children's Health as reported on the Data Resource Center for Child and Adolescent Health website.

ADOLESCENTS' REPORTS

High school students reporting purposely hurting themselves without wanting to die, 2007 is the estimated percent of high school students reporting that at some point in the twelve months prior to taking the 2007 Maine Youth Risk Behavior Survey they purposely hurt themselves without wanting to die (e.g. cutting, burning).

Source: 2007 Maine Youth Risk Behavior Survey.

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, 2007 is the estimated percent of high school students reporting that at some point in the twelve months prior to taking the 2007 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: 2007 Maine Youth Risk Behavior Survey.

High school students reporting seriously considered attempting suicide in the past year, 2007 is the estimated percent of high school students who seriously considered suicide in the twelve months prior to taking the 2007 Maine Youth Risk Behavior Survey.

Source: 2007 Maine Youth Risk Behavior Survey.

High school students reporting at least one suicide attempt in the past year, 2007 is the estimated percent of high school students reporting at least one suicide attempt in the twelve months prior to taking the 2007 Maine Youth Risk Behavior Survey.

Source: 2007 Maine Youth Risk Behavior Survey.

Ages and Stages: Early Childhood

Children who did not receive developmental or behavioral screening, 2007 is the estimated percent of children ages 10 months to five years who did not receive a standardized screening for behavioral or developmental problems, as reported by parents. These data are from the National Survey of Children's Health 2007.

Source: National Survey of Children's Health. Data Resource Center on Child and Adolescent Health website.

Maine home visiting program child health and developmental results is the estimated percent of children who received services through the Maine Home Visiting Program and the change that occurred as a result of participation. Data are for Fiscal Year 2009.

Source: Maine Department of Health and Human Services, Office of Child and Family Services, Early Childhood Division.

Head Start Program is the number of state and federally-funded children in Head Start programs throughout the state during federal fiscal year (FFY) 2009 (October 1, 2008 – September 30, 2009) and FFY 2008 (October 1, 2007 – September 30, 2008). Eligible children was the estimated number of children under age 5 in poverty. Unmet need was calculated by subtracting the number of funded children from the estimate of eligible children.

Source: Maine Department of Health and Human Services, Office of Child Care and Head Start.

Head Start medical screening results and disability services, 2008 is the estimated percent of children who received medical screening and disability services through Head Start in fiscal year 2008.

Source: Center for Law and Social Policy (CLASP) report *Maine Head Start by the Numbers 2008 Program Information Report (PIR) Profile*.

Children with special needs as a percent of total kindergarten population is the percent of children who have identified special needs as part of total kindergarten population in accordance with the federal definitions and mandates for early intervention and public education, 2008-09.

Source: Maine Department of Education.

Ages and Stages: School-Age and Adolescence

Children whose parents have at least one concern about their child's learning, development, or behavior, 2007 is the estimated percent of children ages 0-5 whose parents have at least one concern about their child's learning, development, or behavior. These data are from the National Survey of Children's Health, 2007.

Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health, Data Resource Center on Child and Adolescent Health website.

Children with emotional, developmental, or behavioral problems for which they need treatment or counseling, 2007 is the estimated percent of children ages 0-17 whose parents report that their child has emotional, developmental, or behavioral problems for which they needed treatment or counseling (remedies, therapies, or guidance). These data are from the National Survey of Children's Health, 2007.

Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health, Data Resource Center on Child and Adolescent Health website.

Children who did not receive needed mental health services, 2007 is the estimated percent of children ages 2-17 who needed but did not get mental healthcare or counseling services. These data are from the National Survey of Children's Health, 2007.

Source: Child and Adolescent Health Measurement Initiative. National Survey of Children's Health, Data Resource Center on Child and Adolescent Health website.

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Children Receiving Behavioral Health Services, SFY 2008 is the unduplicated number of children age 0-21 enrolled in MaineCare who received mental health services from a mental health provider that contracted with DHHS. Numbers for children not enrolled in MaineCare were not available. Rate per 1,000 children age 0-21. Data are reported for children with an ICD-9 code between 290.00 and 314.9. For this project, children with a primary mental health diagnosis will have a condition recognized and categorized within that code range, excluding 291, 292, 303-306.9.

Source: SAMSHA's Data Infrastructure Grant (DIG) data set, Maine Department of Health and Human Services, Office of Integrated Services & Quality Improvement.

Mental Health Services Received, SFY 2008 is the unduplicated number of mental health services received by children age 0-21 enrolled in MaineCare. Services are shown as percentage of services received and average service units. Services are also shown as a percentage of services received by children within Child Welfare and as percentage of services received by children not in Child Welfare.

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)

HOME & COMMUNITY BASED SERVICES are habilitative 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. This treatment is for members in need of mental health treatment based in the home and community who need a higher intensity service than outpatient but a lower intensity than Children's ACT. (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)

TARGETED CASE MANAGEMENT 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).

RESIDENTIAL PLACEMENT/TREATMENT 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, and for the physical needs of the child. (MaineCare Benefits Manual, Chapter II - Section 97)

MEDICATION ASSESSMENT & TREATMENT 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 INTERVENTION & RESOLUTION include crisis resolution services provided by agencies that have a contract with DHHS for eligible children ages 20 years or younger that include outreach crisis intervention to home, school, street, emergency shelter or other settings, 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)

PSYCHOLOGICAL/NEUROLOGICAL TESTING-EVALUATION Services include clinical assessment of thinking, reasoning and judgment, meeting face-to-face with the member; time interpreting test

results and preparing the report of test results. Services also may include testing for diagnostic purposes to determine the level of intellectual function, personality characteristics, and psychopathology, through the use of standardized test instruments or projective tests. (MaineCare Benefits Manual, Chapter II - Section 65)

CHILDREN'S ASSERTIVE COMMUNITY TREATMENT (ACT) is a 24-hour, seven 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)

INPATIENT SERVICES furnished in a psychiatric hospital for patients who have been admitted to the hospital for twenty four (24)-hour-a-day acute psychiatric care. MaineCare only covers inpatient psychiatric services for members under age twenty-one (21), or age sixty-five (65) and older. (MaineCare Benefits Manual, Chapter II - Section 46)

CHILD PROTECTIVE SERVICES

Child Protection data, 2008 includes the number of referrals to Child Protective Services, the number of inappropriate referrals that were screened out, and a series of detailed characteristics of the referrals that were assigned to caseworkers for assessment.

Source: Maine Department of Human Services, Office of Child and Family Services Child Protective Services Annual Report on Referrals 2008

Child Welfare Data, 2008 includes the number of reports, assessments, substantiated reports and detailed characteristics of the referral that were made, risk factors assessed, type of abuse indicated, and placements made through the child welfare system.

Source: Maine Department of Health and Human Services, Office of Child & Family Services, Division of Child Welfare, MACWIS Data Warehouse and NCANDS Table Reports, FY 2008.

DEPARTMENT OF HEALTH AND HUMAN SERVICES: Office of Substance Abuse

Prevalence of Lifetime and Past Month Substance Use, 2008 is the percent of use of drugs and alcohol reported by students responding to the Maine Youth Drug and Alcohol Survey (MYDAUS).

Source: Maine Department of Health and Human Services, Office of Substance Abuse, Office of Data and Research, MYDAUS Survey 2008.

Primary Substance Abuse Treatment Services Used, SFY 2009 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 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 at admission in a setting that does not include an overnight stay.

NON-INTENSIVE OUTPATIENT services provide assessment and treatment services. These services may also be provided to others who are affected, regardless of whether the primary abuser is receiving treatment. (Office of Substance Abuse Data 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 individual's need for treatment, and when treatment is indicated, to outline the modality of treatment. (Office of Substance Abuse Data 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 rehabilitation; half-way house; and short-term, transitional and extended shelter. (Office of Substance Abuse Data 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, herself or others, and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting. (SAMHSA.gov)

Source: Treatment Data System, Office of Substance Abuse, Maine Department of Health and Human Services

Children and Adolescents Discharged From Substance Abuse Treatment Services, SFY 2009 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.

Source: Treatment Data System, Office of Substance Abuse, Maine Department of Health and Human Services

Children and Adolescents With a Discharge Status From Substance Abuse Treatment Services, SFY 2009 is the discharge status of children and adolescents age 0-20 from a substance abuse treatment service. Discharge categories include:

COMPLETED TREATMENT: treatment completed for affected other/co-dependent, treatment is complete.

DID NOT COMPLETE TREATMENT: client cannot get to facility for further treatment, client refused service or treatment, noncompliance with rules and regulations, client termination without clinic agreement, termination due to program cut or reduction, treatment not completed for affected other or codependent, 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.

EVALUATION ONLY: Data from TDS discharge form.

Source: Treatment Data System, Office of Substance Abuse, Maine Department of Health and Human Services

DEPARTMENT OF EDUCATION: 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.

Children Age 3-21 Receiving Special Education Services, December 2008 is the number of children age 3-21 receiving special education services on December 1, 2008. 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, 2008.

Children Age 3-21 Receiving Special Education Services for Emotional Disability, December 2008 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.

Children Age 3-5 Receiving Special Education Services for Emotional Disability in a Preschool Setting, December 2008 is the number of children age 3-5 counted on December 1, 2008, 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, separate schools, home, service provider and separate class. 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."

Children Age 6-21 Receiving Special Education Services for Emotional Disability in a School-age Setting, December 2008 is the number of children age 5-21 counted on December 1, 2008, 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 students with disabilities receive 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 21 to 60 percent of the school day.

PUBLIC SEPARATE DAY SCHOOL setting is a placement where a student with a disability receives special education and supportive services for more 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 more 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 more 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 more 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.

Children Age 3-21 With an Exit Status From Special Education Services for Emotional Disability, December 2008 is the number of children age 3-21 who were not receiving special education on December 1, 2008, and were receiving services on December 1, 2007.

School Removals by Type of Student and Type of Removals by Special Education Status, 2008 is reported incidents of prohibited behavior and removals from school during the 2007-08 school year.

Source: Maine Department of Health & Human Services, Office of Substance Abuse and Maine Department of Education, Report on Incidence of Prohibited Behavior and Drug and Violence Prevention, 2007-08.

DEPARTMENT OF CORRECTIONS: Division of Juvenile Services

Arrests of children is the number and rate of children ages 10-17 arrested during calendar years 2008 and 2007. The rate is per 1,000 children ages 10-17. The annual arrest data count all arrests of youth for all offenses, including repeated offenses by the same individual.

Source: *Maine Department of Public Safety, Crime in Maine Reports.*

Admissions to detention is the unduplicated number of detention admissions to the Department of Corrections two juvenile correctional facilities as a result of a court order, JCCO or Prosecutor authorization to hold. Data are for fiscal years 2007, 2008 and 2009.

Source: *Department of Corrections, Division of Juvenile Services*

Commitments to Youth Development Centers by Gender is the number of youth residing in the Department of Corrections two juvenile correctional facilities. Data are for fiscal years 2007, 2008 and 2009.

Source: *Department of Corrections, Division of Juvenile Services*

Ages and Stages: Transition to Adulthood

Disconnected Youth/Teens not attending school and not working is the estimated number and percent of teens ages 16-19 who are not enrolled in school (full-time or part-time) and not employed (full-time or part-time). These data represent calendar years.

Source: *U.S. Census Bureau, American Community Surveys, 2008, TABLE: B14005*

Education Level of Prisoners is the highest educational degree obtained by adult prisoners in a state correctional facility on November 1, 2008.

Source: *Maine Crime and Justice Data Book, 2008*

Youth Transition Data, 2008 include the number and percent of youth ages 15-21 in foster care and those receiving V-9 services and those who aged out of care. Data are for fiscal year 2008.

Source: *Maine Department of Health and Human Services, Office of Child and Family Services.*

Transition Special Education Services is the number of children age 14-21 counted on December 1, 2007, as receiving transition services through special education.

Source: *Maine Department of Education, Office of Special Services.*

DEPARTMENT OF LABOR: Division of Vocational Rehabilitation

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

Children Age 20 or Younger Whose Case Was Closed, FFY 2008 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 2008. 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.

Services Received by Children with Closed Cases, FFY 2008 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 2008.

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The Maine Children's Alliance advocates for sound public policies to improve the lives of all Maine's children, youth and families.

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