Maine's Children's Cabinet

ANNUAL REPORT

2002

"Working Together for Maine Children and Families"

Maine's Children's Cabinet

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Governor, State of Maine

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Welcome to the Second Annual Report of the Governor's Children's Cabinet!

We are pleased to present this Annual Report to the Governor, the Legislature, the Judiciary, and the public. The report summarizes the initial formation of the Cabinet through the initiation and development of our collaborative infrastructure and initiatives to date.

- You will find highlights of the Cabinet's accomplishments and successes this past year as well as recommendations for future growth and priorities to strengthen Maine families.
- You will find our history, vision, mission, goals, and website address [www.state.me.us/cabinet/homepage.htm].
- The Cabinet's unique practical approach to its work and its organizational structure designed to support and further these efforts are on pages nine and ten.
- Concise "thumbnail sketches" of our primary initiatives, with guidance as to where to find additional information.

As we survey our vision, mission, goals, guiding principles, infrastructure, and initiatives, we are able to point with pride to our greatest successes, and with renewed determination to address our ongoing challenge.

Our greatest successes continue to be:

- Overall increased cooperation and coordination across departments;
- Increased coordination and collaboration with regional and local partners;
- Work that is research-driven and focused on outcomes; and
- Resources directed toward prevention, rather than solely on intervention.

Our continuing challenges, with which we will continue to grapple, are:

- A lingering culture within agencies which hampers a collaborative, cooperative spirit – continuing to see the collaborative work of the Cabinet as a temporary "program", rather than a new and permanent way of doing business;
- Categorical funding streams that tend to impede a holistic approach to addressing the problems of children and families while suppressing collaborative creativity; and
- Maintaining the work of the Children's Cabinet with adequate staff and support services.

Despite the challenges, our report also proudly includes a section on what's going right in Maine for its children and families. Clearly, the evidence supports the claim that Maine is a great place to live, to raise children, and to prosper!

J. Duke Albanese, Commissioner
Department of Education; and
Chair, Children's Cabinet

Executive Summary

Since 1995, the Children's Cabinet has worked to foster a change in government systems to better serve the 300,000 youth under the age of 18 in Maine, with particular focus on collaboration and prevention programs. This Annual Report outlines the many results of this focus on collaboration and prevention and includes a work plan for the next fiscal year and longer-term challenges in each program area.

Until the last year, Maine enjoyed the best economic times in its history, making it possible for the state to make great strides for children and families. While poverty is the most salient predictor of negative outcomes for children and families, Maine leads the nation in a number of indicators of well being for children, families and communities.

- In the last five years, the state has been ranked in the top five in the country as the best state to raise a child.
- Maine has the fourth highest rate of children with health insurance in the country. Only 6% of Maine's youth are without healthcare.
- Comprehensive services for juvenile offenders has led Maine to be tied for the third lowest rate in the country of juveniles detained or committed in the system.
- Maine consistently places at the top (2nd in 2001) of Education Week's national rankings of states in the quality of school climate characterized by: small class size; low behavior problems; high student engagement; strong parent involvement; high attendance; local autonomy.

We can be proud of our accomplishments, which include:

- Decreased out-of-state placements of children from 250 to 90.
- 69 Communities representing 319 municipalities have mobilized to create local leadership Councils as part of the Communities for Children initiative.
- Maine's Temporary Assistance to Needy Families (TANF) caseloads are the lowest since the late 1960s and the rate of families returning to the TANF Program is a low 6%.
- Development of in-home behavioral health services serving over 1900 children.

However, these strengths need to be preserved, as there is data to suggest that our greatest strengths – stable families and communities – are facing increased pressures under the current economic conditions. At the systems level, we have had mixed success over the last ten years with some positive accomplishments and some setbacks in the movement towards a coherent approach to promoting the well-being of children and families.

In 1995, Governor King established the Children's Cabinet (comprise of the Commissioners of Corrections, Education, Human Services, Public Safety, and Behavioral and Developmental Services) and charged the group with collaborating to improve services for children and families. The result has been a number of initiatives from increased cooperation (e.g. bringing children back to Maine from out-of-state placements), to collaboration on such initiatives as Communities for Children, Integrated Case Management, and *Maine Marks*. In 1999, the Children's Cabinet was formalized by statute, along with the Council on Children and Families, whose membership includes the Children's Cabinet, the Chief Justice and members of the legislature. In addition, legislation was enacted to require child-serving departments to collaborate in the design and implementation of a children's mental health program. A legislative committee was created to oversee this collaborative process.

Children's Cabinet Highlights

Communities for Children (C4C) is a flagship initiative of the Governor's Children's Cabinet. C4C supports and increases good outcomes for children and promotes positive child and youth development. It has now grown to include 69 local leadership councils made up of key leaders in the community, including youth, and representing 319 municipalities and over 70% of the State's population. These Councils assess the realities facing children and youth in their communities, develop prevention programs and policies, and track the results of their work. The statewide initiative helps these communities by providing training, technical assistance, and opportunities for networking with each other.

Integrated Case Management (ICMS) brings together family members with all their service providers to develop a comprehensive family plan and to coordinate services. An Integrated Case Management Policy Agreement has been developed to promote statewide use of this model. Over 100 volunteer facilitators have been trained to coordinate the meetings and to provide a neutral contact for the families.

Regional Children's Cabinets have worked to highlight the plight of **Youth Who Are Homeless** and to develop services to meet their needs, which include a rapid response to youth, within the first 24 hours of their becoming homeless, coupled with an assessment of a youth's issues and the development of safety plans with youth and their families. This RCC initiative has significantly reduced the number of children on the streets or in shelters.

Local Case Review/Resolution Committees (LCRC) are located in each county in the State and are a resource for families to access when they have a unique need that cannot be satisfied through any system already in existence. Each committee hears cases submitted by family members, agency representatives, teachers, or other sources, and makes a decision on a case-by-case basis. The LCRC members represent many different agencies and can refer the family to available resources. In a few cases, the LCRC can provide limited funds to provide services needed to avoid an out-of-home placement for a child. Prior to accessing LCRC funds, the family must exhaust all other resources available to them. LCRCs are allocated a small pool of funds available, to assist in meeting structural gaps and needs in the system of care for children and families, from funds which are pooled for these purposes from each of the five Children's Cabinet Departments.

Maine Marks, a report highlighting data about the state of children and families in Maine was released by the Children's Cabinet in February 2001. Maine Marks highlights 79 indicator areas, such as #51, *Youth success after leaving the juvenile justice system*, and #63, *Youth living in homeless or emergency shelters*. A follow-up report will be released in the Summer 2002. In the coming years, trends tracked in Maine Marks will be helpful in measuring Maine's success in prevention and collaboration.

Our final highlight is that the Bureau of Human Resources is exploring the inclusion of "collaboration" as a core competency for state workers. This is further evidence that the Children's Cabinet structure is having an impact on the climate of the participating Departments as originally envisioned.

Children's Cabinet Next Steps

While many improvements have been made, much remains to be done. Prevention and collaboration efforts need to be expanded and adopted as the standard government operating strategy. To accomplish all of the goals outlined in this Annual Report, the Children's Cabinet must continue to play a leadership role in the prevention and collaboration efforts in children's policy and programs. The recommendations of the Children's Cabinet's are:

1. Strengthen the Children's Cabinet as the interdepartmental structure that focuses on prevention, cooperation and collaboration.

- Designate one Senior Level Staff member from the Governor's Office as a Children's Cabinet Liaison (and possibly as chair).
- Assure the Children's Cabinet has strong leadership and sufficient staff to carry out its mission.
- Amend Children's Cabinet statute to include the Department of Labor.

2. Strengthen the Regional Children's Cabinets as the interdepartmental structure that focuses on prevention, cooperation and collaboration at the regional and operational level.

- Continue the use of Pooled Flexible Funding to identify and overcome systems gaps and service barriers to families.
- Continue use of the Local Case Review/Resolution Committees.
- Continue to support the Youth Who Are Homeless programs.

3. Strengthen the following Children's Cabinet Initiatives.

- Bolster *Communities for Children* assuring it has adequate resources and that every community is a Community for Children.
- Fully implement the *Integrated Case Management* Policy Agreement and programming statewide to better serve families in need.
- Continue to expand *Maine Marks* and report the indicators of progress towards goals of well being for children, families, and communities.
- *Coordinated Coalition Management* to ensure the coordination and communication among all local and statewide prevention coalitions for better prevention planning.

4. Continue to develop the following programs under the leadership of the Children's Cabinet for future adoption by a lead department or other entity.

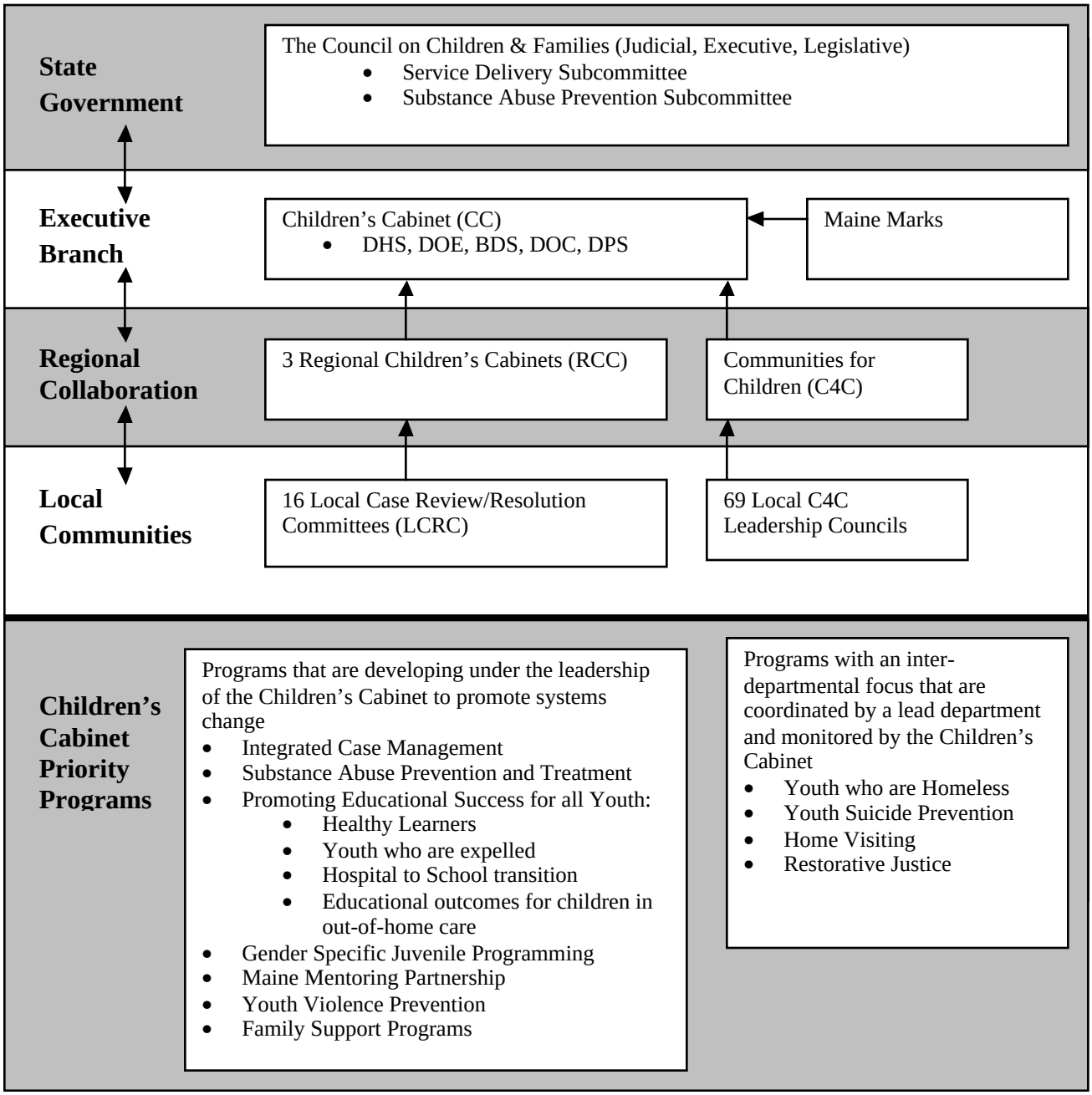
- Substance Abuse Prevention and Treatment
- Promoting Educational Success for all Youth
    - Healthy Learners
    - Youth who are expelled
    - Hospital to School transition
    - Improve educational outcomes for children in out-of-home care
- Gender Specific Juvenile Programming
- Maine Mentoring Partnership
- Youth Violence Prevention
- Family Support Programs

5. Continue to support the following programs which have an interdepartmental focus; are coordinated by a lead department; and, are monitored by the Children's Cabinet.

- Youth Who Are Homeless
- Youth Suicide Prevention
- Early Care & Education
- Restorative Justice

6. Explore pursuing a children's policy agenda using the forum of **the Council on Children & Families,** which brings together the Legislative, Judicial and Executive Branches of Government.

Structures and Priority Programs of the Children's Cabinet



Good News for Maine's Children & Families

- In the last five years, the state has been ranked in the top five in the country as the best state to raise a child.
- Maine has the fourth highest rate of children with health insurance in the country. Only 6% of Maine's youth are without healthcare.
- Smoking among high school students in Maine has dropped 36% since 1997.
- For the seventh year in a row, Maine ranks in the top five States for the low teen pregnancy rates.
- Child support collections on behalf of 61,000 Maine families lead all states. In 2000, $96 million was collected, in 2001 $100 million was collected, and in 2002 $105 million was collected to date.
- Maine's Temporary Assistance to Needy Families (TANF) caseloads are the lowest since the late 1960's and the rate of families returning to the TANF Program is a low 6%.
- Development of a statewide crisis system for all Maine residents.
- Decreased out-of-state placements of children from 250 to 90.
- Development of in-home behavioral health services serving over 1900 children.
- Department of Behavioral and Developmental Services provides mental health referrals and treatment in correctional facilities.
- 69 Communities representing 319 municipalities have mobilized to create local leadership Councils as part of Communities for Children.
- Maine has recently been awarded $3 million each year for the next three years to work comprehensively to reduce binge drinking by 10% and tobacco use by 15%.
- K-12 Alternative Education programs have been established in at least 90 schools statewide with a rising increase in creative alternatives for youth.
- Two new juvenile justice facilities are in place, with comprehensive cognitive-behavioral programs.
- Comprehensive services for juvenile offenders has helped Maine to achieve the third lowest rate in the country of juveniles detained or committed in the system.
- Comprehensive Quality Assurance program, assessing both the internal and external factors related to case management and positive client outcomes.
- Development of 12 Restorative Justice, Juvenile Community Resolution Teams statewide for first-time misdemeanor offenders and their victims.
- We have organized and managed a computer crimes task force which is targeting child pornography
- We have computerized all the criminal history records, making criminal record checks available to caseworkers.
- Training police officers in predominant aggressor identification to eliminate inappropriate dual arrests, and keeping youth in a safe home.
- The Enhanced 911 system has been implemented statewide and has made it easier for youth to call for police, fire or bus help.
- Forbes Magazine rated Maine at the top in education cost efficiency. Per pupil spending is near the national average, while student achievement on the National Assessment of Education Progress (NAEP) is regularly the best in the nation.
- Maine has the highest rate of high school completion in America - 94.5% compared to the national average of 86.5% (USDOE 2001)
- Maine will become the first state in the nation to equip all seventh and eighth grade students and teachers with portable, wireless, personal computers, beginning in 2002 and expanding to eighth grade in 2003.
- Maine consistently places at the top (2nd in 2001) of Education Week's national rankings of states in the quality of school climate characterized by: small class size; low behavior problems; high student engagement; strong parent involvement; high attendance; local autonomy.
- Maine has received national acclaim for its first-in-the-country focus on reforming our high schools, and is now engaged in similar groundbreaking efforts to address student behavior and ethics through character education partnerships.
- Education Week ranks Maine #1 among the states in the quality of school climate, because class size is small, student engagement is high, parent involvement is strong, and local autonomy exists.
- Maine ranks sixth in the county in terms of high school completion.
- Perception of public safety has improved.

Introduction: The Four R's of the Governor's Children's Cabinet

Since the beginning of the King Administration in 1995, the Children's Cabinet has predicated its actions on the belief that children's needs are best met within the context of relationships in their families and their communities.

Our vision flowing from this belief has resulted in steady progress toward achieving the "4 R's" in Maine:

Respecting Children and Youth

Every child has the opportunity to be a child and the education, resources, and support to become a healthy and productive adult.

The Governor and his Children's Cabinet are committed to respecting children and youth. A respected child becomes a respectful adult, a respected child has increased self-esteem, and a respected child respects other children. We also respect a child's right to be a child because we want children to be playful and carefree, in order to explore their creative potential without fear of criticism or harm or abuse. Every child starts out as a helpless infant and we need to adore and care for each child - 100%- in order that he or she may grow up to be a healthy, happy, and productive adult. Respected children and youth need adults who simply rejoice in their being free and energetic selves as integral parts of our families and our communities.

A quick perusal of the issues listed in the section entitled "Respecting Children and Youth," below, shows that this is not an academic "to-do" list; these issues are manifestations of our caring for children and represent our commitment to ensuring the birthright of every child.

We take our cue from the Governor, who, when asked by a young man at a public meeting why the Governor cared so much about whether the boy smoked or not, came down off the podium and put his arm around the boy and answered, "Why? Because I love you, that's why".

Revitalizing Families

Every family recognizes the responsibility and rewards of raising children and is provided the support necessary to fulfill their roles.

Maine was rated first in the nation as the best state in which to raise a child[1] by the Children's Rights Council, a Washington, D.C.-based national advocacy group. We want to keep it that way – and make Maine an even better place to raise children by supporting families to support their kids.

Children learn and grow best within the context of their own families. Therefore, families must have the resources and support they need to provide children with security and a positive environment. The issues listed in the section of our report entitled "Revitalizing Families," below, are intended to work toward the goal of ensuring this environment.

Rallying Communities

Raising children is a shared responsibility that includes a process of establishing and modeling clear standards of behavior.

Children need a good start in life, and communities can play an important role with families in providing that great start. Community groups like Big Brothers/Big Sisters, PTA groups, Communities for Children, Little League, as well as churches, sports, and civic organizations can all contribute to making the community a safe and healthy environment where children can grow. Communities can also involve their children in work or projects that benefit the community, and at the same time, demonstrate to children that they are valued by the community and have much to give to their communities.

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[1] July 1999 report released by the Children's Rights Council.

Our work in this category is intended to help communities and families raise healthy and empowered children, who have a strong sense of civility and responsibility to the community of which they are a part.

Regenerating State Government

State agencies collaboratively support families and communities, keeping family and children at the heart of all decisions.

It is not enough to respect children in all of our efforts, or to revitalize families. Nor is it enough to rally our communities to revisit how they treat their families and children. We must also look to our government and regenerate it with the values and principles of the Children's Cabinet. Our efforts to regenerate government to date on behalf of children and families are listed within this report.

We have dedicated Maine's child-serving State departments to a common purpose – to keep children and families at the heart of all decisions and all actions. Maine's government is organized to partner with communities and families to provide the best possible delivery of services. We have spent the first 7 years of this Administration, and will spend the final eighth year, fine-tuning our governmental processes so that we can work together for the true benefit of children and families. Our work is not only dedicated to addressing and solving current problems, but has also focused substantial resources on prevention and systems change. We work to make sure that we have done everything we can to move our system for caring for children toward the outcomes listed in the table below

1995 – Where We Started 	2002 – Moving Towards …
Problems reach crisis stage before action is taken.	Prevention and early intervention solve emerging problems well before they reach the crisis stage.
Thousands of family problems receive minimal or no response either by the State or private system because of a lack of resources.	A child or family receives help the first time it is requested.
Community and State agencies act independently of each other.	Community and State agencies work collaboratively to find solutions for at-risk kids.
Schools have limited options to deal with the problems of children, culminating in policies of expulsion.	Schools and communities develop a capacity to deal with emerging problems within the school and community system.
Juvenile cases are handled with "retributive justice".	Juvenile cases are handled with "restorative justice".
Media highlights violence.	Media highlights well-being of children and families.
Voices of young people rarely heard in shaping youth policy.	Young people communicate their needs and desire in shaping policy

To accomplish our goals and systems change, the Children's Cabinet and its constituent Departments have developed an impressive array of initiatives for the benefit of children and their families by actively collaborating to create and promote coordinated policies and service delivery systems.

We are also keenly aware of continuing challenges, which will engage us through the balance of the King Administration, and which will certainly be of interest to any future administrations dedicated to improving the lives of children and families in Maine.

Given the events of September 11, 2001, we rededicate ourselves to the proposition of partnering with Maine's children, families, and communities to make a world which is safe, healthy, and productive by respecting children and youth, revitalizing families, rallying communities, and regenerating government.

To this end, this document outlines accomplishments to which the King Administration may point with pride, and outlines a work plan for 2002 and the continuing challenges that will face the next administration.

Respecting Children and Youth

Our Vision for Maine: Every child has the opportunity to be a child and the education, resources, and support to become a healthy and productive adult.

Health Insurance For Children And Adults

Overview

Maine now enjoys the fourth highest rate of children with health insurance in the United States, including both private health insurance and government-provided health insurance; 12,603 children were enrolled in the newly expanded Medicaid and child health insurance program called Cub Care as of March 2002. Our efforts have increased the overall rate of people (both children and adults) with health insurance in Maine, which is the opposite of national trends. With 183,000 children and adults receiving Medicaid or Cub Care, these are the highest numbers of people receiving state health insurance in the history of Maine.

Next Steps for 2002

A waiver has been submitted to allow the State to provide health care coverage for "non-categorical" adults. Assuming the waiver is approved by the federal government, the program would begin within the next year.

Continuing Challenges for 2003-2006

Enroll qualified adults and children in the newly renamed MaineCare (formerly Medicaid and Cub Care) program. Outreach efforts continue, as Maine places a high priority on assuring that as high a percentage of eligible persons as possible are actually enrolled in MaineCare.

Tobacco Use Reduction and Health Promotion

Healthy Maine Partnerships

Partnership For A Tobacco-Free Maine

Bureau of Health, Department of Human Services

The Partnership For A Tobacco-Free Maine (PTM) is the primary program responsible for tobacco prevention and control throughout the state of Maine. The PTM was originally developed as a result of the tobacco excise tax legislation passed in 1997. In November 1998, Maine along with 45 other states across the country sued the tobacco industry for the recovery of the states' Medicaid health care costs attributed to tobacco use. As a result of the Master Settlement Agreement the industry committed to paying the states approximately $206 billion over the next 25 years. Of the $206 billion over the 25 years, it is estimated that Maine will receive $50 million per year.

Through the Fund for a Healthy Maine, the 119th Maine State Legislature dedicated all of the state tobacco settlement funds to health programs. A substantial portion of those funds has been allocated specifically to the PTM to create programs that work to reduce tobacco use and tobacco-related chronic diseases. Two programs in the Bureau of Health (BOH) are partnering with the PTM to develop, implement and evaluate selected programs funded by the tobacco settlement. The two programs are: the Maine Cardiovascular Health Program and the Community Health Promotion Program. An initiative, *Healthy Maine Partnerships*, was established to link these three programs in order to facilitate the coordination and collaboration of the various related program activities.

The PTM, a comprehensive program, also receives funding from a cooperative agreement with the CDC and is designed to reflect the CDC's Best Practices Guidelines for Statewide Tobacco Prevention and

Control Programs. The mission of the PTM is *to reduce death and disability due to tobacco use among Maine citizens by creating an environment in Maine that is supportive of a tobacco-free life.*

The statewide program, which focuses its efforts primarily on population-based strategies to effect policy and environmental change, has four primary goals:

- Prevent initiation of tobacco use by youth;
- Motivate and assist tobacco users to discontinue use;
- Reduce involuntary exposure to secondhand smoke; and
- Identify and eliminate disparities related to tobacco use among population groups

The PTM supports several programs and activities that help to achieve the above goals. These include:

- A statewide multi-media and public awareness campaign
- A statewide coordinated system of tobacco treatment services including the toll-free Maine Tobacco HelpLine, tobacco treatment medication program and training in tobacco treatment for health care providers and other health care professionals
- Funding to 31 local Healthy Maine Partnerships across the state working to reduce tobacco use and tobacco-related chronic diseases
- Enforcement activities related to preventing youth access to tobacco as well as laws regulating smoking in public places, work places and restaurants
- An outreach and training program on Responsible Retailing to assist retailers in complying with youth access laws
- A statewide youth advocacy network and local youth advocacy programs
- A statewide Tobacco-Free Athletes program
- Program monitoring, surveillance, and evaluation of the comprehensive program

The Maine Bureau of Health in the Department of Human Services is a national leader in health promotion and disease prevention. Thanks to sustained efforts to prevent tobacco use among youth by Partnership For A Tobacco-Free Maine, a comprehensive tobacco prevention and control program within the Bureau of Health, smoking among high school students in Maine has dropped 36% since 1997. Maine is one of the few states that continues to allocate all tobacco settlement funds to health programs which include early child care, voluntary home visiting, Medicaid, substance abuse treatment, expanded drug programs for the elderly and disabled as well as the statewide comprehensive tobacco prevention program.

Next Steps 2002

Partnership For A Tobacco-Free Maine continued strategies to protect youth from tobacco use and addiction include:

1) promoting and tracking Tobacco-Free School Policy initiatives and distribution of signage to schools that meet PTM criteria
2) promoting Tobacco-Free Athletes Program for soccer, basketball, baseball and softball
3) promoting tobacco-free municipally owned playing fields
4) providing train the trainer workshops in the Life Skills Training Program for middle school health teachers
5) supporting local Youth Advocacy Programs that work on strategies that support tobacco-free living
6) promoting "No Buts", a responsible retailing outreach and training program
7) supporting the statewide media messages that "tobacco is an addictive drug, the tobacco industry is deceptive and manipulative and secondhand smoke is a health hazard."

Continuing Challenges 2003-2005

1) Youth addiction and access to tobacco products through social sources
2) Countering tobacco industry messages that glamorize and normalize tobacco use targeting young adults

Substance Abuse Prevention, Intervention and Treatment

Overview

Maine has several efforts currently underway to prevent children from abusing substances or to treat those who do:

1) The State Incentive Program: Maine has recently been awarded $3 million each year for the next three years, plus an additional $20,000 for training in Year 1, to work comprehensively to reduce binge drinking by 10% and tobacco use by 15% by achieving the following goals:

   a) Coordination of Funding: to develop and implement a sound strategy to identify, coordinate, leverage, and/or redirect, as appropriate and legally permissible, all substance abuse prevention resources (funding streams and programs) within the State that are directed at communities, families, youth (age 12-17), schools and workplaces.

   b) Development of Comprehensive Prevention State System: to develop and implement a comprehensive, long-range prevention program system to ensure that all State prevention resources fill identified gaps in prevention services targeting youth ages 12-17 throughout the State with science-based prevention programs.

   c) Development of an Evaluation Tool: to measure progress in reducing substance use by establishing targets for measures included in the National Household Survey on Drug Abuse.

   Eighty-five percent, or $2,555,000, of the State Incentive Program grant will be awarded to "sub recipients" The remaining fifteen percent will be used for a project evaluation, staffing for the program, materials, and administrative costs.

2) The Maine Safe and Drug-Free Schools: The Data Collection Project is a partnership between Maine's Office of Substance Abuse (OSA) in the Department of Behavioral and Developmental Services (BDS), the Maine Department of Education (DOE), and the Research Triangle Institute (RTI). The purpose of the Safe and Drug Free Schools and Communities Act of 1994 (SDFSCA), also known as Title IV of the Improving America's Schools Act (IASA), is to prevent violence in and around schools and to strengthen programs that prevent the illegal use of alcohol, tobacco and other drugs by enhancing the State's capacity to gather data on alcohol, tobacco, and other drug (ATOD) and violence prevention programs. This law requires parental involvement and coordination with related federal, State, and local efforts and resources; and it makes federal assistance available to states, local educational agencies, public and private nonprofit organizations, and institutions of higher education for selected programs, services, and activities.

3) "Youth Voices" on Maine Public Broadcasting System (PBS) : Maine PBS worked with four Maine Youth Voices groups two years ago, guiding them through the design and production of their own public service announcements (PSAs). At the same time, a Maine PBS producer and crew created a documentary that followed the efforts of these four groups, culminating in the completion of their PSAs. This collaboration continued with a second production in the 2000-01 school year when Maine PBS worked with a second set of four Maine Youth Voices groups, each of whom created its own 5-7 minute mini-documentary or dramatic production analyzing some facet of the underage drinking issue in their respective communities. In the 2001-02 school year, this collaboration continues for a third year, with another production planned for broadcast in the spring of 2002.

4) Substance Abuse Treatment in Juvenile Correctional Facilities: , Juveniles residing in the Long Creek Juvenile Development Center (formerly the Maine Youth Center) and the Mountain View Youth Development Center (formerly the Northern Maine Youth Detention Center) now receive more comprehensive substance abuse services and treatment.

5) Adolescent Drug Courts: Adolescent drug courts began operating in February 2000 through the cooperative effort of the Office of Substance Abuse (in BDS), the Juvenile Division of the Department of Corrections (DOC), and the Judiciary. Drug treatment court programs are offered in the Biddeford, Portland, Lewiston, Augusta, West Bath, and Bangor district courts. Evaluation reports show an improvement in abstinence from drug use and in increased work and school attendance.

Next Steps for 2002

1) State Incentive Grant: The primary work of 2002 will be to distribute the nearly $3,000,000 in grants to community coalitions through a competitive RFP. One RFP will be specifically directed to the Native American population. Additional funding will go to coalitions that join together across communities and combine alcohol and drug abuse prevention with their work in prevention of other health and welfare problems such as teen violence, pregnancy, and sexually transmitted disease.
2) Safe and Drug Free Schools: With a change in federal policy through the reauthorization of the Safe and Drug Free Schools law, current work will need to focus on working with local education agencies to continue to use this funding for alcohol, drug and violence prevention activities, and to streamline and simplify the reporting process to ensure wide participation of school systems.
3) Underage Drinking Initiatives: This effort is currently expanding to include college-age students. Through a new discretionary grant from the Office of Juvenile Justice Programs, five colleges will develop environmental strategies to change campus drinking behavior. In addition, the University of Maine system will develop a systemwide effort to combat underage and risky drinking behavior of students.
4) Substance Abuse Treatment: With the creation of the adolescent drug treatment courts, it became clear that there was an inadequate array of treatment services for young people. Using the remainder of a federal treatment capacity expansion grant, OSA will increase the availability of more intensive out-patient treatment options for youth in the drug court communities. In addition, an RFP has been issued to create a new residential adolescent substance abuse treatment program.

Continuing Challenges for 2003-2006

1) New drugs continue to become available, and old drugs that have not been seen in large quantities for many years are resurfacing. Youth report that it is relatively easy to access an array of illegal drugs as well as alcohol and tobacco. Their alcohol and drug use leads to a high rate of accidental death and injury as well as being strongly linked to many of the other social problems that youth face.
2) It is critical to ensure that all systems are aware of potential substance abuse, and can screen for it and locate appropriate treatment resources.
3) We must ensure that both the prevention and the treatment opportunities that are offered are effective for the population to whom they are targeted.

Teen Pregnancy Reduction

Overview

For another successive year, Maine has realized one of the very lowest rates of teen pregnancy in the United States according to the Centers for Disease Prevention and Health Promotion. Similarly, the teen abortion rate for Maine has declined for the fifth year in a row. For the seventh year in a row, Maine ranks in the top five States (4th) for the lowest rate of teen pregnancy. These rates are a tribute to Maine teens, their parents, communities, health education efforts in Maine's schools, family planning agencies, Bureau of Health program efforts, and access to prevention services through Maine Medicaid and school health programs. The Bureau of Health's Teen and Young Adult Health Program supports many of these efforts, including: accessible family planning services; consultants to schools and communities to develop comprehensive health education curricula that includes effective family life education; community education with businesses and youth serving organizations; and media campaigns promoting abstinence. These efforts are complimented by other State and local agencies whose programs promote healthy choices for our youth.

Next Steps for 2002

1) Further support Maine schools in developing health curricula that are aligned with the Maine *Learning Results* and that use effective strategies for teaching abstinence-based family life education.

2) Develop a partnership between the Bureau of Health and the Office of Substance Abuse to assist communities in addressing the connection between underage drinking and teen pregnancy.

Continuing Challenges for 2003-2006

1) Supporting communities as they develop programs and services that support young people in making healthy life choices.

2) Supporting parents and families to increase their communication with their children and adolescents about facts and values on sensitive issues, including adolescent sexuality.

Infant Mortality Reduction

Overview

Infant death is a critical indicator of the health of a society since it reflects the overall state of maternal and infant health and the many social, environmental, and health care system factors that contribute toward the health of both of these vulnerable populations. One hundred years ago in Maine, about 1 in 8 babies born did not live to see their first birthday. Today, for babies born full term, that number has dropped to 1 in 1000. During the last decade, Maine has consistently had the lowest or one of the lowest infant mortality rates in the nation.

Over the 15-year period (1985-2000), Maine's annual infant mortality rate (IMR) ranged from a low of 4.4/1,000 live births (1996) to a high of 8.9/1,000 live births (1985). Comparing rates from year to year can be misleading because of the potential for large rate changes as a result of Maine's small population. For that reason, it is more accurate to look at 5-year averages. For the same 15-year period the 5-year average IMR ranged from a high of 8.1/1,000 live births (1985-1989) to a low of 5.3/1,000 live births (1995-1999).

The infant mortality rate is made up of two major components: neonatal mortality (death in the first 28 days of life) and postneonatal mortality (death from one month of age until the first birthday). The leading causes of neonatal death are birth defects, disorders due to prematurity and low birth weight, and pregnancy complications. The leading causes of postneonatal mortality include sudden infant death syndrome (SIDS), birth defects, and injuries.

Preventable pregnancy complications resulting in fetal or neonatal death include those associated with alcohol use (fetal mortality is 77% greater in women who use alcohol), tobacco (fetal mortality is 35% greater in women who use tobacco) and illegal substances. Tobacco addiction is also associated with low birth weight, prematurity, sudden infant death syndrome, and respiratory problems in newborns as well as an estimated 15% of costs for all complicated births.

The initiation of early and adequate prenatal care is another essential intervention that may improve pregnancy outcomes and reduce infant mortality rates. This stems from the fact that much of prenatal care consists of screening for risks, treating any medical condition or risk that arises, and providing education, as well as early and ongoing adequate prenatal care. Monitoring this indicator over the same 15 year period (1985-2000), we also see improvement in this area. By individual years, the proportion of pregnant women receiving early and adequate prenatal care ranged from 65.1% in 1985 to a high of 84.8% in 1998. Looking at 5-year averages, the proportion of pregnant women receiving early and adequate prenatal care increased from 66.8% (1985-1989) to 84.7% (1996-2000).

Next Steps for 2002

Next steps involve continuing known strategies that contribute to Maine's low infant mortality rate. Those include primary, secondary and tertiary prevention activities, such as:

1) Community-Based initiatives: Community-based efforts that work to create community environments that are healthier for families (such as Communities for Children, Campaign for a Healthy Maine, Healthy Communities).
2) Universal Home Visits: Traditionally home visits during a child's infancy were offered to high-risk families. Now Maine's system of home visits is being expanded to include almost all newborns of first-time parents.
3) Universal Vaccinations: For the past five years, all necessary childhood vaccines have been provided for free by the Bureau of Health to licensed health care providers for all children.
4) Folic Acid: Ensuring that all women of reproductive age take adequate amounts of folic acid is critical to preventing spina bifida and neural tube defects.
5) Nutrition: Supplemental nutrition products and education through such programs as Women, Infants & Children (WIC), Maine Nutrition Network, and University of Maine Cooperative Extension assure proper nutrition to pregnant women and young children, with a focus on those at high risk.
6) Screening Programs: Preconception and prenatal genetic testing and counseling services, and universal newborn screening for metabolic disorders.
7) Preventive Care: Availability of preventive reproductive health care through private and public providers such as family planning clinics, and rural and migrant health centers. Assuring that women before conception or during pregnancy have access to effective tobacco and substance abuse treatment programs.
8) Access: Medicaid and MaineCare cover all pregnant women and infants under 200% of Federal Poverty Level, which is about 40% of pregnant women and infants in Maine.
9) Specialty Care: Transportation services to and availability of specialty care for high-risk pregnancies and sick infants are important for all Maine pregnant women and infants. Maine's tertiary care hospitals provide these critical services throughout Maine, and programs such as Katie Beckett and Children with Special Health Needs Program assure coverage for specialty care for some sick children.

Continuing Challenges 2003-2006

1) Access to prenatal care relative to: geographic distribution of providers in relation to the population; the ability to pay for the services; transportation for women and infants living in rural areas or without access to a vehicle; the ability for pregnant women and parents to balance employment demands within the hours that provider services are available.
2) Maintain or expand funding for MaineCare for the provision of prenatal and well baby care.
3) Maintain funding for parent education and support through home visitation through the Fund for a Healthy Maine (FHME).
4) Changing demographics and the need for responsive perinatal health care. For instance, we need to respond to the varied health challenges of refugee populations such as nutritional deficiencies, infectious and non-endemic diseases, and traumatic circumstances.
5) As new information about preventing birth defects becomes known, we face challenges in disseminating that knowledge.
6) Determination of those most likely not to receive early and adequate prenatal care and focus interventions on them.

Childhood Immunizations

Overview

Maine continues to be one of 13 states that have a universal vaccine policy, reflecting the Department of Human Services' philosophy that vaccines should be

freely available to all children, regardless of their ability to pay for them. In accordance with this universal policy, the Maine Immunization Program provides all recommended vaccines for children 0 – 18 years of age, and influenza, pneumococcal, and first dose measles, mumps and rubella (MMR) for adults. Currently over 700 providers throughout Maine participate to receive vaccines, free of charge, from the Maine Immunization Program to administer to their patients. We have established a goal of providing immunization coverage to 90% of the children in Maine.

Maine has always had some of the highest immunization rates in the country, and despite declining childhood immunization rates nationally, Maine has sustained high coverage rates. According to the National Immunization Survey, a large, on-going survey of immunization coverage among pre-school children in the United States (19 - 35 months old), Maine ranked 6th in the nation for children up-to-date with a series of 4 DTP/DTaP, 3 Polio and 1 MMR (4-3-1) with a rate of 84%, higher than the national average of 78%, for the period January to December 2000. Preliminary results for this 4-3-1 series show Maine ranking 1st in the nation with 86% coverage for the period of July 2000 – June 2001. For the period July 2000 to June 2001, Maine led the nation for the 4-3-1-3 series with a rate of 86%; the national average was 78%. The rate for the 4 DTP/DtaP, 3 Polio, 1 MMR, 3 HIB series (4-3-1-3) was 85%, again making Maine 1st in the nation and above the national average of 77%.

This progress is not without challenges, however; when additional vaccines are considered, Maine's rank changes. For example, preliminary results of the 4 DTP/DtaP, 3 Polio, 1 MMR, 3 Hib, and 3 Hep B series (4-3-1-3-3) show Maine ranking 17th in the country with a coverage rate of 78%. The lower rate on the 4-3-1-3-3 series is believed to be due to lower Hepatitis immunization, reflecting public concern about thimerisol, a mercury-based preservative believed to be contained in some pediatric vaccines. While Maine's pediatric vaccines do not contain thimerisol, this is a powerful example of the importance of sustained educational efforts for healthcare providers and the public about immunizations and vaccines.

Maine was the first state to secure funds for developing an Internet based multi-state computerized immunization registry, ImmPact. ImmPact is intended to be a repository for accurate and up-to-date immunization records for all persons born, residing, or receiving vaccine in the State of Maine. The primary purpose of the system is to collect data related to vaccine administration, and to promote effective and cost efficient prevention of vaccine preventable diseases. After completion of an initial pilot phase, the Department of Human Services has recently promulgated rules for the operation of the immunization information system. The program is currently in the process of active provider enrollment into the ImmPact registry. Currently approximately 110 pediatric providers are enrolled in the registry, reflecting approximately 36% of Maine pediatric population.

During 2001, rules related to Immunization Requirements for School Children were amended to add varicella to the list of required immunizations, as well as to amend the exemption language for clarity and to conform with the provisional statute. While the amended rule will likely become effective in April 2002, the varicella requirement will not be implemented until the start of the school year in 2003. The new requirement will be phased-in incrementally over a five-year period. The Maine Immunization Program will work with school nurses and other staff from the Department of Education concerning the implementation process.

Next Steps for 2002

During 2002, the Maine Immunization program will work to better identify high risk and underimmunized populations across the State. Identification of these populations will aid in the development of strategies that can be used to reduce barriers to immunization for these populations.

This year, the Maine Immunization Program will increase efforts focused on adult and adolescent populations. Strategies focusing on immunization, proactive leadership and advocacy will be used to provide audience-appropriate information, and the knowledge and motivation that are essential for successful immunization programs for these groups.

Future activities will include the development of quality vaccine preventable disease surveillance and outbreak control systems, based on national models of excellence. Specifically, the program will undertake development of a surveillance system for varicella. Such a system may include sentinel reporting at pilot sites to create baseline data prior to the implementation of the school requirement for varicella. Protocols will be developed with input from sentinel sites to include active surveillance for complications of varicella.

Development of high-quality surveillance systems will assist the State's preparation and ability to respond in the event of bio-terrorism events, a concern that emerged with national urgency after the events of September 11, 2001.

Maine will continue its efforts to increase enrollment of providers and children in the immunization registry, and remains committed to preparing for future public health challenges with innovative and effective immunization information systems. The Maine Immunization Program will also continue to develop partnerships around information technology, to ensure that such tools provide maximum benefits to the public and private healthcare communities across the State.

Continuing Challenges for 2003-2006

Many challenges lie ahead for the Immunization Program. National funding priorities may threaten the State's ability to continue to proactively focus on developing a strong immunization infrastructure. With the potential for reduced federal funding, the Maine program may need to rally additional resources in order to continue to provide universal vaccination coverage for all of the State's children.

Issues pertaining to the vaccine supply continue to present challenges to the program and to health care providers who seek full immunization of their pediatric populations. During this current year, nearly every recommended childhood vaccine faced shortage situations, and currently revised schedules for several childhood vaccines are in place, due to the inability of the vaccine manufacturers to keep current with the needed national supply. These supply challenges will force the Immunization Program to work closely with Maine health care providers to ensure that patient tracking systems effectively recall children for booster doses when supplies are once again adequate.

The rising cost and complexity of the vaccine schedule present significant challenges, which require extensive work on vaccine accountability systems within the Immunization Program. In 2003, the program will continue to establish rigorous accountability procedures, to ensure that public vaccine resources are maximized. To this end, the program will continue to establish benchmarking and evaluation processes, and work closely with health care providers to ensure that proper vaccine handling and storage protocols are in place. These challenges present opportunities to strengthen the productive collaborations between the Immunization Program and Maine's health care community.

Finally, as immunization programs are increasingly successful in containing and eliminating childhood diseases, an ongoing challenge remains to communicate to the public the importance of sustaining a commitment to full vaccination of the State's children. As disease incidence is reduced, and the devastating results of disease become increasingly distant, a potential for complacency may creep into the public mindset. A constant challenge, directly related to the success of immunization, remains keeping Maine's childhood immunization rates among the highest in the nation. The program will continue to work towards our Healthy People 2010 goal of 90% immunization coverage, and will continue to be a strong educational and technical assistance resource to all Maine people.

Children's Mental Health Services

Overview

Maine provides mental health services to children through a comprehensive, coordinated, interdepartmental system led by the Department of Behavioral and Developmental Services (BDS). Maine is one of the first states to set up funding for children's programs that crosses Department and agency lines. The result will be a single system of care to tie together the roles of the various youth-serving Departments.

Over the four years since passage of Chapter 790 which established the Children's Mental Health Program, expenditures for Children's Services from BDS alone increased from $17.9 million in FY98 to $33.0 million in FY01, or a growth rate of 84%. During this period the expenditures for Medicaid seed money increased from $4.9 million to $13.2 million, or by 166%.

The Children's Services budget for FY02 totals $36.7 million in State appropriations, which will generate an additional $29 million in federal Medicaid matching dollars, for a total of $65.8 million. To date, Maine's mental health system has:

1) Significantly reduced in the number of children placed in out-of -State hospitals and residential treatment facilities. At the time Chapter 790 became law, the out-of-State census of Maine children was approximately 260. In December 2001, the census was 107, due in part to substantial development of Maine residential treatment options by Department of Human Services (DHS), and to systemic changes initiated by BDS in collaboration with Department of Education (DOE), Department of Corrections (DOC) and DHS.
2) Implemented an interdepartmental Systems Access component. Children's Crisis Services are called in when a child is at risk for an out-of-home or out-of-state placement, assuring the consideration of less restrictive options before placing a child outside of his or her home.
3) Reduced the lengths of children's hospital stays through the use of discharge meetings. Discussions at these meetings involve hospital staff, community case managers, BDS utilization review staff and state agency personnel from DOE, DOC, DHS and DOE.
4) Expanded the Clinical Case Management pilot in Southern Maine to other BDS regions in the past year to provide mental health clinical services to State wards through the co-location of master's level mental health staff in DHS regional offices.

Next Steps for 2002

1) Refine Medicaid policy for key behavioral health and developmental services for children and youth delivered in community and local settings that offer treatment and support to children and their families.
2) Commence operational usage of the BDS Enterprise Information System (EIS). The EIS represents the foundation of an electronic information and data system that supports the children's system of care, providing an automated mechanism for client enrollment, service monitoring and fiscal expenditures.
3) Further advance BDS Children's Services quality improvement activities and functions, centering on strategic protocols and procedures for BDS Quality Improvement Specialists and the service provider community. Focus on contract monitoring of service delivery, technical assistance, analysis of system trends and identification of areas for improvement.
4) Training for Targeted Case Management services agencies emphasizing family strengths practices and actively involving families as equal partners in case management agency training teams.

Continuing Challenges for 2003-2006

1) Promote and implementing an integrated and comprehensive children's system of care.
2) Reduce the need for families to seek out of home treatment for their children by building an accessible system of community based services in the State of Maine. A major ingredient in this strategy is to assist families to become less reliant on the system and more reliant on their own strengths and natural supports and, through supporting communities, to become more responsible within their own environment.
3) Avoid the consequences of developing parallel systems of care that, by their nature, present institutional and service inequities that are driven by arbitrarily defined eligibility criteria for services, classes of children, funding mandates, special populations or divergent State agency missions. The desired alternative is the development of a system of care that responds to all children in need and to their families, within established and equitable parameters for access.

Learning Results

Overview

The journey toward implementing a standards-based education system in Maine's public schools has been marked by many milestones, including the publication of Maine's Common Core of Learning, the work of the *Learning Results* Task Force, the inclusion of the Guiding Principles of the *Learning Results* in statute and of their Content Standards and Performance Indicators in major substantive rules, the enactment of the Omnibus Bill for the implementation of the *Learning Results* in the Spring of 2001, the adoption of amendments to Chapter 125 Basic School Approval and to Chapter 127, a major substantive rule outlining assessment and graduation requirements, and the establishment of a system of *Learning Results*. Further, the development of a comprehensive local and state assessment system to measure student achievement of the *Learning Results* has been undertaken. This has been an inclusive journey engaging educators, parents, students, school board members, legislators and other citizens in redefining what it means to be educated in Maine schools.

Next Steps for 2002

The Omnibus Bill for the implementation of the *Learning Results* charged the Commissioner with developing rules to accomplish the purposes of Standards and Assessment of Student Performance of the *Learning Results* as outlined in Title 20-A, Chapter 222. It was determined that Chapter 127, Instructional Program, Assessment, and Diploma Requirements, a major substantive rule of the Department, last updated in 1991, was the appropriate vehicle for these rules. The process to amend the rule began in November 2001 and concluded in April 2002. Chapter 127 frames the implementation of the system of *Learning Results* in Maine. The standards-based accountability model in Maine is one of assistance to the personnel in a school unit, so personnel can focus on improving student performance. Department activities in the coming year include:

1) The provision of technical assistance to school units statewide.
2) The piloting of the School Assistance Process.
3) The development of assessments and assessment systems as options for school unit adoption.
4) The establishment of Comprehensive Education Plans by local school systems.

Continuing Challenges for 2003-2006

As Maine moves toward a standards-based, results-oriented system, we must provide for transitions between our current input model and a true results-based model. To accomplish this we will need to:

1) Move away from a focus on course offerings to emphasize assessment of student learning.
2) Establish and implement local assessment systems.
3) Implement the School Assistance Process.
4) Define a thoughtful and appropriate process for reviewing the content standards of the *Learning Results* as specified in Chapter 131, the *Learning Results* rule.

Medicaid Funding for Special Education Services

Overview

In 1995, School Administrative Units (SAUs) received minimal MaineCare reimbursements for the health-related services provided in the SAU. Since that time, SAUs have been reimbursed by MaineCare more than $86 million through the MaineCare/Department of Education collaborative. Of this total the majority of reimbursements (approximately 78 million) has been for School Based Rehabilitation Services (SBRS), and approximately $8 million has been reimbursed for Day Treatment Services.

MaineCare reimbursements have been utilized by the local SAUs in a variety of ways. Almost half (43%) stated that they used the revenue freed up by these reimbursements to maintain or expand special

education and/or health related programs; more than a quarter of the respondents (28%) used the revenues to purchase equipment or materials related to special education and/or health related programming; and, approximately 11% of the SAUs allocated these revenues to pay for licensure, other professional fees and/or continuing professional education. More than 90% of the reimbursements have been reinvested by SAUs in some type of health-related program.

In April, 2001, four regional trainings relating to school based reimbursement options were provided by personnel from the Bureau of Medical Services and the Special Services Team to 120 local superintendents, directors of special services, chief financial officers, support staff, billing agents and others. Several other trainings related to the MaineCare in Schools Initiative have been offered over the years to Maine Administrators of Services for Children with Disabilities (MADSEC) and Maine Association of School Business Officials (MASBO).

Next Steps for 2002

1) Complete technical assistance materials and provide regional trainings to SAUs in the areas of Day Treatment Utilization and Reimbursements requirements and Targeted Case Management Utilization and Reimbursement Requirements.

2) Continue collaborative meetings between Bureau of Medical Services staff in policy, record keeping, finance, provider relations and Office of Special Services consultants in education, policy and funding, school nursing, school based health centers.

Continuing Challenges for 2003-2006

1) Planning, Developing, Implementing and Evaluating a system of School-Based, School-Linked Mental Health Services.

2) Exploring strategies in collaboration with MaineCare for improving access, availability and affordability of appropriately trained support staff to provide the health, mental health and educational support services necessary for Maine students to improve functional abilities within the school and community environment.

3) Exploring strategies in collaboration with MaineCare for improving the access, availability and affordability of transition services for children who leave the 0 to 5 year system and enter the K-12 system, and for students who exit the secondary schools and continue into post-secondary and work experiences.

4) Exploring strategies for improving reimbursement and funding options for services/programs offered through School Based Health Centers.

Reintegration of Youth From Youth Development Centers

Overview

P.L. 2001, Chapter 452 "An Act to Implement the Recommendations of the Task Force on Educational Programming at Juvenile Correctional Facilities" requested interagency initiatives to address the effectiveness of discharge and transition services for youth. Since public schools play a critical role in the reintegration of Maine's juvenile offenders, it is important that the transition process be well conceived and supportive. The Department of Education and the Department of Corrections, in collaboration with a constituent group, are developing standards and technical assistance pertaining to reintegration planning and transition services. The constituent group includes juvenile correctional officials, juvenile community corrections officers, organizations representing school boards, school administrators, teachers, parents, and the Truancy, Dropout, and Alternative Education Advisory Committee, as well as other interested local officials and community members.

Next Steps for 2002

Reintegration Teams for youth leaving Mountain View and Long Creek Youth Development Centers will better coordinate services between schools and correctional facilities. The Reintegration Process provides

that when a youth is committed to the Youth Development Centers, notification will be made to the Superintendent of that youth's local school administrative unit to establish communication and information sharing linkages. Educational records will be transferred to the school at the facility. When the youth has progressed through treatment levels to the extent that he or she is ready to be released, the schools will be invited to participate in a Community Reintegration Planning Meeting at the center where progress on the Rehabilitation Plan will be discussed. Schools will form their own Reintegration Team consisting of the Superintendent or designee, Principal, teacher(s) of the reintegrating student, the student, parent or guardian, school counselor, and the juvenile community corrections officer. This team will develop an individualized plan, covering school programs, placement and activities, which will be monitored and adjusted as needed. The plan will have been fulfilled upon achievement and maintenance of plan standards. Supporting this process are local school board policies and training for counselors and school employees regarding confidentiality of information. Technical assistance developed by the Department of Education includes: implementation of statewide standards; Reintegration Team training in the management of records and confidential information; establishment of individualized plans through Reintegration Teams; and development of systemic understanding between schools and development centers.

Continuing Challenges for 2003-2006

1) To maintain communication links as staff turnover occurs.
2) To ensure ongoing training for Reintegration Teams.
3) To continue departmental collaboration.

Department of Corrections Girls Project

Overview

The Girls Project is a Children's Cabinet initiative to address the growing numbers of girls in the juvenile justice system.

The project began by taking an in-depth look at a group of girls at the Long Creek Youth Development Center (formerly the Maine Youth Center). Consistent with national research, almost every girl had a history that included physical, emotional and/or sexual abuse. They struggle with mental health and substance abuse problems. They have experienced academic failure and exploitation by older males. Their crimes are usually related to familial and social relationships.

Early childhood trauma appears to be a major factor underlying these girls' mental health and substance abuse problems, as well as their criminal behaviors. The juvenile corrections system recognizes the need for gender specific treatment for these girls and others like them in Maine. The Girls Project will research best practices for assessing and treating Post Traumatic Stress Syndrome while recognizing that treatment needs to be integrated, individualized and consistent with best practices for adolescent girls.

Next Steps for 2002

The immediate goal is to develop ways of responding to girls in the correctional system that will help them create successful lives by addressing their needs appropriately. Another short term goal is to better serve girls who are involved in more than one department of government; for example, those in the custody of the Department of Human Services who also receive mental health services from the Department of Behavioral and Developmental Services.

Continuing Challenges for 2003-2006

A long term goal of this project is earlier identification of girls dealing with trauma, so that meaningful intervention can help them sooner, hopefully before they enter the correctional system.

Education of Youth Who Are Homeless

Overview

Maine continues to receive federal funding under the Stewart B. McKinney Act for administration and provision of grants to school administrative units for developing programs and services for homeless students to assure their access to school. Maine's state plan for meeting the provisions of federal and State law for homeless students is aligned with Maine's coordinated plan to assure that all students may achieve the *Learning Results*.

Maine currently funds two projects – the Portland Street Academy in Portland and the Merrymeeting Project in Bath. The Portland Street Academy records contacts made with 198 homeless youth in 2000-2001. There were 72 different schools of origin reported by youth participating in the project. The Street Academy, as part of the Portland Partnership for Homeless Youth, helps homeless or street -involved youth to find greater stability in their lives. Using Rapid Response funding, individuals develop goals around eight life areas including primary care, mental health, social supports, substance abuse, education, vocation, employment, and housing. The Merrymeeting Project in Bath served 46 youth in 2000-2001, and has an ever-increasing volume of referrals. Its effective outreach program specifically designed for the rural, coastal area establishes mentoring relationships that allow for further development of efforts to address issues and educational needs. The Project engages in crisis intervention, assessment, referrals, transportation, family mediation, clothing and food provision, and educational goal-setting.

Next Steps for 2002

The Reauthorization of the Elementary and Secondary Education Act ("No Child Left Behind" legislation) includes revisions to the McKinney-Vento Act that broaden the definition of homelessness and increase responsibilities of schools to meet the education needs of homeless children and youth. Maine currently is working to transition students from Shelter Schools to their schools of origin or current location, as States receiving funding can no longer maintain separate educational programs for homeless youth.

Continuing Challenges for 2003-2006

Maine must ensure that all barriers to enrollment, attendance, and success in school are removed. Challenges in this regard are:

1) Developing a greater public awareness and sensitivity of homelessness.
2) Creating a one-stop, on-site service delivery system for youth.
3) Providing more transportation.
4) Ensuring safe homes.
5) Providing housing options.
6) Securing designated funding for homeless students.
7) Providing alternatives in education.
8) Providing outreach programs particularly in rural areas.

Expelled Youth

Overview

Concern with the rate of students being expelled across the State, and the limited to non-existent access to educational opportunities when expulsion occurs, has lead to a focus of attention on Maine's expelled youth. The Muskie Institute is currently conducting a research survey of all high schools to analyze the similarities and differences in the policies, actions and reactions of schools in regard to expulsion, and the types of behaviors that have led to removal from school. Currently, schools have limited options to deal with problems when they occur, thus the reliance on expulsion. Schools and communities must develop the capacity to deal with emergencies and problems within the community and school system.

Next Steps for 2002

A forum was held in Aroostook County for stakeholder groups in education, law enforcement, and social services to explore options to expulsion. A steering committee has been formed to pursue integrated case management. This community-school partnership could serve as a model for others facing the challenge of meeting behavioral and educational needs effectively.

Continuing Challenges for 2003-2006

1) To direct attention to the issue of expelled youth.
2) To utilize the data gathered by the Muskie Institute concerning expelled youth to form a response to meet the needs of schools and this population.
3) To track the success of the Aroostook County Integrated Case Management project to consider use of this approach as a model for other regions.

Alternatives in Education

Overview

Most programs are for high school-age youth, but programs for elementary and middle school youth also exist. Creating a shift in addressing a student's learning needs may be small or very significant. Alternatives for Maine students have a clearly stated purpose: to promote a sense of belonging and caring; to have clear instructional objectives; to provide for individualized attention; to be innovative and flexible; and to help all students meet the Maine *Learning Results* and its *Guiding Principles* successfully. Alternatives in education work toward reducing the dropout rate and increasing the number of high school completors in today's climate of the ever increasing need for training and education to ensure success in the workforce.

Next Steps for 2002

A Summer Institute will be held for educators exploring Alternatives in Education. The purpose of the Institute will be to help educators help students meet the rigorous standards of the *Learning Results* and its assessments, while remaining flexible to meet the needs of students who need alternative approaches to learning.

Continuing Challenges for 2003-2006

1) To develop and disseminate educational approaches to meet the divergent needs of learners.
2) To encourage school systems to develop alternative education opportunities.
3) To create a funding mechanism for the start-up costs of alternative education programs.

Higher Education Initiative

Overview

The Department of Education has set the goal that Maine people will rank among the highest in the nation in the percent seeking and attaining two and four year advanced degrees, and in the percent participating in life-long learning opportunities. To achieve this goal, the following efforts are being pursued:

1) The enhancement of Maine's public K-12 education system on a foundation of quality standards, high expectations for all students, and preparation for post-secondary education study is underway.
2) The standards for the review and approval of educational personnel preparation programs have been realigned with Maine's *Learning Results*, with Maine's results-based initial teacher certification standards, with Maine's infusion of technology expectations, and with an adaptation of the National Council for Accreditation of Teacher Education (NCATE) standards. This realignment resulted in

revisions to Chapter 114 - Policy, Procedures and Standards for the Review and Approval of Educational Personnel Preparation Programs, effective March 4, 2002.

3) Increased coordination among Maine's public higher education systems is underway.

4) The creation of the Higher Education Attainment Council, charged with creating a vision for higher education attainment in Maine along with establishing appropriate timeframes as well as benchmarks for measuring improvement, assessing progress, and assuring adequate capacity to meet goals is being encouraged.

5) The establishment of a community college system through the collaboration of the University of Maine System (UMS), and the Maine Technical College System is being pursued. The community college initiative is referred to as the Community College Partnership of Maine. At the heart of the partnership are agreements between the associate and baccalaureate degree levels. To date, some 124 agreements have been finalized. While there continue to be associate degree enrollments in both the University of Maine System and the Maine Technical College System, several hundred partnership students are presently enrolled in the "associate to baccalaureate" degree program.

6) Establishing stronger links among systems at all levels – 0-5, K-12, and post-secondary – is also a priority.

Next Steps for 2002

1) Given the current cycle of program approvals, the first educational personnel preparation program assessment under the revised standards for review and approval will occur during the academic year 2002-2003.

2) The Council will begin its work in late-spring or early- summer, 2002 and will be administered by the Maine Development Foundation.

3) A report outlining key progress indicators, assessments of quality, and recommended next steps to establish a community college system in Maine is being finalized for submission to the Governor.

Continuing Challenges for 2003-2006

1) The assessment of educator personnel preparation programs utilizing the revised standards will represent a significant shift from evaluating program compliance to evaluating the performance of candidates.

2) Legislative funding for the Council will represent 50% of the resources necessary for the Council to function effectively. The other 50% will need to come from private contributions.

3) Support for, and further implementation of, the community college partnership initiative are seen as critical to the realization of efforts to encourage more Maine citizens to pursue higher education. Challenges include developing additional articulation agreements and continuing efforts to reduce tuition for partnership students.

Maine Mentoring Partnership

Overview

Over the next few years, Maine's goal is to provide 30,000 youth in Maine with mentoring relationships. Currently there are an estimated 5,000 mentoring matches in Maine, which represents 1.7%of Maine's young people. Maine's Children's Cabinet created the Maine Mentoring Partnership, as a partnership of government, public and private mentoring program providers, funders and private for-profit supporters to increase accessibility of mentoring for all Maine youth. Maine Mentoring Partnership is an organizational member of Maine's Promise, the Maine partner of America's Promise. The mission of Maine Mentoring Partnership is to advocate for, support, and foster youth mentoring programs in Maine.

Maine Interfaith Mentoring, the first initiative of Maine Mentoring Partnership, is a statewide, faith-based mentoring initiative to build an infrastructure and replicable model to support Maine communities of faith as

they partner with schools and community organizations. Its mission is to increase the number of mentoring relationships available to children and youth in Maine by mobilizing volunteers from congregations across a wide interfaith spectrum.

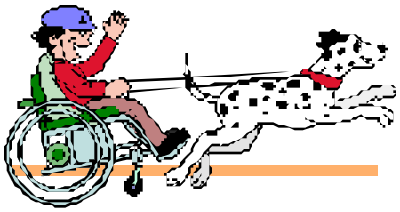
Next Steps for 2002

A State Mentoring Partnership is a collaborative effort of public and private sector leaders that serves as an advocate and resource for mentoring. It also acts as a broker, establishing partnerships between organizations that provide mentoring services and organizations that are sources of potential mentors to help increase the quality, capacity and scale of mentoring statewide. Maine Mentoring Partnership is:

1) Further developing its statewide Leadership Council to raise the vision and re-evaluate the strategic direction for mentoring in Maine, which will open doors to new resources for mentoring and increase the visibility of mentoring throughout the State.
2) Developing a Providers Council with representation from local mentoring partnerships, coalitions, and providers to advise about mentoring needs around the State.
3) Re-evaluating the Strategic Plan to bring mentoring to a responsible scale in Maine by:
    a) Defining the need for mentors statewide;
    b) Assessing the barriers that prevent mentoring providers from meeting the need;
    c) Putting forth a reasonable numeric goal for reaching scale; and
    d) Outlining a clear strategy to overcome those barriers and measure how well Maine is progressing toward its goal.
4) Formalizing the Executive Director position to support and orchestrate the efforts of the Leadership and Providers Councils.

Continuing Challenges for 2003-2006

1) Mentor Recruitment and Referral -- Targeting organizations from all sectors to serve as mentors and continuing to create a statewide database of quality mentoring programs.
2) Technical Assistance and Training – Providing mentor/mentee training and technical assistance to organizations interested in starting, strengthening or expanding quality mentoring programs, partnerships or coalitions.



3) Public Awareness – Continuing to develop the media campaign to raise awareness of and the need for mentoring statewide.
4) Public Policy – Creating a strategy to expand and strengthen the public investment in mentoring.
5) Resource Development/Distribution – Continuing to generate public and private sector resources.
6) Data Collection/Tracking – Continue to develop a statewide system to track the prevalence of mentoring and to evaluate the impact of mentoring on student outcomes and attitudes.

Services for Youth Who Are Homeless:

Overview

The Regional Children's Cabinets are developing plans to highlight the plight of youth who are homeless and developing services to meet their needs. Rapid responses to youth, within the first 24 hours of their becoming homeless, coupled with an assessment of a youth's issues and the development of safety plans with youth and their families significantly reduces the number of children on the streets or in shelters. In March the 120th Legislature approved $375,000 for services for homeless children in all three regional cabinet regions of the State (the Homeless Children's Initiative.) The Regional Children's Cabinets supported two pieces of legislation to address the issue of homelessness among youth in their regions:

1) Partnership for Homeless Youth[2] established a mandate for development of comprehensive community plans for youth who become homeless.

2) Youth in Need of Services (YINS)[3] extended services by establishing a one-year pilot to provide outreach and intensive case management to youth 14 years and younger in need of assistance for securing stable housing.

The Regional Children's Cabinets accomplishments in reducing homelessness of youth include:

RCC I and the Portland Partnership for Homeless Youth provide oversight for development and implementation of the Region I response for addressing needs of youth who are homeless in Southern Maine. Hours have been expanded at the teen day center and residential shelter so that youth have a safe place to go off the streets, during the day and evening, seven days a week and can connect with needed services. Linkages have been strengthened with the DHS liaison position housed in the teen center. A new service approach was designed, known as the HIP (Holistic Individualized Plan) Program, whereby youth obtain intensive and coordinated guidance in setting and achieving life goals. Wraparound funds are used to support these goals. RCC I created a community Service Review Team that meets monthly to problem-solve challenging individual cases, and developed a vocational model designed to engage youth in paid work experiences and training.

The Region I YINS pilot shows promising results with early intervention of youth in York and Cumberland counties. Youth are remaining in their homes and in school, with intensive case management services and mediation provided by local agency. Cross systems work is leading to improved linkages with State agencies, schools, law enforcement agencies and local service providers.

RCC II began developing a Pilot Program for youth who are homeless in the central part of Maine. They held a day of Technical Assistance and Action Planning, followed by meetings throughout the Region to review and identify the challenges and opportunities to creating a continuum of services for youth who are homeless. The Regional Cabinet will define next steps to assess, plan, and develop comprehensive and best practice services, including involuntary treatment for youth who are homeless in the region.

Region III initiated the Rapid Response to Youth Who Are Homeless Pilot in the Bangor area. The goals of the program are: to respond when a youth becomes homeless or is in immediate danger of becoming homeless; to get a youth off the street and into a safe, stable home within 72 hours of becoming homeless; and to reconnect him/her with his/her school system and/or family as soon as possible. The initial results of this Rapid Response program show that youth who received the services had significantly better outcomes than the comparison group of youths. For example, 12 months from the initial intake, 100% of the Rapid Response youth were in school, in a training program, or had a job. Only 31% of the comparison group did. At the one year mark, 0% of the Rapid Response youth indicated that during the last six months they were involved with gang activity, had been hurt by someone, attempted suicide, were involved with juvenile justice system, had inadequate clothing, had gone hungry, or had engaged in prostitution. This 0% figure is in stark contrast with the percentages for the control group of 31% [gang activity], 38% [hurt], 17% [suicide], 42% [justice system], 23% [inadequate clothing], 31% [hungry], and 31% [prostitution].

Next Steps for 2002

Over the next year we will be implementing on a statewide basis (including Region II) the newly enacted and funded Homeless Children' s Initiative.

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[2] Resolve 55. LD 2181. Resolve, to Help Homeless Young People Return to Home or Safe Living Situations." Effective June 9, 1999.

[3] Chapter 778, LD 1623, An Act to Provide Services for Children in Need of Supervision. Effective May 10, 2000.

Continuing Challenges for 2003-2006

Ending the homelessness of children continues to be our goal.

Adolescent Suicide Prevention

Overview

1,883 Adult and 267 Youth Gatekeepers in schools and community agencies received training in suicide prevention. 30 School Health Education Teachers were trained in the ASAP/Lifelines curriculum to develop help seeking skills among students. 152 people learned to conduct awareness sessions in their communities. 2,815 individuals participated in awareness education. 139 Substance Abuse Clinicians, over 300 BDS Mental Health Clinicians, and 142 DHS clinicians receive training annually. The Maine Youth Suicide Prevention Program (MYSPP) built a comprehensive set of strategies consistent with recommendations from the Office of the Surgeon General. The collaborative effort among State and private sector agencies and individuals strives to increase public awareness about preventing youth suicide, reduce the incidence of suicide behavior among Maine youth aged 10-24, and to improve youth access to appropriate prevention and intervention services.

The program's strategies include: increasing public awareness that suicide is preventable, training educators, public safety personnel, clinicians, clergy, health care providers, and others about suicide prevention; disseminating data and information resources statewide; and training and guiding agencies and groups on effective suicide prevention methods and practices.

The project has developed and distributed a wide variety of materials for youth:

1) 1,250 posters and 56,000 book covers designed and developed by youth distributed to schools statewide,
2) 8 public service spots developed by and for youth and distributed to radio stations in five communities around the state,
3) 106,440 Teen Yellow Pages booklets updated, reprinted and distributed to every school Superintendent in 2001 plus 110,000 of the same developed and distributed in 1999.

Throughout the year, requests for MYSPP interventions all around the state came from school employees who had attended MYSPP gatekeeper training! The MYSPP gatekeeper trainer, working with local crisis service provider agencies, responded to calls for assistance from elementary, middle and high schools. While the specific circumstances varied, many involved suicidal behavior among multiple students in one school community. Our coordinated response provided training, awareness education and crisis intervention services. Individual students received the crisis assessments and stabilization services they needed.

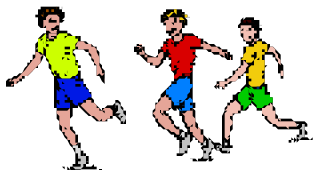
A fifth grade boy who took part in developing the MYSPP videotape on youth firearm safety (produced with Children's Cabinet funds) sought help for a suicidal peer. He went to his Guidance Counselor and told her of his concern; she knew how to respond and followed up with the peer. The peer did, in fact, have a very well thought out plan for the next day using his father's gun, to which he indeed had access. The peer got the help he needed. The Guidance Counselor went back to the boy what had approached her initially to thank him – his reply was "I just did what the video said to do!"

Next Steps for 2002

1) Finalize and disseminate school suicide prevention, intervention and post-intervention guidelines to Maine schools.
2) Improve the system of providing suicide prevention technical assistance to schools by increasing coordination among Children's Cabinet agency programs.
3) Secure grant or other funding to provide requested support to local communities and to evaluate the impact of MYSPP implementation.
4) Solicit assistance from adolescent boys in improving their access to services.

Continuing Challenges for 2003-2006

According to the 2002 Youth Risk Behavior Survey, 1 out of 10 Maine high school students reported attempting suicide, and 1 in 20 reported being treated medically for a suicide attempt. During the most recent years for which data are available, Maine's youth suicide rate has come closer to the national average rate. Further progress will be directly related to the program's ability to maintain adequate support for program activities including:



1) Development and dissemination of suicide prevention and crisis prevention protocol guidelines for Maine schools.
2) Continuing to provide state of the art educational resource materials and program information statewide.
3) Providing training and technical assistance to school health educators to implement suicide prevention education within the school health education curriculum.
4) Continuing to provide gatekeeper training to adults and youth in schools and communities statewide which will, in part, depend on increasing the number of trainers to deliver youth suicide prevention gatekeeper training and awareness education statewide.
5) Continuing to provide training for facilitators of skill-building groups for high-risk youth.
6) Continuing to increase public awareness of suicide prevention through the development and dissemination of suicide prevention public service messages, presentations and materials for adult and youth audiences.
7) Providing ongoing, advanced level education in effective suicide prevention practices to clinicians statewide.
8) Continuing to improve the quality of suicide data to effectively measure suicide attempts and completions.
9) Evaluating program effectiveness.

The guiding principle of the MYSPP is to Do No Harm. This means that suicide prevention work must be done carefully and in a systematic way. However, most calls for assistance either come in the midst of a crisis or are requests to work only with youth. It's a continuing struggle to work towards proactively building safe and caring school climates where adults are trained to recognize and assist at-risk youth, and ensure that suicide prevention protocols are in place and linkages are made with community crisis services.

Demands from schools and community agencies continue to increase, without a corresponding increase in MYSPP resources.

While we are beginning to see some positive results from early evaluation of program activities, it is very difficult to evaluate the impact of the MYSPP.

Expanded Services For Juvenile Offenders

Overview

Expanded assessment, diagnostic, and treatment services for youth offenders in various correctional settings is now available. Over the past two years BDS, in collaboration with the Department of Corrections, Juvenile Services, has been developing a mental health program for adolescents placed at the Long Creek Youth Development Center in South Portland. BDS mental health personnel have been instrumental in the development of the new Assessment and Orientation Unit and in implementing a mental health screening protocol for all youth admitted to the facility. The mental health program has conducted behavioral health assessments for residents that include assessment, diagnosis, intervention planning and treatment needs of youth. BDS resources will be provided at the new Mountain View Youth Development Center in Charleston. Committed youth are now receiving more comprehensive assessment and treatment, and improved community placements utilizing the Maine Operating Approach. (M.O.A.) The MOA is highly intensive, and fosters vocational and educational skill development, and changes in thinking, feelings, and behaviors to promote responsibility and accountability. The program also prepares the resident for

transition and adjustment to less restrictive phases of programming and gradual movement toward release. The MOA strategies include Assessment and Case Management; Therapeutic Milieu/Normative Culture; Cognitive Behavioral Psycho-educational Program; Skill Development; and Progression through a Phase and Level System.

In addition to the facility-based programs, BDS has placed mental health program coordinators (LCSW's) in each of the four regional Juvenile Services offices of the Department of Corrections. These staff consult with Juvenile Community Corrections Officers in their regional offices to assist in developing case plans and accessing appropriate mental health services. A primary goal of this collaboration is to divert potential future involvement with the juvenile justice system, and specifically new admissions to youth correctional facilities.

Next Steps for 2002

Continue to refine mental health services at the Youth Development Centers.

Continuing Challenges for 2003-2006

Continue to facilitate collaboration between BDS and DOC to ensure the continued effective delivery of these services to juvenile offenders.

Two Re-Designed Youth Development Centers: Long Creek and Mountain View

Overview

The Long Creek Youth Development Center [formerly the Maine Youth Center], and the Mountain View Youth Development Center [formerly the Northern Maine Youth Detention Center], instituted a total multi-disciplined team approach in working with youth committed and held within these facilities. Mental health services at the Centers have been enhanced by placing a BDS Mental Health Program Coordinator there to review and assess the mental health needs of the youth and assist with after care planning. Caseworkers from the Department of Human Services assist in developing coordinated plans for youth in their custody while in the facilities and upon release to the community. A liaison funded by the Department of Education assures appropriate education plans are in place for those youth released from the facilities. DOE consulted with DOC in developing the Learning for Life curriculum now in place in both facilities. This educational approach uses project-based learning with real-life application that takes into account individual learning styles and abilities.

Next Steps for 2002

In the beginning steps for developing a continual process of Quality Improvement at all levels, including the practice, program and system levels, the Division of Juvenile Services (DJS) will take steps to assure the development of comprehensive correctional case plans focused on dynamic factors related to the risks of continuing antisocial conduct. The recently organized collaborative between the Behavioral Health Sciences Institute and DJS to create the Center for Juvenile Justice will assist DJS to accomplish the following in the next year:

1) Entire staff train in the techniques of Motivational Interviewing.
2) All staff trained on the techniques of Integrated Case Management.
3) Reliability and validity of assessment instruments measured. (Youthful Offender Level of Service Inventory)
4) Initiation of a program to ensure program effectiveness. (Correctional Program Assessment Inventory)
5) Alignment of its policies and procedures to be compliant with Title 4-E provisions of the Social Security Act.
6) Continuation of its efforts to implement a comprehensive program of Integrated Case Management and Intensive Aftercare Services.
7) Regular reviews of detained youth, with the goal of identifying viable alternatives on a timely basis.

8) Participation in a research study to review detentions in Maine.

Continuing Challenges for 2003-2006

1) The Division of Juvenile Services will develop plans to assure all programs offered to juvenile offenders are based on demonstrated effectiveness related to client needs and responsivity factors.
2) Recidivism rates will be reduced by 20%.
3) Continual improvement of programs and services, which target criminogenic needs of committed juveniles, will improve public safety.
4) The Division will introduce and monitor correctional case management practices to assure continual improvement in the scores of pre- and post- assessments of risk factors of juvenile offenders.
5) The Division of Juvenile Services will attain and maintain quality assessment, case planning and program effectiveness.
6) The Division will reduce the number of detainee days, consistent with public safety concerns, by providing a variety of programs and services for targeted juveniles.

HIV/AIDS/STIs

Overview

In 1998, Maine high school students reported receiving high levels of HIV risk reduction information and skills. Maine educators report a high rate of teaching specific HIV topics compared to other states. Maine male high school students indicated a slight reduction of the onset of sexual intercourse and students who are sexually active have continually reduced the number of sexual partners and increased condom use. Still about one third of all new HIV infections are among people 13-29 years of age, meaning that many were infected in their teens and early twenties. Nationally, one out of every four new HIV infection is believed to take place among adolescents.

Next Steps for 2002

1) Continue to offer no cost "Programs that Work" HIV curriculum implementation training to school and youth agency staff. Presently, 77% of public high schools and 54% of middle schools have received training in these researched, skill-based curricula. Plus, 60% of youth serving agencies have been trained. These curricula have been proven to delay the onset of sexual intercourse and/or increase HIV risk reduction behaviors (condom use).
2) Design, implement and evaluate an HIV education program for young men who have sex with men based on a need assessment and youth participation in the planning process. There are no models nationally for this population.
3) With the Centers for Disease Control, analyze the Youth Risk Behavior Survey data to better understand Maine's reported lower-than-national-average condom use rate among high school students and low sexual responsibility rating. Conduct a meeting of State-level program representatives to strategize how to increase dual birth control and condom use messages for sexually active youth.

Continuing Challenges for 2003-2006

1) Lowest Condom Use Rate Among High School Adolescents in U.S. among 22 states that conduct the Youth Risk Behavior Survey (YRBS):

Maine high school students, specifically females, report the lowest condom use rate in the country, due to the highest contraceptive pill use. The message of dual protection of both pregnancy and sexually transmitted infections must be incorporated into messages of sexual responsibility. Six out of ten sexually active, senior class (12th grade) males used a condom at last intercourse. The rate decreases, as students get older.

Sexually transmitted infection rates continue to be disproportionably highest among adolescent females. This indicates that young females are at risk for HIV infection.

1) Approximately one half of all new HIV infections in Maine are among men who have sex with men.

There continues to be limited HIV education designed for young men who have sex with men. This population is at extreme risk due to their isolation, a silence about sexual orientation and a lack of support in schools and youth-serving agencies. One out of ten Maine high school students reported being verbally harassed or attacked based on perceived sexual orientation while in school or on their way to and from school. (YRBS 2001)

Childhood Lead Poisoning Reduction

Overview

Lead poisoning is still the most prevalent environmental health disease among Maine's preschool children, with one-and-two year olds showing the highest rates of poisoning. Each year, almost 500 children in Maine are identified with abnormally high levels of lead in their bodies (> 10 µg/dl). Lead poisoning can lead to neurological problems such as developmental delays, behavioral problems such as Attention Deficit Disorder (ADD), and learning disabilities. Most children who are poisoned have no symptoms initially. The only way to determine if a child is lead poisoned is through a blood lead screening test. For this reason, it is recommended that all health care providers routinely screen children at risk for lead exposures.

Children are at risk if they live in homes built before 1978 and especially in pre-1950 homes. These homes are likely to contain lead-based paint that is the culprit in most lead poisoning cases. Lead-based paint in good condition poses no threat but when the paint begins to deteriorate it can generate paint chips, flakes and dust. These chips of paint and the minute particles that settle into house dust can be picked up on a young child's fingers. Children's hands are frequently in their mouths where lead particles can be swallowed and absorbed. Over time, this lead can accumulate in a child's body and cause lead poisoning. This is the source of the majority of lead poisoning cases in Maine.

There is another scenario commonly found in Maine. Many young families today are purchasing older homes and renovating or remodeling them. If this work is not done with a great deal of caution it can generate lead contaminated dust that permeates the air throughout the house. This can lead to lead poisoning in the children and even the adults who breathe it in. Children who are poisoned by breathing in lead-contaminated dust get poisoned faster and at higher levels than other children.

Statistical analysis of lead poisoning in Maine's children revealed that children enrolled in Medicaid are twice as likely to be lead poisoned. This probably happens because these children are more likely to live in older, poorly maintained homes. Furthermore, while the Centers for Medicaid and Medicare mandate that all one-and-two year olds on Medicaid be screened for lead exposure, less than 25% of these children are tested each year.

On a positive note, the annual rate of lead poisoning in all children who are tested has declined in Maine over the past 7 years, from a high of 14.1% in 1994 to 4.9% in 2000. Since fewer children are poisoned, we are now challenged to determine what populations of children, besides Medicaid enrolled children, are truly at risk and target our efforts to those high-risk children. Medical providers, in particular, need to know how to quickly and easily identify at-risk children in need of testing for lead exposure.

At the same time, we must continue to work with our partner agencies at the Department of Environmental Protection (DEP) and Maine State Housing Authority (MSHA) to prevent lead exposures in the homes that are poisoning Maine's children. It is only by eliminating these sources of lead exposure that children in Maine will be safe from the devastating, lifelong effects of lead poisoning.

Next Steps for 2002

1) Identifying all lead poisoned children (blood lead levels > 10 ug/dl) in Maine through reports from the Health and Environmental Testing Laboratory.

2) Providing all families with lead poisoned children with information and education through visits from Public and Community Health Nurses.

3) Providing all families with children whose blood lead levels are 20 µg/dl and higher with a complete environmental investigation and assistance with accessing resources for lead remediation activities.

4) Collaborating with a physician-directed project called "Kids Run Better Unleaded" to educate health care providers about the need for lead screening in young children.

5) Collaborating with the EPSDT program to promote lead screening in the Medicaid population.

6) Collaborating with the University of Southern Maine, Muskie School, Institute for Public Sector Innovation, to provide statewide public health education on lead poisoning, including producing and maintaining a website and a periodic newsletter, TV Public Service Announcements (PSAs), and numerous printed materials and presentations.

7) Collaborating with the DEP and MSHA on primary prevention efforts such as offering "Lead Smart Renovator" classes to homeowners and contractors, and offering federal grant money to low-income homeowners for lead abatement work.

8) Maintaining comprehensive surveillance databases and epidemiological analyses of blood lead screening results.

Continuing challenges for 2003 - 2005

1) To identify the target population of high-risk children for lead exposure (beyond the Medicaid population).

2) To identify and overcome the barriers to lead screening in the Medicaid enrolled population.

3) To continue funding to support current activities and to expand health education efforts.

4) To secure adequate funding in Maine to address the primary issue of lead-based paint in older homes.

5) To identify ways to partner with current community based initiatives.

Ensuring the Public Safety of Children

Overview

The Department of Public Safety (DPS) is working to ensure the public safety of children.

Enhanced-911 is a data base that can be accessed with current addresses, and the right Police, Fire and EMS agencies to call in case of an emergency. This system is designed to have E-911 calls directed to a Public Safety Answering Point (PSAP) and the dispatchers will direct the correct emergency responder to the correct location. If a child who uses 911 is too young, scared or unsure of what to say, the preprogrammed database will contain all the appropriate information for a call taker to send the appropriate emergency responder. DPS will undertake a educational project this year to inform young children about E-911 with a "Red E. Fox" program which has been successfully used nationwide.

The computerization of Criminal History Record Information (CHRI) is nearing completion. There are hundreds of thousands of paper copies of criminal history records, some supported by fingerprints and some not. This project allows criminal history records to be built forward on all new requests, which can be disseminated to criminal justice and non-criminal justice agencies in a timely manner. The advantage of this for children is that companies, agencies and other employers can then request a CHRI check and then can make informed decision as to whether to employ, or hire a person or not. An employer who operates a business that has children around could find out if any perspective employees have been convicted of any crime that would make it unsafe for them to be around children.

Next Steps for 2002

1) Implement E-911 in Aroostook and Hancock Counties.

2) Complete the Criminal History Record Information program.

Continuing Challenges for 2003-2006

1) Educate the law enforcement community with the best practices and training involving Domestic Violence issues, School Resource Officer issues, Restorative Justice issues and Community Policing issues.All of these issues intersect with children in many ways.
2) Increase our law enforcement first responder staff because of emerging issues with drug and alcohol abuse, as well as other community safety issues.

Youth Advocacy Program

Overview

31 communities across the state have formed local Youth Advocacy Programs (YAP), consisting of young people from a diversity of backgrounds and ranging in age from 12-17. Most of these groups have gone through a weekend training at Camp Kieve that focuses on teamwork and on helping them develop a plan to reduce youth tobacco-use in their own communities. After being trained, these groups returned to their communities to further develop and implement their new programs.

At the same time that the 31 YAP groups are working locally, together they comprise a Statewide Youth Advocacy Network that can regularly share ideas and successes, as well as look to coordinating efforts statewide in the future.

Next Steps 2002

Local YAP programs will include the issues of physical inactivity, and improving nutrition, in addition to tobacco prevention.

At the State level, the Partnership For A Tobacco-Free Maine will collaborate with the Maine Cardiovascular Health Program to develop regional training's for both adults and youth working on Youth Advocacy Programs.

Continuing Challenges for 2003-2006

Recruitment and retention of at-risk youth on local, as well as State-level, YAP boards.

Revitalizing Families

Our Vision for Maine: Every family recognizes the responsibility and rewards of raising children and is provided the support necessary to fulfill their role.

Adoption

Overview

Families adopted 432 Maine children in 2000, and 300 in 2001. This spectacular achievement – an incalculable blessing for these children and their adoptive families – earned the U.S. Department of Health and Human Services' National Adoption Award from Secretary Donna Shalala. This is unquestionably, one of the highest achievements in human services anywhere in the United States!

Next Steps for 2002

Open statewide enrollment for 140 children in the Maine Adoption Guide's post- adoption support program.

Continuing Challenges for 2003-2006

Explore the possibility of adding "guardianship" as a permanency option for children in the custody of the Department of Human Services.

Healthy Families / Home Visitation Services

Overview

First time parents are more likely to receive services from home visitors than ever before. The Fund for a Healthy Maine provided $4,300,000 for home visitation services via the Healthy Families program. Home Visitors provide education and support of first-time parents and families of newborns for short and long-term support and assistance. DHS has contracts with 16 agencies to provide this service, using a variety of models including "Parents as Teachers" and the "Parents Are Teachers, Too" programs. In 1996, in response to a legislative Task Force's recommendations, three Healthy Families pilot sites were established. Following the success of these sites, a new legislative Task Force to Study Strategies to Support Parents as Children's First Teachers was established and staffed by DHS and the Children's Cabinet. The work of this Task Force led to the inclusion of expanded funding for several home-visiting models in the Tobacco Settlement funding for a Healthy Maine. In 2002, it is projected that 5000 first-time parents will be served.

Next Steps for 2002

Assure statewide coverage of home visitation services so that they are available on a voluntary basis to all first-time parents. Begin evaluation of the home visiting program. Sponsor a "visioning summit" for all early care and education programs in the fall of 2002.

Continuing Challenges for 2003-2006

Ensure that all early care programs at the regional and local levels of service delivery are fully coordinated. Use results of program evaluation to assure that early care programs are accomplishing their goals and objectives.

Child Support Collection and Payment Enforcement

Overview

The persistence, determination and creativity of our child support programs in the Bureau of Family Independence in the Department of Human Services on behalf of 61,000 Maine families each month, leads all states, according to the federal Health and Human Services Department, by collecting $96 million in 2000 and $100 million in 2001 on behalf of Maine families (and to repay taxpayers' financial assistance.) Close cooperation with custodial parents, the Maine court system, and cooperative Maine employers has helped Maine DHS double the amount of collections over the past five years, making it one of the most efficient State agencies in collecting funds on behalf of custodial parents in the nation. Child support is a critical factor for tens of thousands of Maine families and often is the difference that allows that family to be self supporting.

Next Steps for 2002

Implement a non-custodial parent outreach and investigation project. The goal is to identify non- custodial parents who do not participate in paternity identification and payment of child support.

Continuing Challenges for 2003-2006

Identify ways that child support collection efforts can help strengthen families.

Welfare Caseload Reduction and Reduction in Maine's Family Poverty Rate

Overview

Seven Thousand (7,000) heads of household were assisted in the workplace, with child support collections, with child care, with filing for the earned income tax credit, through Parents As Scholars, through A.S.P.I.R.E. and by linkages with other work and anti-poverty agencies that are making this wonderful difference. The USDA advised DHS during the year that Maine has achieved the fourth-highest rate of eligible food stamp recipients who are actually receiving the benefit, and attributed this to our staff, outreach and supportive program. Maine's Temporary Assistance to Needy Families (TANF) caseloads are the lowest since the late 1960s and the rate of families returning to the TANF Program is a low 6%.

Next Steps for 2002

The TANF Block grant is up for Congressional reauthorization. Maine is working with national organizations and the federal government to make sure the model programs that we have put in place are able to continue. These include Parents as Scholars and ASPIRE. As clients come to the end of their five year eligibility for TANF, we need to assure they can continue to receive benefits if they are participating in education, treatment, training or work. Over the next year we will be continuing to expand services to "multi-barrier" clients. Also, we are working with school systems and special education to expand child care for special needs populations. Finally, the new technology system for TANF, Food Stamps, Medicaid and ASPIRE (the ACES system), is scheduled to come on line in June, 2002.

Continuing Challenges for 2003-2006

Continue to work with national organizations and the federal government to provide top-of-the-line services to Maine's poor people.

Fewer Out-Of-State Placements

Overview

Hundreds of new residential program spaces were created for Maine children and youth with behavioral health needs, increasing access in Maine for children returning from out-of-State placements and serving

more Maine children right here at home. Hundreds of emotionally disturbed Maine children previously served out-of-State have been returned to Maine. The number of children in out of State placements has been reduced from more than 250 on any given day, to 100.

Next Steps for 2002

In the new fiscal year we will continue with planned development of residential options for our children. At the same time, however, we will be taking time to review the status of the rapid residential development of the past few years in relation to current and projected future needs. This assessment will be one of the key components in the development of a comprehensive and coordinated three-year resource development plan (2003-2006). A second area of strategic focus in the year ahead will be an interdepartmental effort to reduce the number of children coming into custody because their parents are unable to gain ***timely access to a high level of service(s***) ***and support(s)*** necessary to adequately manage their children within the home or residential placement and community.

Continuing Challenges for 2003-2006

1) One future challenge related to children in out-of-State placement lies in the need for a unified and integrated approach to service delivery between BDS and DHS, as it relates to children who are in state custody and who also have serious emotional behavioral and/or developmental disorders .

2) A second significant challenge rests in our ability to reduce the overall number of residential placements each individual child experiences.

Rallying Communities

Our Vision for Maine: Raising children is a shared responsibility, which includes a process of establishing and modeling clear standards of behavior.

Communities for Children

Overview

Communities for Children (C4C) is a flagship initiative of the Governor's Children's Cabinet. C4C supports and increases good outcomes for children and promotes positive child and youth development. It has now grown to include 69 local leadership councils made up of key leaders in the community, including youth, and representing 319 municipalities and over 70% of the State's population. These Councils assess the realities facing children and youth in their communities, develop prevention programs and policies, and track the results of their work. The statewide initiative helps these communities by providing training, technical assistance, and opportunities for networking with each other. Since June 1997:

1) 69 local Maine communities have joined the initiative.
2) 27 AmeriCorps* VISTA members served full-time in local Communities for Children and in statewide organizations such as the Maine Mentoring Partnership.
3) Over 1,000 local community leaders, including youth, learned effective, research-based prevention models through annual, daylong regional Prevention Training Institutes.
4) 8 Youth Trainers earned certification as Prudential Youth Leadership Trainers.
5) Community leaders learned about the five Promises of America's Promise through the six daylong Governor's Service Institutes.
6) Leaders of Communities for Children Leadership Councils meet with each other in smaller, regional Cluster Conversations annually to share resources and progress with each other.
7) The C4C web site connects all 69 communities with information about each other and the initiative.
8) America's Promise named Maine one of its three model states, largely because of the unprecedented statewide mobilization the Communities for Children initiative has been able to accomplish.
9) With only a planning grant of $1,000, Communities for Children Partners at the local level have:
    a) Created safe homes
    b) Provided information about rapid response for youth who were homeless
    c) Developed teen/community centers
    d) Created mentoring programs
    e) Afforded youth service opportunities
    f) Established community-wide youth asset development campaigns, leading in one instance to the creation of an elected Youth Advisory Council for the Portland City Council
    g) Started literacy programs
    h) Opened after-school programs with structured activities
    i) Set up parenting education and support groups
    j) Built skateboard parks or town playgrounds for children
    k) Provided anti-bullying education.

Next Steps for 2002

1) Increase the number of Communities for Children partner communities by the end of 2002 to 75.
2) Place 36 VISTA volunteers in partner communities and related agencies throughout the State.

3) Renew Corporation for National Service AmeriCorps*VISTA grant for another 3 years.
4) Collaborate with the Maine Mentoring Partnership on the goal of increasing the numbers of mentors available to children and youth in partner communities, with special emphasis on utilizing faith-based organizations.
5) Introduce a statewide Youth Asset Development Concert/Lecture Series.
6) Develop a statewide university-based mentoring system through partner communities, based on the model created in Waterville.
7) Formalize the partnership between Communities for Children and the national Communities in Schools program.
8) Support three local Communities for Children Coalitions for Prevention Project partners as they develop prevention programs to cover children and youth aged birth to 18, including Healthy Families, Healthy Learners, Anti-Bullying, Mentoring and Suicide Prevention programs.
9) Create a plan to establish the Communities for Children Evaluation Resource Center in collaboration with the Muskie School of Public Service Institute for Public Sector Innovation. The center will support 63 partner communities and provide an avenue for research on how best to promote prevention through community-based efforts.

Continuing Challenges for 2003-2006

1) Recruit additional partner communities until all Maine "service centers" are included, moving toward a total of approximately 90 communities and 100% of the State's population.
2) Find annual funding to support the work of all the partner communities. Even $1,000 to $10,000 a year is a significant source of partnership support for each of the local Children's Leadership Councils.
3) Increase the opportunities for partner communities to meet with each other regionally.
4) Improve the website and listserve to enable greater resource sharing among all of the partner communities, including technical assistance for the development of specific projects, such as community and family resource centers and mentoring programs.
5) Create better coordination of the work of State agencies in local communities through collaborative funding opportunities.

Partnership with America's Promise

Overview

AMERICA'S PROMISE
THE ALLIANCE FOR YOUTH®

Maine is engaged in a 3-year partnership with America's Promise to enhance and expand current efforts to mentor, protect, nurture, prepare, and serve the children of Maine by developing Centers of Promise in communities. This program promotes the fulfillment of "five promises" for all children: a healthy start, a caring adult, safe places, marketable skills through effective education, and an opportunity to give back to the community through service. The priority that has been identified for the next few years is to focus on the promise that calls for an increase in the numbers of children and youth in Maine who have a caring adult by increasing the number of children with mentors. To accomplish this a Maine's Promise Executive Committee was established by Governor Angus King. The committee, chaired by Celeste Viger of Verizon, will support the growth of mentoring in Maine.

Next Steps for 2002

1) Create the "Promise Fund," an endowment to support the work of Maine's Promise, particularly as it is focused on the support of mentoring programs—particularly through the Maine Mentoring Partnership and through Communities for Children and Communities of Promise sites.

2) Work with Waterville's Community for Children which was selected as one of 15 Communities of Promise in the country to receive special attention from the national staff of America's Promise, as it develops into a national demonstration site.

Continuing Challenges for 2003-2006

1) Generate adequate resources to make the partnership with America's Promise real to local partner communities.
2) Develop a method of tracking the numbers of children and youth who are served for each of the "five promises."

Community Resolution Teams for Juvenile Offenders

Overview

Community Resolution Teams serve as an alternative for juvenile offenders charged with misdemeanor, non-violent first time crimes. This approach holds them accountable to their victims and their communities. The primary goal of the Community Resolution Teams is to resolve the case to the satisfaction of the victim(s), while promoting an understanding of the impact that crime has on both its victim(s) and the community.

An offender, his/her family, the victim, victim supporters, the community and police officers participate in a group meeting facilitated by a trained community volunteer. As an example, a victim explain that the vandalism of his mailbox may have seemed like a big joke to the youth, but actually resulted in the victim being unable to receive mail for the week it took to replace the mailbox, the expense of buying the new mailbox and the frustrating search for someone to install the new mailbox when the victim didn't have those skills himself. An outcome of this particular conference could be that the juvenile will pay to replace the mailbox and perhaps even install it for the victim, as well as apologize either in writing or in person. The result has a much greater impact on the juvenile than an impersonal appearance in a courtroom.

Next Steps for 2002

1) Identify an additional eight communities interested in providing Community Resolution Teams to work with the youth in their communities. Information and orientation sessions are available to any interested community. Information is available in several forms, including videos and information packets. A toll-free number allows people in communities more direct communication with CRTs.
2) Establish a web-based data collection site for community resolution teams to provide information about their teams and update case status.
3) Provide at least four facilitator trainings at different locations throughout the State.

Continuing Challenges 2003-2006

The Department of Corrections would like to see Community Resolution Teams in each community by the year 2006.

Community-School Grants

Overview

Students have received improved health education and care in schools which have obtained community-school grants. With these grants, schools have developed interventions to reduce tobacco use, physical inactivity, poor nutrition, and secondary and tertiary tobacco-related diseases. Funds may be used for school health services or coordinated school health programs with a focus on comprehensive school health education.

Next Steps for 2002

Schools are currently involved in implementing extensive needs assessments. The assessments will generate baseline data on the 8 components of a Coordinated School Health Program and on program coordination. This assessment looks at programs, policies, and services in the schools. It gathers information from students, parents, teachers, administrators, and staff. The information produced will point to strengths and challenges in the school and help to target recommendations for work plan development. This assessment will be done again in subsequent years to measure changes.

Continuing Challenges for 2003-2006

1) Continuing and improving collaboration and communication among community and school partners and State Departments is a goal of this initiative.
2) Currently, 59 schools in Maine are participating in this grant; we hope to eventually have all Maine public schools participating.

Ethical and Responsible Behavior in Maine Schools and Communities

Overview

In 2000, Maine received a four-year federal grant to support Maine's Character Education Partnership (CEP) to further the work of the Commission on Ethical and Responsible Student Behavior. Grants were awarded to seventeen school districts, and their work has continued to develop in important ways during Year Two of the federal grant. An additional grant program funded by a combination if federal CEP funds and a $50,000 appropriation by the State Legislature allowed the Department of Education to make funding available this year for grants to ten additional school administrative units (SAU) not currently receiving Maine Character Education Partnership (CEP) grants, linked to Maine's *Learning Results,* for comprehensive conflict resolution and character education in one or more public elementary or secondary schools. The funds can be used for the following kinds of programs: conflict resolution/management; bullying prevention; peer mediation; civil rights awareness; diversity training; and/or character education. They meet to share their work and identify "best practices", and to discuss any implementation obstacles they encounter and share ways in which those obstacles might be addressed.

In January of 2001, Maine's Commission for Ethical and Responsible Student Behavior issued its report "Taking Responsibility: Standards for Ethical and Responsible Behavior in Maine Schools and Communities." These statewide standards continue to be distributed statewide with approximately 10,000 reports and 15,000 executive summaries printed and distributed by the end of February, 2002.

State Partner efforts to provide technical assistance statewide continue as well. The National Center for Student Aspirations provides professional development and planning assistance through student workshops and focus groups, administrative meetings and parent workshops.

Outreach continues through a number of statewide events, including the CEP website, conferences, and presentations with school districts and the State Partners to the grant (Institute for Global Ethics, National Center for Student Aspirations, the Department of the Attorney General, and KIDS Consortium.)

Next Steps

1) The Department is assisting in the development of pilot programs for linking Maine's *Learning Results* with Taking Responsibility and a citizenship/stewardship initiative with the Maine Resource Stewardship Alliance.
2) The Institute for Global Ethics provided training for approximately twenty (20) facilitators, statewide, who are available to provide facilitation services in the identification of community values under a voucher program available to all school administrative units that are not currently receiving character education grants from the Department.

3) Portfolios submitted to the Department by all grantees will be reviewed for the specific purposes of evaluating performance; identifying "best practices"; and making recommendations for future programming. Feedback will be provided to the participating sites and the identified "best practices" will be added to the Department's clearinghouse and made available statewide.

Continuing Challenges for 2003-2006

1) The greatest challenge for Year Three (2002-2003) of the CEP grant will be consistent evaluation and demonstration of the effectiveness of the partners' character education programs.

2) Year Four (2003-2004), of the CEP grant will be a year of very limited funding for each partner and the hope is that each district's program will have been sufficiently seeded by then to endure.

3) A new federal grant program will require that CEP programs be supported by scientifically-based research. Over the next three years, the Department will be applying for another grant, and if awarded, will be working with the CEP partners and other districts interested in implementing character education programs of this type.

Regenerating Government – in Partnership with Communities and Families

Our Vision for Maine: State agencies collaboratively support families and communities, keeping family and children at the heart of all decisions.

Creation of the Governor's Children's Cabinet

Overview

Governor Angus King established the Children's Cabinet in 1995 to oversee and coordinate the delivery of services to children in Maine. The Children's Cabinet is composed of the Departments directly related to children and families: Corrections, Education, Human Services, Behavioral and Developmental Services, and Public Safety. Senior staff from the Department of Labor and the State Planning Office also provide staffing assistance to the Children's Cabinet to ensure that the Cabinet has prompt access to labor and economic development data, as well as to information on youth issues considered by the Planning Office.

In our view, the creation of the Children's Cabinet is a milestone in Maine State Government on behalf of our children.

In his charge to the Children's Cabinet, the Governor emphasized the important leadership role of the Commissioners in collaborating and promoting the concept of a seamless service delivery system for children and families, and in promoting the need to pool funding to maximize limited resources. Following some initial planning meetings, the Children's Cabinet began operations with a two-day retreat in December, 1995, during which time the Commissioners articulated a common vision of a coordinated, community-based system of services for children and families and outlined a plan for operations. [4.]

The Children's Cabinet has actively collaborated since 1995 to create and promote coordinated policies and service delivery systems that support children, families, and communities.

Next Steps for 2002

1) Continue with the current mode of operation for the Children's Cabinet.
2) Identify a significant issue that the Children's Cabinet Departments should address during the next session
3) Capture elements that constitute the enduring legacy of the Children's Cabinet including:
    a) Collaboration
        i) Integrated Case Management (ICMS) – Ask each Department to identify situations that would trigger ICMS in its case management systems.
        ii) Ask universities and colleges to include collaboration in their students' training curricula.
        iii) Pursue a Leadership Training seminar.
    b) Early Intervention and Prevention: Consider holding a summit on Early Intervention similar to the summit held on Collaboration in July 2001.
4) Children's Cabinet staff will continue to meet weekly, but will also work with the existing groups working on ICMS, Maine Marks, and Early Intervention to sharpen our focus on these three issues.

[4] For complete details on the development and work of the Children's Cabinet, see the Cabinet's 2001 Annual Report at the Children's Cabinet website (see Appendix.)

Continuing Challenges for 2003-2006

1) A lingering culture within agencies which hampers a collaborative, cooperative spirit – continuing to see the collaborative work of the Cabinet as a temporary "program", rather than a new and permanent way of doing business;
2) Categorical funding streams that tend to impede a holistic approach to addressing the problems of children and families while suppressing collaborative creativity; and
3) Ensuring that the Children's Cabinet includes consideration of economic development and family support issues by considering formal statutory inclusion of the Department of Labor as a member of the Children's Cabinet.
4) Maintaining the work of the Children's Cabinet with adequate staff and support services.

Regional Children's Cabinet

Overview

The creation of the Governor's Children's Cabinet allowed, in turn, the creation of three mirror-image Regional Children's Cabinets composed of senior staff from each of the 5 Cabinet departments. This is the first time that State government has had such an effective organizing principle with which to innovate and disseminate children's policy and practice throughout the State.

The composition of each of the Regional Cabinet mirrors that of the Governor's Children's Cabinet; i.e. each contains representatives from the Departments of Corrections, Education; Human Services; Behavioral and Development Services; and Public Safety. Parents and other interest groups also sit on the Regional Cabinets.

Region I includes York and Cumberland Counties. Region II includes Kennebec, Somerset, Androscoggin, Southern Oxford, Knox, Lincoln, and Waldo counties. Region III includes Penobscot, Piscataquis, Washington, Hancock, Aroostook Counties.

Next Steps for 2002

1) Expand the Integrated Case Management System (ICMS).
2) Continue to focus on the Youth Who Are Homeless initiative.
3) Continue to strengthen the Local Case Resolution Committees.
4) Support the opening and operation of the Mountain View Youth Development Center in Charleston and the Long Creek Youth Development Center in South Portland.
5) Sponsor cross-trainings of children & family resources.
6) Focus on transition initiatives, including:
    a) hospital to school;
    b) school expulsions to community;
    c) youth to adult services; and
    d) residential and correctional institutions to community

Continuing Challenges for 2003-2006

A continuing challenge will be to balance local needs with State level policy in carrying out the initiatives of the three Regional Cabinets.

Local Case Review/Resolution Committees and Pooled Flexible Funds

Overview

Local Case Resolution Committees (LCRC) are located throughout the State and are a resource for families to access when they have a unique need that cannot be satisfied through any system already in existence. Each committee hears cases submitted by family members, agency representatives, teachers, etc., and makes a decision on a case-by-case basis. The LCRC members represent many different agencies and can refer the family to available resources. In a few cases, the LCRC can provide limited funds to provide services needed to avoid an out-of-home placement for a child. Prior to accessing LCRC funds, the family must exhaust all other resources available to them.

LCRCs are allocated a small pool of funds available, to assist in meeting structural gaps and needs in the system of care for children and families, from funds which are pooled for these purposes from each of the five Children's Cabinet Departments.

Pursuant to 5 MRSA Chapter 439 §19133, the Governor's Children's Cabinet is authorized to:

1) "provide services to children with multiple needs within the child's community by supporting case review and resolution at the local level using appropriate funds pooled from each department of the cabinet;"
2) "coordinate funding and budgets among the departments of the cabinet related to child and family services in order to carry out the [Cabinet's] purpose, collaborate to share resources, remove barriers and support initiatives that prevent health and behavioral problems in children;"
3) "conduct long-range planning and policy development leading to a more effective public and private service delivery system;"
4) "coordinate the delivery of residential and community-based children's services among the departments;" and
5) "assess resource capacity and allocations."

Accordingly, the Departments of the Children's Cabinet may choose to contribute funds from their respective accounts to a cumulative fund each fiscal year, for the following purposes:

1) Enable a Child to Remain at Home - To fund a pivotal need essential to allowing a child to remain at home and avoid an imminent out-of-home placement for which no other source of funds is available, without which the child would require an out-of-home placement, and which is outside the usual scope of traditional and reasonable household expenses; and
2) Systems Improvements – To fund systems improvements in accordance with the mission and work plan of the Children's Cabinet and the Maine Marks performance indicators.

Next Steps for 2002

1) Support existing LCRCs.
2) Start a LCRC in Oxford County.
3) Develop an improved reporting system for the Regional Children's Cabinets to use in reporting on LCRC activities.

Continuing Challenges for 2003-2006

Develop a feedback system in which LCRCs can report back about where systems are failing individual youth, and use this feedback to make system improvements.

Council on Children and Families

Overview

The Council was created in statute when the Children's Cabinet was codified in State law. It consists of 13 members: the 5 Commissioners of the Children's Cabinet, 3 Senators appointed by the President of the Senate, 4 Representatives appointed by the Speaker of the House, and the Chief Justice of the Supreme Judicial Court. The members of the Council for 2001 are listed below, with two changes in membership as noted:

Executive Members: Commissioners J. Duke Albanese-Education, Kevin W. Concannon-Human Services, Lynn Duby-Behavioral and Developmental Services, Michael Kelly-Public Safety, Martin Magnusson-Corrections

Legislative Members: Sen. Beth Edmonds [replacing Sen. Mike Michaud]; Sen. Susan Longley; Sen. Mary Small; Rep. Julie O'Brien; Rep. Lillian LaFontaine O'Brien; Rep. Roger Sherman; Rep. Elizabeth Watson

Judicial Member: Chief Justice Leigh Saufley [replacing former Chief Justice Daniel E. Wathen]

Based on its statutory purpose and goals, the Council crafted its mission to engage all three branches of government in Maine in a collaborative effort to effectively help all children and families in Maine.

Next Steps for 2002

1) Taking a stand against underage drinking; and
2) Determining whether systems are responding to children and families early enough in order to avoid more serious problems later on.

Continuing Challenges for 2003-2006

1) Engage in "systems thinking," to address children's issues across all three branches;
2) Improve communication among all three branches of government participating on the Council, and learn more about how our colleagues in the other two branches (Judicial and Legislative) approach and frame these issues;
3) Work collaboratively on issues that involve all three branches;
4) Ensure a statewide perspective in the development of policy;
5) Focus on the family as a whole; and
6) Ensure that our work includes all children -- not just those involved with government.

Integrated Case Management

Overview

The Integrated Case Management initiative provides Maine families and children with access to services to improve their health, safety, economic stability, self-sufficiency and quality of life that are planned, managed, and delivered in a holistic and integrated manner. Integrated Case Management (ICMS) coordinates services across departmental and community-based agencies. An interdisciplinary venture, ICM comprises the four disciplines of child welfare, domestic violence prevention, mental health, and substance abuse services, and includes both public and private sectors. The key features of the ICMS model are: the case involves the entire family; a comprehensive family plan is developed through a facilitated team approach, which includes family participation; and one person assumes the role of Lead Case Manager. Since the initiative began in 1996, ICM has accomplished the following:

1) In both the greater Bangor and the Bath/Brunswick communities, ICM has been incorporated as a working model, and its scope is being extended to additional communities.
2) In Region III a number of new cross-systems initiatives, in both the Downeast and Aroostook county areas, include ICM as the foundational building block.
3) During the past year, 2300 contact hours of training and organizational support were provided through a range of seminars and training events on topics such as ICM Practice, ICM Facilitation, ICM Skills, Working Across Systems, and Inter-departmental Practice.
4) In concert with local agencies, ICM identified and addressed systemic challenges to establishing a culture and practice for the integrated delivery of services across State departments.

Next Steps for 2002

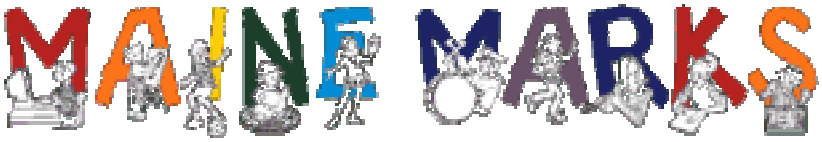
1) Issuance of an Integrated Case Management Joint Policy Resolution from the Children's Cabinet that directs the consistent and comprehensive integration of family-centered services delivery across the child-and family-serving Departments of State government.
2) Identification and expansion of current cross-systems work being done throughout the State in order to further strengthen and extend a seamless system of integrated delivery of services that includes an ICM component for those complex cases that engage multiple State and community agencies.
3) Convene meetings with the Regional Children's Cabinets to develop ICM implementation plans for the next year, with particular attention paid to how to expand the utilization of ICM in Regions I and II, either through building upon their present systems for coordinating service delivery, or through supporting the creation of a comprehensive system of family-centered services delivery.
4) Convene meetings and provide cross-departmental training opportunities for senior managers in all Departments to identify both department-specific steps for increasing cross-systems family work, and inter-departmental actions that will allow children and families to receive ICM services when they are requested.
5) Expand opportunities for comprehensive ICM training for case managers to facilitate, and/or be a participant in, ICM team meetings, and for management staff to provide vision and support for their staff working across systems to implement ICM policies and procedures.

Continuing Challenges for 2003-2006

The ICM Assessment Report highlights some of the continuing challenges to moving forward with the integration of service delivery systems across multiple State departments and community agencies. Listed among those challenges are the following:

1) Consistent and continuous provision of uniform support for the implementation of ICM, particularly commitments from State agencies and their management, as well as commitments from regional Children's Cabinets;
2) Inclusion of Integrated Case Management as an operational performance measure for appropriate staff and as a performance measure for services contracted by Departments for meeting the needs of children and their families;
3) Incorporation of comprehensive ICM training within existing departmental training systems;
4) Integration of ICM values and practice into other Children's Cabinet and departmental initiatives in a coordinated format that promotes communication between the various initiatives and protocols of the Children's Cabinet and its departments; particular attention should be directed to interdepartmental sharing of fiscal resources, such as funding for family case management, and the addressing of systemic funding barriers.

Maine Marks for Children, Families and Communities



Overview

The purpose of Maine Marks is to report on indicators that track the child, family and community well-being outcomes established by the Children's Cabinet.

The Children's Cabinet identified indicators for inclusion in Maine Marks for Children, Families and Communities to track progress on the stated outcomes of the Children's Cabinet. The indicators are intended to measure the concept of "child well-being" from a balanced perspective. Simply put, these indicators should help to answer the question, "How are the children and youth in Maine?" In line with the Children's Cabinet vision, the indicators provide a holistic view that transcends categorical program areas, and an opportunity for policymakers and taxpayers to answer the question, "How well are we doing in our efforts to keep Maine as one of the best states in the country to raise a child?" The Maine Marks Program has four broad goals, all set at the direction of the Governor's Children's Cabinet:

1) To develop, implement and report on a set of indicators to measure progress on the child and family well-being outcomes of the Children's Cabinet;
2) To develop and maintain a set of partnerships in support of the Maine Marks Program;
3) To provide education and training on the function and use of social indicators in policy-making and program management; and
4) To maintain and enhance the use of Maine Marks for the betterment of all Maine citizens

Building on this work, Maine, along with 13 other states, has been funded by the Packard, Kauffman and Ford Foundations to participate in a multi-State initiative to use child well-being indicators to build a change agenda in States and local communities in order to improve school readiness and ensure early school success. State leaders are creating indicators that can be tracked over time at the state and local levels and can be used as benchmarks of what all young children need in order to succeed. Maine's team has examined the existing Maine Marks to determine which marks target school readiness indicators. We have examined the current data sources, and have added additional sources to provide a breadth of information for each indicator.

Next Steps for 2002

1) Expand the number of Maine Marks measures for which there is reliable time-series data.
2) Continue efforts to increase public awareness of the purpose and content of Maine Marks.
3) Consider various options for how the Maine Marks data can be released in the future. For example, should a full, hard copy version be issued annually? Could more reliance be placed on the web page, combined with a hard copy Executive Summary in some years?
4) Begin to provide Maine Marks data at the county level, beginning with the five counties served by the Region III Children's Cabinet.
5) Consider ways to refine and extend the Maine Marks website to provide more comprehensive and useful information for decision-makers and other interested individuals or parties.

In the Multi-State Child Well-Being Indicator Project funded by the Packard, Kauffman and Ford Foundations, we will be obtaining the data for each indicator to set the baseline. The team will examine the data at six-month intervals for any the changes. At the comprehensive states meeting we will share our indicators and determine the core indicators for all States and the "core plus" for each State.

Continuing Challenges for 2003-2006

1) Explore ways to make it easier for decision-makers and interested parties to use Maine Marks data for policy making, priority setting, and program development. For example, should the Maine Marks report be supplemented by topic-specific briefings, issue papers, or seminars?
2) Regularly revisit the indicators included in Maine Marks through an inter-organizational collaborative like that used to develop the measures. Consider modifying, adding, or dropping measures to make the tool more useful.
3) Continue to expand the Maine Marks website to make it a more useful and comprehensive resource for the public and for decision-makers.
4) Explore ways in which Maine Marks data can be produced at geographic levels smaller than counties.
5) Expand efforts to evaluate Maine Marks, looking especially for ways to make it more useful for its various audiences.

With respect to the Multi-State Child Well-Being Indicator Project funded by the Packard, Kauffman and Ford Foundations, we intend the foundation work to begin the cross-State effort. The fourteen States involved in the project believe that cohesive focused examination of data will raise the awareness of the importance of the early childhood period.

Coordinating School Health Programs

Overview

Children cannot achieve their full potential when they are hungry or fearful or abusing alcohol and other drugs or discouraged. Healthy school environments create an atmosphere for learning. By addressing the physical, mental, social, and emotional needs of young people, we can give them the opportunity to reach their true potential as learners. A Coordinated School Health Program (CSHP) consists of the implementation of eight components of school health for children and families. These eight components are: Comprehensive School Health Education; Physical Education and Physical Activity; School Counseling, Physical and Behavioral Health Services; Nutrition Services; School Climate; Physical Environment; and Health Promotion/Wellness. The vision for coordinating Maine's Comprehensive School Health Programs is to be the best in the nation in nurturing our young people to grow into aspiring and healthy adults. The program's mission is to ensure that agencies of State government join together with families, schools, and community members to build coordinated school health programs which promote and improve the health and education of all young people. Its goals are to create, advance, and sustain coordination of school health programs, across all State agencies, that guide and support communities in improving their capacity to serve and promote the health and learning of all young people.

Adolescent health is an area of significant concern and focus. According to the 2001 Maine Youth Risk Behavior Survey, 25% of Maine high school students used cigarettes in the last 30 days. This is a 14% decrease since 1997. This brings Maine students in line with the national average and shows our prevention efforts are working.

Physical activity and nutrition are areas of significant concern and focus. The percentage of students exercising for 20 minutes or more, 3 times a week dropped from 71% to 66%, and only 42% of Maine high school students receive physical education one or more times a week.

A number of specific initiatives fall under the coordination of school health programs, including the following:

1) Healthy Maine Partnerships: 54 School Administrative Units (SAU's) have school health coordinators funded through the Partnerships. A formative evaluation tool for all eight components of a CSHP is being piloted with administrators, staff, parents, and students to identify their current prevention program efforts and to help them begin planning and implementing their 5 year action plan with the community. Local school health advisory councils and system leadership teams are being put into place to lead, guide, and facilitate local prevention work with schools.

2) Healthy Learners' Initiative: 8 schools have addressed social adjustment and bonding to schools for students in pre-K to 3rd grade

3) DOE prevention representation is being established on each of the RCCs.

4) Community/School resources: CSHP Guidelines, CSHP website, Media Campaign grant for Physical Activity and Nutrition initiatives with SAUs/communities and Hannaford Bros.

5) Component area work i.e.; nutrition education, suicide prevention policy and procedure work, character education/conflict resolution, school construction initiatives, etc.

6) State's Key Advisory Committee – over 30 State non-governmental associations are coming together to support the coordination of school health programs.

Next Steps 2002

1) Our first step is to secure funding for Maine's work to continue. Our 5- year agreement with the Center for Disease Control and Prevention's Division of Adolescent School Health (CDC-DASH) ends in 2002. We will re-apply to CDC-DASH for their next 5- year allocation of funding and work to begin securing State agency funds to support this work.

2) Expand our work with local Maine School Administrative Units (SAUs) to coordinate their School Health Programs. This will include issuing a guidelines document to SAUs, providing them with a web based tool for program evaluation and holding statewide recognition for SAUs who have exemplary School Health Programs.

3) Continue to monitor and address those health risk behaviors that are impacting Maine youth and their families.

Continuing Challenges 2003-2006

1) Better coordination in gathering health related data from SAU's and interpreting it.

2) Increased partnerships and involvement of parents, communities, and youth with schools to provide quality health programs and services in support of children/adolescents as learners.

3) Address youth obesity: Persons who are overweight in adolescence are at high risk of numerous health problems including hypertension, coronary heart disease, gallbladder disease, non-B insulin dependent diabetes, and some cancers. In the United States, the percentage of children ages 6 through 17 who are overweight has increased more than twofold since the 1960's, with the largest increase in the 1980's. Combine this with the decreased time our children are getting exercise and this raises great concerns for the future health of Maine citizens and the nation.

4) The availability of mental health services continues to be an issue for children and families. Our schools are still a primary vehicle for providing mental health services to students.

Related Websites

http://maine.gov/cabinet/homepage.htm	Governor's Children's Cabinet
http://www.geocities.com/mainecc3/mainecc3.html.	Region III Children's Cabinet
http://www.mainementoring.org	Maine Mentoring Partnership
http://www.communitiesforchildren.org	Communities for Children
http://www.mainemarks.org	Maine Marks

Alphabetical Index of Initiatives