

# HEALTHY PARENT: HEALTHY CHILD

A Report to
Gov. Joseph E. Brennan
On Maternal and Child
Health in Maine



September - 1980

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# HEALTHY PARENT:
# HEALTHY CHILD

Report of the

Governor's Task Force on Maternal and Child Health

September, 1980

Kathryn Monahan Ainsworth, Chairperson

Donna Overcash, Professional Staff to the Task Force

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GOVERNOR'S TASK FORCE

ON MATERNAL AND CHILD HEALTH

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GOVERNOR'S TASK FORCE
ON MATERNAL AND CHILD HEALTH

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MICHAEL R. PETIT
Commissioner

September 12, 1980

The Honorable Joseph E. Brennan
Governor of Maine
State House
Augusta, Maine 04333

Dear Governor Brennan:

It gives me great pleasure to submit to you "Healthy Parent: Healthy Child," the final report of the Governor's Task Force on Maternal and Child Health. This document is in response to your charge to assess the health needs of Maine's children, adolescents and women of childbearing years, and to develop recommendations for improving health services.

Development of these recommendations involved sincere dedication to the improvement of maternal and child health on the part of Task Force members and of the many private citizens who worked so diligently with us. Although consensus on the issues was not always attainable, certain basic philosophies served to unite us in our work. Some of these philosophies are:

- A recognition that mothers and children in our society are a particularly vulnerable population, often dependent upon others for care and support, including basic health needs;

- A belief that, even though its financial resources are limited, our society will not refuse to assist its needy mothers and children whose basic health needs are not being met;

- An awareness that mothers and children are especially responsive to timely health care and that effective preventive health services will result in long term economic benefits and in a higher quality of life for all Maine citizens;

- A belief that public education is crucial in promoting health, because the more individuals know about what keeps their bodies healthy and what protects them from injury, the healthier they will be;

- A conviction that through the combined efforts of individuals and their families, the community, and the resources of government many of the health problems plaguing women and children can be alleviated.

Task Force members are acutely aware of the present economic situation with rising costs and inflation and the resultant drain on finances for existing

programs and services. However, we have concluded that precious dollars spent now on preventive efforts will promote long term financial savings. As other reports before ours have noted, the State has delayed too long in emphasizing prevention.

Implementation of the recommendations contained in this report would, I believe, result in significant improvement in the health status of Maine's children, adolescents and women.

The Task Force thanks you for the opportunity to engage in a partnership venture with State Government to work towards improvements in the health of Maine's present and future citizens.

Sincerely,

Kathryn Monahan Ainsworth

Kathryn Monahan Ainsworth
Chairperson

KMA:wjb
enclosure

Healthy Parent: Healthy Child

A Report to Governor Joseph E. Brennan
on Maternal and Child Health

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## FOREWARD

In September 1979, Governor Joseph E. Brennan appointed a group of interested citizens, consumers and professionals in the field of maternal and child health to a Task Force and charged them with the development of recommendations on the needs and problems of Maine's women of childbearing age and their children.

Specific concerns to the Governor were the absence of a coordinated system of maternal and child health services; the widespread concern about the problems of adolescent pregnancy; and the potential for improving health problems through prevention and early intervention. The Task Force was asked to assess Maine's resources and capabilities for addressing maternal and child health problems, to take into account information gathered during public hearings, and to build public awareness of the problems and issues involved in the area of maternal and child health.

"Healthy Parent: Healthy Child" represents a culmination of the efforts of the Task Force, after a year of discussions, inquiry and decision-making.

The report is presented for review by Governor Brennan.

## ACKNOWLEDGMENTS

Many individuals contributed significantly to the efforts of the Governor's Task Force on Maternal and Child Health, either through active participation on Task Force subcommittees, through presentation of testimony at public hearings, or through behind-the-scene efforts.

Although space does not allow us to acknowledge all of these persons individually, we appreciate their efforts and applaud their concern for the health and well-being of Maine's women, adolescents, and children.

In particular, however, the professional assistance of Donna Overcash with the staff support provided by B. J. Hill and Wilma Bickford is gratefully acknowledged. In addition, appreciation is accorded to Sondra Everhart and Andrew Coburn for their unfaltering assistance with the final production.

# EXECUTIVE SUMMARY

## Background

Responding to the request from Governor Joseph E. Brennan, the Task Force on Maternal and Child Health set forth to define maternal and child health care in Maine; to assess the needs of Maine's women of childbearing years, children and adolescents; and to develop recommendations on the extension and improvement of health services to mothers, children and their families.

This report is a product of many hours of discussion, debate and inquiry surrounding current policy issues, health problems and client needs in maternal and child health. Reaching consensus among Task Force members was a difficult and demanding task. Many issues and potential recommendations were eliminated early in Task Force deliberations due to considerations of cost, significance, and appropriateness to the subject of maternal and child health. Despite our deletions, the scope of the Task Force inquiry encompasses broad and comprehensive health, social service and educational needs of children and families. Research and evaluation of existing maternal and child health programs, services, policies and statutes were limited by time and resources.

By late Spring the Task Force developed and reached general agreement on thirty-eight preliminary recommendations and was still discussing four other issues. One of the issues still being discussed was an overall plan for dealing with adolescent pregnancy although many of the preliminary recommendations already addressed specific needs of adolescents. In early June, five regional hearings were held throughout Maine to solicit public comment on the preliminary recommendations and issues "under discussion." Over 300 people participated during the process of public hearings. The Task Force received and summarized all public comments and officially took action on all requests for revisions, changes and additions. An example of one such public concern was the problem of accessibility to maternal and child health services due to the lack of transportation.

"Healthy Parent: Healthy Child" embodies the ideas, viewpoints, findings and conclusions of people from many walks of life: lawmakers; social workers; midwives; nurses; pediatricians; gynecologists and obstetricians; psy hologists; educators; planners; persons who work with young children, adolescents, handicapped children, abused and neglected children, mothers and babies; and persons within the executive branch of State Government who have planning and management responsibilities for programs and services for women and children. The recommendations contained in this report are varied in their subject matter as they relate to perceived problems in maternal and child health, but each of them aims toward the promotion of healthy mothers, babies, children and adolescents.

## Major Policy Issues

In the course of our deliberations, the Task Force encountered several key policy issues which had a significant influence in shaping the focus of our research and our recommendations. Among these issues are:

1. The need for a definition of maternal and child health that is broad enough to encompass more than physical health of women and children;

2. The roles and responsibilities which individuals and family units should assume with regard to their health;

3. The extent of State Government's involvement in developing maternal and child health services with recognition of the need for local participation; and

4. The appropriate balance between preventive and treatment approaches to meeting maternal and child health needs.

### The Definition of Maternal and Child Health

The Task Force recognized early in our work that agreement on a definition of maternal and child health was crucial for determining the scope of our activities and developing our approach to the issues and problems of women and children in Maine. Historically, maternal and child health has been defined narrowly as services, programs and activities con-

ducted by state Maternal and Child Health and Crippled Children's Programs that were funded by Title V of the Social Security Act.

These services focused, in large part, on the major causes of death, sickness and disability in pregnant women, infants and children. With the eradication and control of many communicable diseases, improvements in medical technology and increases in the availability of medical care, the needs and problems of pregnant women and children have changed dramatically. These changes have led to a recognition of other significant health concerns. Child abuse and neglect, handicapping conditions, high risk and unintended pregnancies, and death and injury due to accidents pose a greater threat today in human and economic terms than do sickness and disease.

Consequently, the Task Force chose a broad approach to maternal and child health which includes the psychological, social, educational and developmental aspects of health. For the purposes of our deliberations, maternal and child health services are defined as "all efforts to promote health and to prevent and alleviate disease, illness and handicapping conditions in mothers, infants and children." We felt the need for a comprehensive maternal and child health strategy to assure adequate and accessible health care to women of childbearing years and their children. A comprehensive maternal and child health strategy must address the health problems and health needs of women and children, but must also clarify the roles and responsibilities of the individual, the family and the community.

## The Family and Maternal and Child Health

The Task Force feels that the family is crucial both to our understanding the health needs and problems of mothers and children and to our efforts to solve these problems. As implied by the title of this report, "Healthy Parent: Healthy Child," the health of the child is intimately involved with the quality of relationships within the family. To affirm the importance of the family does not, however, answer many of the important questions concerning the roles, responsibilities and potentially conflicting interests within the family unit.

For example, the Task Force confronted the problem of balancing rights and responsibilities of parents with the interests of the child, when we addressed the issue of accessibility to prenatal care for pregnant adolescents.

The law is ambiguous on whether prenatal care can be provided to an adolescent without the consent of parents or legal guardian. Common practice in some parts of Maine is to deny prenatal care until parental consent is given. While this policy protects the rights of parents, in many cases it jeopardizes the health of the pregnant adolescent and her baby. The adolescent will often delay seeking appropriate medical care, rather than risk a confrontation with her parents.

The Task Force recognizes that parents and families have responsibilities for promoting the health and development of their children. Furthermore, we believe that the healthy family remains the best environment for the care and nurturing of the child. At the same time, we are acutely aware of the need to provide basic health and social support services for those families who for reasons of economic insecurity, inadequate education or deprivation are unable to assume total responsibility for the care of their children.

## The Roles and Responsibilities of the Government and the Community

In addition to the Task Force's concern over the roles and responsibilities of the family, many discussions centered on important philosophical and policy questions concerning the appropriate roles for State Government and local agencies. The majority of health and related services are provided in the community by private physicians and hospitals and publicly funded private health and social service agencies. In addition, there are a variety of voluntary agencies such as La Leche League, Childbirth Education and Parents Anonymous, which represent increasingly important sources of maternal and child health services.

The Department of Human Services and other state agencies have limited statutory mandates, resources and capabilities for addressing the health and health related needs of families. Categorical federal funding, for example, restricts client eligibility for many health and social services.

The Task Force envisions a partnership between State Government, private health care providers, local community agencies and citizens. Leadership and financial and technical support from State Government combined with the commitment, guidance and resources of local communities are the key to significant improvements in the delivery of maternal and child health care.

## Prevention

While the Task Force realizes that the treatment of health problems is an essential component of health care, a continued focus on treatment ignores the enormous social and economic advantages for the individual and society of pursuing policies and programs aimed at preventing many of these health problems. Task Force recommendations in the areas of mental health and home visiting services are examples of our commitment to prevention.

Prevention can have both immediate and long term results. For example, the use of contraceptive methods by sexually active adolescents can prevent unintended or unwanted pregnancies, but knowledge and self-awareness acquired through education and family support can have a more lasting effect on their decision about whether or not to become pregnant.

In order to achieve this greater emphasis on prevention it will be necessary to redefine some maternal and child health services, to develop new priorities for the use of existing resources and, in some cases to develop additional resources.

These policy issues form the basis for many of the Task Force's major findings and recommendations which are summarized in the following sections.

## Major Findings

Based on the work of its three subcommittees and a special working group on adolescent pregnancy, the Task Force developed findings and recommendations in four areas:

1. Women in childbearing years and newborns;
2. Infants and children;
3. Adolescents and teenage pregnancy; and
4. The administration of maternal and child health services in Maine.

The following represents a summary of some of the major findings in each of these areas:

1. Women in Childbearing Years and Newborns.

   A. Women and newborns in need of perinatal health care services are faced with an array of administratively independent providers of service, each offering various elements of service and weak or non-existent agency to agency referral mechanisms.

   B. Unintended, unwanted and unplanned pregnancies among women, including adolescents, can result in a host of social, emotional and economic difficulties which have an adverse effect on the health and well-being of mother and child.

   C. Eligible women and adolescents in Maine who are pregnant for the first time and do not have the necessary income to purchase early and adequate prenatal health care are not provided with state and federal income support and medical assistance.

   D. Many of Maine's babies are born in small, rural hospitals or in hospitals that do not have intensive care facilities for newborns. Fifty percent of the high risk babies come unexpectedly from healthy, low risk pregnancies. The financial cost of long term convalescent care and the psychological cost of long term family and newborn separation are problems for many Maine families.

2. Infants and Children.

   A. Children, without the knowledge of how their bodies function and how to keep them healthy, develop poor health habits and behaviors which are detrimental to their health and well-being.

   B. A substantial number of Maine's children, particularly among the poor and rural population, are not effectively reached by presently available health maintenance services. Currently, available services often do not focus upon psychosocial, environmental, and developmental determinants of health.

   C. Maine children suffer needlessly from emotional problems and mental disorders, many of which could be alleviated through early intervention and efforts at primary prevention.

   D. Only 35% of Maine children under five years of age who have handicapping conditions or developmental problems receive adequate services. No single department or agency within State Government has a clearly assigned responsibility to assure that these children are identified and receive appropriate health and educational intervention.

   E. Child abuse continues to be a problem of significant proportions which threatens the health and safety of children in Maine.

F. Dental disease affects more children in Maine than any other known disease or affliction.

G. Accidents are the leading cause of death among children, age 1-19, in Maine. There does not exist a coordinated, comprehensive statewide accident prevention program.

3. Adolescents and Teenage Pregnancy.

A. Adolescents face numerous barriers to health care. Among these are the availability and appropriateness of health care specific to their needs. In addition, accessibility to health care is limited by certain legal restraints and the adolescent's lack of money and transportation.

B. One of every seven live births in 1979 was to a teenager from the time of menarche (puberty) to age 19. Teenagers are medically, economically and emotionally at high risk for pregnancy complications which have an adverse effect on their health and the health of their babies.

4. The Administration of Maternal and Child Health Services in Maine.

A. There is no comprehensive maternal and child health program or service delivery system in Maine.

B. The administrative and programmatic requirements of the numerous federal and state categorical funding sources for maternal and child health inhibit the development of a coordinated, comprehensive maternal and child health system.

C. There is currently no policy development or planning process for maternal and child health within State Government to establish or implement a comprehensive program.

D. The coordination of maternal and child health services locally or regionally is a problem of significant proportions that has not received adequate attention by policymakers.

E. The absence of a comprehensive program at the local level is due to the lack of coordination and integration of community programs and services and the lack of involvement and participation of citizens in the maternal and child health system.

## Recommendations Requiring Immediate Action

The Task Force presents the following recommendations for immediate action by the Governor and the Legislature. They are NOT ranked in importance by Section or within each Section. The remaining recommendations are found in the body of this report. They are specified as either First or Second Priority and require similar attention.

### Section I Women, Mothers and Newborns

1.1 We recommend that the Department of Human Services assure that the components of a comprehensive perinatal program are available and accessible to families in Maine by conducting the following activities:

- Coordinate and assume a leadership role in the perinatal program;
- Define service elements and standards;
- Assess available services and identify service gaps statewide;
- Coordinate existing funding sources;
- Develop new funding sources involving state, federal and private participation;
- Plan and develop programs and services as needed including design, implementation, data collection and evaluation;
- Develop other resources including staff training and staff development and consultation;
- Promote and provide assistance to the establishment of local and regional committees with responsibilities aimed at perinatal care;
- Identify families in need of perinatal (maternity) care and the reasons for lack of care and examine appropriate funding resources to provide adequate perinatal care.

1.2 We recommend that the Department of Human Services strengthen its current level of commitment to family planning services and view family planning services as one of its major prevention efforts.

1.6 We recommend that the Department of Human Services develop and implement a plan of action to strengthen family planning services most responsive to adolescents at risk of unwanted pregnancies by the provision and promotion of:

- Outreach activities,
- Male involvement,
- Clinic educational materials,
- Evening and Saturday clinics, and
- Non-medical and counseling services.

Funding level, staff training and development community information activities and technical assistance shall be examined and the Department's participation defined, in relationship to the other funding sources.

1.7 We recommend that the Commissioner of the Department of Human Services assure that income maintenance and medical assistance be reinstated for first-time pregnant women who are otherwise eligible, in an effort to promote early prenatal care.

Section II Children

2.2 We recommend that the Department of Human Services investigate means of establishing a network of home health visitors within the State aimed at reaching all children within particular localities.

2.3(A) We recommend that the Department of Educational and Cultural Services require that health education become a mandated part of the public school curriculum from K-12, and that this education shall emphasize life styles and activities that will

that will have a long-term effect on the health and health related behavior of children. The content of the health education courses should be decided by local educational bodies. Curriculum should include coverage of at least, but not limited to, the following topics and be presented in a format appropriate to the age and grade level of the child:

- Child growth and development
- Nutrition
- Dental health
- Mental health
- Health care consumer skills
- First aid including cardiopulmonary resuscitation
- Harmful effects of substance abuse, including alcohol, drugs and tobacco
- Human sexuality and reproduction
- Parenting skills

2.8 We recommend that the following steps be taken to strengthen mental health services aimed at primary prevention and early intervention for children and adolescents in Maine:

(A) That a committee be formed representative of the Department of Mental Health and Corrections as lead agency, and in partnership with the Department of Human Services, Department of Educational and Cultural Services and the Maine Criminal Justice Planning and Assistance Agency (MCJPAA) to develop the criteria and provide support for a systematic statewide inventory of current mental health activities for children and adolescents. The criteria shall include collectively established definitions and indices. The inventory shall include those existing mental health related activities beyond the traditional service oriented programs.

(B) That the committee review and assess the results of the inventory, in order to: determine the geographical and demographic areas lacking in appropriate mental health activities for children and adolescents; and identify, secure funding sources for, and request proposals for the provision of comprehensive prevention and early intervention services.

(C) That the alliance of the three departments and MCJPAA recognize, encourage and solicit the assistance of a community-based coalition of professionals, consumers and interested citizens to participate in the establishment of priorities, the monitoring of progress and the maintenance of effort in the provision of preventive mental health services for children and adolescents.

(D) We recommend that the Department of Mental Health and Corrections use its authority to increase the proportion of mental health services for children and their families that are provided by Community Mental Health Centers (CMHC) by requiring in their contracts for service with the CMHC's the following:

(1) That each Community Mental Health Center develop a children's services unit in proportion to the population of children or as modified by the statewide inventory, and

(2) That each CMHC provide a specific description of their consultation and education services available to children, families, and schools, as well as other child-caring agencies.

2.9(A) We recommend that there be developed within State Government a clearly defined policy of early and ongoing identification and intervention on behalf of children with special needs and handicapping conditions.

2.10(A) We recommend that the Department of Human Services and the Department of Personnel make the necessary changes in the state personnel system to ensure the hiring, training and maintenance of well qualified staff in the area of protective services and support services.

Section III Adolescents

3.1 We recommend that the Department of Human Services convene a working group to address the subject of adolescent health services.

The working group shall consist of parents, adolescents, attorneys, members of the public with responsibilities for medical care, mental health care, social services and ecucation for adolescents and department staff who work in the area of child welfare and child health.

In an effort to assure medical counseling and educational services to adolescents, to remove the barriers that adolescents face in acquiring health services, to protect the rights of parents and to encourage parental responsibility for the health care of their adolescents, the working group shall be charged with the responsibility of developing legislation and policies affecting relevant state agencies and services involved in adolescent health.

3.2(A) We recommend that the Department of Human Services promote the accessibility of prenatal care for adolescents by taking the following steps:

(1) The Department shall work with the community health care providers in the development of policies that actively support the participation of the family in the health care of the adolescents. Health care providers should refer the pregnant adolescent to appropriate counseling services for support and assistance in communicating with her family;

(2) The Department shall assist and promote the provision of specific training in the involvement of the family for personnel who are in the position of counseling pregnant adolescents;

(3) The Department shall present and advocate legislation that would make prenatal health care available to adolescents without requiring the consent of their legal guardian.

Section IV The Administration of Maternal and Child Health

4.3 We recommend that the Commissioner of the Department of Human Services evaluate and clarify the role, functions, and responsibilities of the various organizational units within the Department which are responsible for maternal and child health programs and services. Specific steps that should be considered are:

(A) Evaluating the feasibility and desirability of consolidating programmatic and administrative authority and responsibility in a separate and single organizational unit which would encompass all maternal and child health programs, services and activities. Specific programs/organizational units that should be examined, include:

- Programs, services and activities currently under the Division of Child Health

- Public health nursing
- Early periodic screening diagnosis and treatment
- Immunization services
- Dental health
- Family planning
- Health for underserved rural areas and rural health initiatives, activities and projects.

(B) Examining the feasibility and desirability of elevating the organizational unit responsible for these maternal and child health programs, services and activities to a bureau level agency.

4.6 We recommend that the Department of Human Services actively promote and assist the formation and development of local and regional committees with the following purposes, functions and responsibilities:

1. To promote and advocate for maternal and child health at the local level;

2. To establish formal inter-agency mechanisms for needs assessment, program planning, development and implementation with the aim of coordinating and integrating health and health related programs and services at the local level for mothers, children and families;

3. To provide a potential mechanism for obtaining local input into the policy and program development process at the state level;

4. To advocate for additional local funding for maternal and child health; and

5. To develop additional local resources for maternal and child health through the development of "non-service" approaches to the delivery of maternal and child health services, including the use of volunteers and other community resources.

## Conclusion

Given the broad definition of maternal and child health adopted by the Task Force, and the limited time within which we worked, the final report falls short of being an exhaustive report on the health of Maine's women and children. It is however, a first step in understanding the complexities and breadth of maternal and child health problems in Maine.

"Healthy Parent: Healthy Child" presents a sensitive and rigorous portrayal of the needs of some of Maine's most vulnerable citizens, as perceived by Task Force members.

Recognizing that additional work is required in several specific areas such as adolescent health and policy development and program planning, the Task Force recommends specific working groups to continue our probings. Further work on the expansion of existing resources while continuing to examine present priorities is crucial to a rational, humane and cost-effective approach to maternal and child health.

The main body of our report follows. Recommendations are grouped according to client groups. Section I addresses the women, mothers and newborns in Maine; Section II provides recommendations for children and Section III addresses the needs of adolescents. The final section, Section IV addresses the administrative issues involved in the development of a comprehensive statewide maternal and child health program.

The Task Force ends our deliberations with a sense of hope. We feel that the rising health-consiousness of our citizens speaks well for Maine's future. The emphasis on becoming healthy and staying healthy through exercise, improved nutrition and absence of substance abuse portrays to us healthier individuals who accept responsibility for their own well-being. These improved healthy attitudes have great significance for parents and children as attitudes are passed down from generation to generation. Healthy parents have healthy children.

We have confidence that future generations will take the next steps which will bring us closer to a healthier world for us all.

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# Section I. Women, Mothers, and Newborns

## Introduction

Women of childbearing years, mothers and newborns require a variety of medical care, screening and diagnosis, information and education, and family support services to ensure timely conception and the subsequent health of mother and baby.

Perinatal health care services in Maine are delivered by a complex assemblage of health, education and social service providers offering a multitude of related services. The purpose of a system of perinatal care is to provide a continuum of comprehensive services to mothers and babies that will assure positive health outcomes and identify potential high risk families in need of specialized care. Throughout the preconceptional, prenatal, labor, delivery, and post partum stages, the woman and newborn need the assistance and involvement of private physicians, health professionals, and a variety of publicly-funded health care providers who work together to ensure early and effective client entry into maternal and child health care channels.

## Perinatal Health Care

### Problem Statement

Women and newborns in need of perinatal health care services are faced with an array of administratively independent providers of service, each offering various elements of service and weak or non-existent agency to agency referral mechanisms.

### RECOMMENDATION

1.1 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE THAT THE COMPONENTS OF A COMPREHENSIVE PERINATAL PROGRAM ARE AVAILABLE AND ACCESSIBLE TO FAMILIES IN MAINE BY CONDUCTING THE FOLLOWING ACTIVITIES:

- COORDINATE AND ASSUME A LEADERSHIP ROLE IN THE PERINATAL PROGRAM;
- DEFINE SERVICE ELEMENTS AND STANDARDS;
- ASSESS AVAILABLE SERVICES AND IDENTIFY SERVICE GAPS STATEWIDE;

- COORDINATE EXISTING FUNDING SOURCES;
- DEVELOP NEW FUNDING SOURCES INVOLVING STATE, FEDERAL, AND PRIVATE PARTICIPATION;
- PLAN AND DEVELOP PROGRAMS AND SERVICES AS NEEDED INCLUDING DESIGN, IMPLEMENTATION, DATA COLLECTION AND EVALUATION;
- DEVELOP OTHER RESOURCES INCLUDING STAFF TRAINING AND STAFF DEVELOPMENT AND CONSULTATION;
- PROMOTE, AND PROVIDE ASSISTANCE, TO THE ESTABLISHMENT OF LOCAL AND REGIONAL COMMITTEES WITH RESPONSIBILITIES AIMED AT PERINATAL CARE;
- IDENTIFY FAMILIES IN NEED OF PERINATAL (MATERNITY) CARE AND THE REASONS FOR LACK OF CARE AND EXAMINE APPROPRIATE FUNDING RESOURCES TO PROVIDE ADEQUATE PERINATAL CARE.

IMMEDIATE ACTION

Rationale

This proposal addresses the fragmentation and lack of cohesiveness of all the components of a perinatal program in Maine. Currently, the woman in childbearing years who is seeking preconceptional, maternity or newborn health care services is left to negotiate a vast array of services and providers. Many of the components of a perinatal program are already in place in Maine either through the private sector of physicians, hospitals and childbirth education programs or through the local and regional health and social services agencies. The funding base for these services involves a combination of private fees-for-service, third-party insurance payments (e.g., Medicaid, private insurance policies), private grants and endowments and public funds (e.g., municipal, state and federal).

The continued effectiveness of the delivery of perinatal health care services in Maine is contingent upon the degree of communication, concerted action and mutual cooperation of the array of health care providers.

The woman's ability to obtain care and service is often related to her degree of motivation and knowledge, and the visibility, availability and accessibility of services in the community. Other factors such as age,

economics and presence of crisis and complications experienced by the woman, mother and newborn determine whether they will receive adequate perinatal health care.

Therefore, a well-coordinated, harmonious system of perinatal health providers joined together by an effective cross-referral mechanism will ensure the client's entry into the health care system and the receipt of comprehensive care and service.

The Department of Human Services can provide a crucial leadership role in the promotion of linkages and interrelationships among all the perinatal service providers. In order to foster this type of coordination and cooperation, the Task Force recommends a "one-name, one-number" model. A health professional within the Department will be Director of the Perinatal Program and will carry the major responsibilities of enhancing the communication and referral mechanism; coordinating existing funding and developing new and additional resources where they are lacking; and defining service elements and minimum standards of care.

The recommended components of a Comprehensive Perinatal Program are:

PRECONCEPTIONAL CARE

- Infertility Services
- Family Planning
- Genetic Counseling
- Mental Health and Social Services
- Nutritional Education and Counseling

PRENATAL CARE

- Risk Assessment
- Medical Care
- Genetic Counseling
- Transportation
- Professional Education
- Nutritional Services
- Mental Health and Social Services
- Family Support Services (i.e., homemaker-home health aide, public health nurse)
- Childbirth and Parenting Education

LABOR AND DELIVERY

- Maternal Transportation
- Professional Education
- Medical Care
- Inpatient Obstetrical Services, including perinatal intensive care

POST PARTUM CARE

Nutrition Counseling
Family Planning, including high risk follow-up
Medical Care
Family Support Services, including homemaker, home visitor and public health nursing services.
Mental Health and Social Services
Patient Education (e.g., parenting, child care and child development)

NEWBORN CARE

Birth Defect Diagnosis and Genetic Counseling
Newborn Screening
Medical Care
Nursery Services, including neonatal intensive care
Nutrition Services
High Risk Infant Follow-up
Professional Education
Transportation to and from specified medical care facilities

With the advent of modern obstetrical practices, along with the overall improvement in the standard of living and the nutritional status of the general population, has come a significant improvement in maternal and infant mortality rates in Maine. A Comprehensive Perinatal Program, as described, represents a broader perspective of health that combines the psycho-social and medical/obstetrical aspects with a strong focus on prevention and early intervention. The Task Force feels that in order to secure the positive health outcomes of Maine's women and babies, the Department must assure that all families in their childbearing years receive perinatal services; that planning and program development activities take place in areas where services are lacking; and that women, mothers and newborns who can not afford access to perinatal services have an alternative payment mechanism available to them.

The Task Force attempted to assess the financial resources necessary to provide a Perinatal Program Director in the Department of Human Services. Salary, fringe benefits, travel, first year start-up money including office expenses, equipment and a data collection and management system, we roughly estimate will require $85,000 for the first year of the Perinatal Program. Both Federal and State funds are potential and appropriate sources of support.

## Women in Their Childbearing Years

Problem Statement

Unintended, unwanted and unplanned pregnancies among women including adolescents, can result in a host of social, emotional and economic difficulties which have an adverse effect on the health and well-being of mother and child.

RECOMMENDATIONS

1.2 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES STRENGTHEN ITS CURRENT LEVEL OF COMMITMENT TO FAMILY PLANNING SERVICES AND VIEW FAMILY PLANNING SERVICES AS ONE OF ITS MAJOR PREVENTION EFFORTS.

IMMEDIATE ACTION

1.3 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE THAT PAYMENT BE AVAILABLE FOR FAMILY PLANNING SERVICES INCLUDING PREGNANCY TESTING FOR MARGINAL AND LOW INCOME WOMEN AND ADOLESCENTS.

SECOND PRIORITY

1.4 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DESIGN, COORDINATE, AND INCORPORATE INTO ITS CURRENT ACTIVITIES A PUBLIC EDUCATION CAMPAIGN STRESSING THE VALUE AND AVAILABILITY OF CONTRACEPTIVE SERVICES. THESE EFFORTS SHOULD COMPLEMENT PRESENT ACTIVITIES IN THE LOCAL COMMUNITIES.

SECOND PRIORITY

1.5 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DESIGN AND IMPLEMENT A PROPOSAL FOR DEVELOPING A TRAINING CAPABILITY FOR ALL PROFESSIONALS WHO DEAL WITH WOMEN, INCLUDING ADOLESCENTS, AT RISK OF PREGNANCY.

SECOND PRIORITY

1.6 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DEVELOP AND IMPLEMENT A PLAN OF ACTION TO STRENGTHEN FAMILY PLANNING SERVICES MOST RESPONSIVE TO ADOLESCENTS AT RISK OF UNWANTED PREGNANCIES BY THE PROVISION AND PROMOTION OF:

- OUTREACH ACTIVITIES,
- MALE INVOLVEMENT,
- CLINIC EDUCATIONAL MATERIALS,
- EVENING AND SATURDAY CLINICS, AND
- NON-MEDICAL AND COUNSELING SERVICES.

FUNDING LEVEL, STAFF TRAINING AND DEVELOPMENT, COMMUNITY INFORMATION ACTIVITIES AND TECHNICAL ASSISTANCE SHALL BE EXAMINED AND THE DEPARTMENT'S PARTICIPATION DEFINED, IN RELATIONSHIP TO THE OTHER FUNDING SOURCES.

IMMEDIATE ACTION

Rationale

THE PROBLEM

All pregnancies should be wanted.

A child whose birth is planned, expected or anticipated "is far more likely to be off to a healthy start in life and to receive the continuing parental love and support needed for healthy development" than a child whose birth is not planned. [1] For many parents, economic stability and marital harmony are a prerequisite for having a child. For others, family planning is more than the question of "when" to have a child; the question is "whether." There are couples at high risk of conceiving a child with an inherited disorder. They may wish to consider that risk in deciding whether or not to have children. [2] Unplanned and unintended pregnancies can be prevented with contraceptives that are relatively safe and effective. Efficacy, however, depends on the correct and consistent use of contraceptives.

In Maine, family planning and counseling services and contraceptives are provided both by the private sector of primary care physicians and by a network of publicly funded family planning clinics. Little is known about the degree of family planning services available in the private sector or about the adequacy of these services. The woman seeking family planning services may either pay

full fee at the physician's office, and by prescription for contraceptives; use her Medicaid card for purchase of service if she is eligible; or visit a clinic funded by public and private dollars to provide family planning services. The majority of family planning clinic clients are funded by a combination of Title XIX (Medicaid), Title XX of the Social Security Act and the federal Family Planning Grant (Title X). Approximately 10 percent of the clinic clients participate in a sliding fee scale subsidized for the most part by the federal grant. Few clients in the clinic system pay full fee.

The clinic system is available in limited areas of the State and is operating close to capacity with some waiting lists for appointments extending to three or four weeks. Until very recently, community information activities were severely curtailed so that many women were unaware of services or how services could meet their needs when they were available.

The Task Force feels that any woman who wishes to prevent an unintended pregnancy should not be restricted by the lack of the availability of family planning services or the inability to purchase contraceptive services. The Task Force feels that financial assistance for family planning services, including pregnancy testing, should be made available to marginal and low income women so that they can purchase family planning services from either the public or the private sector.

## THE MAGNITUDE OF THE PROBLEM

Among an estimated population of 240,000 women* in childbearing years in Maine, 70,000 used the family planning clinics for services in 1979. Many of these women have low or marginal incomes and thus find the purchase-of-services system of private physicians beyond their means. An estimated potential population of 62,000 low and marginal income women have been identified by the Federal Department of Health and Human Services as in need of subsidized family planning services.

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* 1977 estimated population 239,588 women ages 15-44, excluding children under age 15 who are of childbearing maturity. This does not reflect women giving births that year or women who are not sexually active or infertile. (Department of Human Services).

While the above data relate to service utilization in the public and private system, women continue to experience unwanted or unplanned pregnancies as indicated by the number of women who seek abortion as an alternative to childbirth and the number of out-of-wedlock births in Maine. We do not know how many of the out-of-wedlock births were planned. Since 1975, the number of out-of-wedlock live births has steadily increased, from 9.8 percent of all live births in 1975 to 12.7 percent of live births in 1979:

*Chart Ia.* Number of out-of-wedlock live births by age

| | Less than 15-18 | 19-25 | 24-45+ | Total all Ages | Total All Live Births | Percent of out-of-Wedlock to Total Live Births |
|---|---|---|---|---|---|---|
| 1979 | 726 | 977 | 380 | 2083 | 16,435 | 12.67 |
| 1978 | 666 | 888 | 390 | 1944 | 15,919 | 12.2 |
| 1977 | 682 | 787 | 311 | 1780 | 16,252 | 10.95 |
| 1976 | 633 | 625 | 273 | 1531 | 15,046 | 10.17 |
| 1975 | 616 | 633 | 247 | 1496 | 15,232 | 9.82 |

Source: Resident Live Births,
Division of Vital Records, Department of Human Services

We estimate that 4,000-5,000 women in Maine in 1979 chose abortion as an alternative to childbirth. An accurate accounting of information on pregnancy termination for 1979 is not yet available, due to the fact that the reporting of abortions was extremely inadequate until 1978 when reporting became mandatory. There still remains incompleteness in reporting and we will not have an accurate count of terminations of pregnancy by age of the woman until later in 1980 when newly reported information is compiled. *See Chart Ib, page 9.*

*Chart 16.*

Terminations of Pregnancy

| | 1975 | 1976 | 1977 | 1978 |
|---|---|---|---|---|
| Total | 611 | 584 | 545 | 4464 |
| % per 1000 live births | 40.1% | 38.8% | 33.5% | N/A |
| Abortions | 67.9% | 74.7% | 73 % | N/A |
| Reporting | Deficient | Estimated completeness 20 % | Estimated completeness 15 % | Mandatory Reporting |
| Spontaneous | | | | 312 |
| Induced | | | | 4011 |

Source: Division of Vital Records, Department of Human Services

Family planning clinics perform about 7,000 pregnancy tests per year. A six-month survey and a 12-month survey of pregnancy tests provided in family planning programs show that 92 percent of these clients were NOT seeking pregnancy at the time they came in for the pregnancy test. Of the 7,000 tests, 45 percent were performed for teenagers less than age 20. Fifty percent of the teens seeking pregnancy tests were using NO method of contraception when they came to family planning. A remaining 45 percent represented "no attempt" to use "any method," whether it was an effective method or not. Five percent of the teens were seeking pregnancy, but they were mostly between 18-19 years old.

Because of the direction given to the Task Force at the beginning of our deliberations, we did not discuss or attempt to resolve the issue of abortion. Nonetheless, approximately 5,000 women in 1979 including adolescents chose abortion as an alternative to pregnancy and childbirth. For those women who seek pregnancy terminations, the following issues require further consideration:

A. The availability, accessibility and adequacy of pregnancy counseling;

B. The need for and availability of post-abortion counseling and follow-up.

Of particular concern are those adolescents at risk of repeat high risk pregnancy and those who use abortions as a method of contraception.

ON THE NEED FOR PUBLIC EDUCATION

Many women will continue to experience pregnancies they were not seeking or planning unless they have access to information and education that will help them understand how pregnancy can occur, and/or counseling about their personal sexuality to clarify their feelings about whether or not they desire pregnancy.

Providers of family planning, pregnancy testing and counseling, abortion, and prenatal care find that many women, especially younger teens, are ignorant about the risks of pregnancy associated with sexual activity, e.g., belief that they can not get pregnant until they are a certain age, or during a certain time of the month, or unless they have frequent sex, etc. The providers also find that many women are ambiguous in their feelings toward their sexuality and their sexual activity; become sexually active and risk pregnancy under peer pressure, adopt passive attitudes toward pregnancy or feel the use of contraceptives is immoral because it is "planned" sex and not spontaneous.

School family life or sex education programs and the family planning programs are two possible resources for educational activities. However, school programs, where they do exist, are intended for long term educational impact on knowledge and behavior. Motivation to exercise control over fertility would be more effectively addressed by specific informational activities oriented toward the sexually active female and male. These are not available in Maine schools. Family planning clinics offer services, but at the moment they are primarily for those who take the initiative to come to the program and have already overcome the informational and educational barriers. Counseling in human sexuality is not always particularly appropriate for adolescents since their sexual behavior has undergone considerable change in the past few years. Few professionals in associated fields (school guidance counselors, community mental health workers, etc.) are sufficiently trained to offer such a service and few programs have sufficient salary ranges to attract trained professionals.

ON THE NEED FOR TRAINING

There are limited training resources in the public sector: family planning training in Region I (federal region which includes Maine) is limited by funds for travel and per diem, so that each year only a few staff from each program receive any benefit from this source. The training available from Title XX

is, in many cases, too generic to adequately increase skills in the family planning setting. Other resources can be called upon, depending upon the finances available and the commitment to training of the individual program personnel. In addition, Family Planning agencies are overwhelmed by requests from teachers and other school personnel, health and social service agency staff, and community groups in need of education and orientation in sexuality, reproductive health and contraception.

The development of seminars, workshops, and other training activities specific to the field of family planning and contraceptive counseling would benefit scores of related professionals and para-professionals who interact with students and clients.

ON THE NEED TO DEVELOP AN ACTION PLAN FOR ADOLESCENT FAMILY PLANNING

Age-specific information from the 1980 Census will not be available for several months. Based on estimates by the Bureau of Health Planning and Development, Department of Human Services, and using the 1970 Census information, there are approximately 209,600 adolescents aged 10-19 in Maine:

*Chart Ic.* Estimated Population of Maine 1980

| AGE | MALE | FEMALE | TOTAL |
|---|---|---|---|
| 10-14 | 49,110 | 47,190 | 96,300 |
| 15-19 | 57,780 | 55,520 | 113,300 |
| Total | 106,890 | 102,710 | 209,600 |

It is conservatively estimated that 55,000 male and female adolescents in Maine are sexually active. Of this total, 12,000 girls are currently served by eight family planning programs around the State.

For teens, confidentiality is of supreme importance in seeking out family planning services. Cooperation between the private sector of physicians and the publicly funded family planning clinics would more adequately address the issue of availability and accessibility to family planning services for adolescents. However, many adolescents do not acknowledge

and confront their sexual behavior until long after they have initiated sexual activity. For many it is a highly emotional issue with which they cannot confront their families. It is, therefore, unlikely that they will go to a physician in their community or to clinics which are conspicuous in their location.

As with general health services, teenagers differ in their degree of mobility and transportation to family planning services and their level of motivation to seek out services. Motivation generally exists when there is a threat of pregnancy.

Public education on the availability of family planning services can promote prevention in the already sexually active female and male adolescents. Another easily identified target group for adolescent contraceptive services are those teenagers who are facing a repeat pregnancy. Contraceptives can help them avoid premature parenthood or a subsequent high risk pregnancy.

In the subsidized family planning clinic system, the major program in the State preventing pregnancies among sexually active adolescents, the extent to which teen clients successfully avoid unintended pregnancies is highly questionable. This is due to the nature of adolescent sexual activity and to the awkwardness of matching contraceptive services to their particular life styles. Furthermore, these clinics must reach out to thousands of adolescents who are sexually active but who are not receiving reproductive health services for any variety of reasons, e.g., inaccessibility, apprehension, ignorance, or fear.

The Task Force believes that a plan of action to strengthen services most responsive to adolescents at risk of unwanted pregnancies will remove many of the barriers to service that adolescents face.

## Maternity Care

### Problem Statement

Eligible women and adolescents in Maine who do not have the necessary income to purchase early and adequate prenatal health care are not provided with State and Federal income support and medical assistance.

### RECOMMENDATION

1.7 WE RECOMMEND THAT THE COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES ASSURE THAT INCOME MAINTENANCE AND MEDICAL ASSISTANCE BE REINSTATED FOR FIRST-TIME PREGNANT WOMEN WHO ARE OTHERWISE ELIGIBLE, IN AN EFFORT TO PROMOTE EARLY PRENATAL CARE.

IMMEDIATE ACTION

### Rationale

Significant improvements such as better nutrition and housing, increased economic status, and improved prenatal, obstetrical and pediatric care in Maine have contributed to a reduction in health hazards for mothers and babies. Yet, despite the progress over the years, infancy remains the most risky of all the developmental stages of life.

Low birthweight (e.g., under 2500 grams) and congenital disorders including birth defects are the two principal threats to infant survival. [1] In 1979, there were 851 live births (5%) under 2500 grams and 240 babies born with congenital anomalies (1.5%). *Chart Id, page 21.*

Given no prenatal care, a mother is three times as likely to have a low birthweight child. [2] Low birthweight is often associated with increased occurance of mental retardation, birth defects, growth and development problems, blindness, autism, cerebral palsy and epilepsy. [3] Of the known conditions accounting for low birthweight babies, three-fourths of the risks can be predicted in the first prenatal visit. [4] Many maternal factors are associated with low infant birth: lack of prenatal medical care, poor nutrition, smoking, alcohol and drug abuse, age (especially youth of the mother), social and economic background, and marital status. [5]

Of the resident live births in Maine, 2.4% (390) reportedly received no prenatal care. *Chart 1d.* According to 1977 data available from the National Center for Health Statistics, 20.9% of the pregnant women in Maine did not obtain prenatal care in their first trimester of pregnancy.

Early prenatal care, beginning at the point the woman knows she is pregnant and consisting of prenatal diagnosis, emotional and nutritional counseling, supplemental vitamins, information about maternal behavior and routine medical care, can augment the positive health outcome for mother and baby.

The Task Force feels that no one should be denied prenatal care for their inability to pay. In 1977, the past administration decided to discontinue Aid to Families with Dependent Children (AFDC) and subsequent Medicaid coverage to the woman who was pregnant for the first time. Once the baby is born, the eligible mother and child can receive AFDC and Medicaid.

The Commissioner of Human Services, by policy, could reinstate the AFDC coverage for pregnant women, but a legislative appropriation would be necessary for the State's share of income support. The Federal program would supply the remainder. The Task Force roughly estimates that $190,800 of State funds would be required combined with $595,200 of Federal dollars.

Problem Statement

There exists in Maine; a lack of public awareness of the importance of early prenatal care; a lack of awareness among some prenatal care providers of pregnant women at risk of pregnancy complication; insufficient financial resources for pregnancy related education; and a lack of and poor distribution of qualified educators.

RECOMMENDATION

1.8 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES COORDINATE AND MONITOR A PUBLIC EDUCATION CAMPAIGN INVOLVING NEWSPAPERS, RADIO, AND TELEVISION TO PROMOTE THE USE OF EARLY PRENATAL CARE, INCLUDING CHILD-

BIRTH AND PARENTHOOD EDUCATION, FAMILY PLANNING EDUCATION, NUTRITION AND BREASTFEEDING EDUCATION AND THE HARMFUL EFFECTS OF SUBSTANCE ABUSE DURING PREGNANCY.

SECOND PRIORITY

Rationale

The National Center for Health Statistics reported that approximately 3,397 women in Maine did not receive prenatal care in their first trimester in 1977. The Task Force established the need for early prenatal care in Recommendation 1.7. As a support to Recommendation 1.7, the Task Force feels that a mass media campaign on pregnancy related issues will influence women to seek early prenatal care.

Formal education programs that are school based reach a large proportion of the population, but students do not always internalize the information presented. The students' need regarding maternity cycle information may not be great enough to last into their childbearing years. Reaching the target population, of women seeking pregnancy and pregnant women, through the media will increase learning, and learning can bring about behavior change.

The printed form of the mass media has long been of value in transmitting information, and should not be overlooked in an educational campaign. However, various polls and studies indicate that the audio-visual communication systems have a greater impact on the general population. These branches of the media are present in most places where people gather, they are less formal, they are more conducive to repetition and reinforcement, and can be adapted to various learning abilities. The Department should utilize the expertise already developed by other interested groups. For example, the Blue Cross/Blue Shield Company, the March of Dimes and the Lung Association have been successful in creating spot announcements on health on television and radio. Public educational television utilizes some of its time to focus on health related issues. These and other appropriate resources should be encouraged to develop and distribute maternity cycle information, and to advertise the nonprofit groups which provide this type of education.

The program, as proposed, would have an impact on all pregnant women, but would focus on two sub-groups: those who need reinforcement of previous information, and those whose educational experience was either abbreviated or whose

frame of reference did not allow for adequate learning.

Based on similar projects, the Task Force estimates that approximately $85,000 would be necessary for an extensive campaign.

Problem Statement

Childbirth education, including natural childbirth and Caesarean preparation, parenting skills, child care, and child development, is provided to potential parents in Maine by a vast array of disassociated educators within varying degrees of training and expertise.

RECOMMENDATION

1.9 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSIST IN THE DEVELOPMENT OF A COMMITTEE OF CHILDBIRTH EDUCATORS AND OTHER SELECT PROFESSIONALS TO STUDY THE NEED FOR GUIDELINES FOR TRAINING EDUCATORS, CERTIFICATION OF PERINATAL EDUCATORS, AND STANDARDS FOR NEW AND EXISTING PERINATAL EDUCATION PROGRAMS, INCLUDING CHILDBIRTH, PARENTING, CHILD CARE AND CHILD DEVELOPMENT EDUCATION.

THE ASSISTANCE IN DEVELOPING A COMMITTEE ON PERINATAL EDUCATION SHALL BE PROVIDED IN THE FOLLOWING WAYS:

- BY SPONSORING A STATEWIDE CONFERENCE ON PERINATAL EDUCATION AT A CENTRAL GEOGRAPHICAL LOCATION IN 1981; AND
- BY PROVIDING STAFF ASSISTANCE AND OPERATING EXPENSES FOR A STATEWIDE COMMITTEE ON PERINATAL EDUCATION.

FIRST PRIORITY

Rationale

Currently, in Maine, expectant parents are either referred to childbirthing education classes by their doctor, hospital, or friend, or they are persuaded by advertising to select a specific educator. For the most part, the degree and quality of educators is outstanding for a group of individuals who are not professionaly trained, who do not receive more than minimal fees-for-service and who are not joined together by a professional organization or accreditation. Many of the educators are parents having nursing degrees or have been trained by a select group of qualified educators.

Of concern to the population of "para-professional" educators is the lack of and poor distribution of qualified educators, and the need to increase fees or develop additional resources to meet the ever-growing demand for their services. It is their feeling, and shared by the Task Force, that the concept of higher fees emphasizes the increased need to examine the qualifications of all childbirth educators. The potential for the "big business" approach to overshadow the traditional "living room" method of providing education on childbirth, parenting and child care, is an awesome fear expressed by many educators.

Childbirth, or more broadly, perinatal education can be very beneficial for preventing problems in pregnancy, labor and delivery. It can provide the expectant parent with invaluable information for an exciting and first-time pregnancy and childbirth experience. Parents can learn more about the types of birthing techniques, the bonding needs between the child and the parents, about the choices for breastfeeding, and the early stages of the development of the child. Perinatal education has been shown to prevent complications such as low birthweight babies, caesarean birth and toxemia of pregnancy and reduce future problems, such as child abuse and neglect. Incorrect information given out by untrained or poorly trained educators may be detrimental to expectant parents. The parents need to have an opportunity to determine which classes, and which instructor, is appropriate for them and can provide them the correct information.

The Task Force recommends that the Department sponsor a forum in which the educators from all over the State can gather to discuss and decide the important issues of their field. Currently, there is no mechanism to bring the educators together. The cost for the conference would be reimbursed to the Department through Conference fees. Staff assistance could be provided by existing staff within the Department, without requiring tremendous drain on their time and responsibilities. Operating costs for travel for a 15 member committee for one year would approximate $6,000, to be provided by a combination of state, federal and private dollars. Conference proceeds may be used to offset the cost of the forthcoming committee.

Problem Statement

The field of obstetrics is a rapidly changing and continuously developing field. Physicians and health professionals are in constant need of updated information and skills.

RECOMMENDATION

1.10 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE THAT FINANCIAL ASSISTANCE IS AVAILABLE FOR REGULARLY SCHEDULED SEMINARS IN THE FIELD OF OBSTETRICS TO CONTINUOUSLY UPDATE THE EXPERTISE OF PROFESSIONALS PROVIDING PRENATAL CARE.

SECOND PRIORITY

Rationale

Obstetrical care in Maine is provided by physicians and allied health professionals (e.g., nurses, midwives, etc.) with varying degrees of skill and experience in obstetrics.

Seventy-five percent of the State of Maine is rural. The physical remoteness of some areas, and the cost of travel often limit a practitioner's ability to participate in meaningful continuing education. A broad based educational program would encompass a large range of subject areas, and bring education to the individual in a convenient, non-stressful environment. It is hoped that the practitioner will be encouraged to utilize this opportunity in improving his or her practice.

At present, the State has a minimum level of continuing education units (CEU) for physician licensing, but does not deal with the problem of CEU's in specific fields or educational update for the allied health professional. A family physician may have an adequate number of CEU's for licensure, but no education in obstetrics. This recommendation would help to assure that those delivering prenatal care, maternity care and obstetrical care, are continuously updating their training in the advances of obstetrical care including nutrition, bonding, breastfeeding, and the effects of alcohol and substance abuse during pregnancy.

It is estimated that the cost of consultants, and audio-visual equipment and tapes would be approximately $50,000 obtained from a variety of federal, state and private sources.

Problem Statement

The traditional operating room setting for the hospital based birthing experience is under scrutiny for non-complicated births, as evidenced by:

- the number of parents who choose non-hospital births;
- the waiting lists for the existing hospital based alternative birthing rooms; and
- the increasing demand for alternatives and the expression of dissatisfaction by the purchasing public.

RECOMMENDATION

1.11 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ENCOURAGE HOSPITALS WITH OBSTETRIC SERVICES TO PROVIDE A BIRTHING EXPERIENCE THAT IS BOTH SAFE AND SATISFYING FOR THE PARENTS AND CHILD AND PROMOTES PARENT-CHILD BONDING AND BREASTFEEDING.

SECOND PRIORITY

Rationale

This recommendation does not attempt to resolve the issue of the risks involved in non-hospital births versus hospital based births. Nor does it address the group of expectant parents who choose home-based and alternative birthing locations, regardless of the availability of alternatives at the hospital. The Task Force does recognize, however, the increasing patient demand for an alternative birthing experience in the hospital.

In addition, the Task Force has concern for the non-hospital birthing environment that does not provide immediate access to specialized maternal and newborn care. Approximately 20% of women experience some complication during labor, but nearly 50% of high risk babies come unexpectedly from healthy low risk pregnancies, making prediction of birthing complications difficult.

Tremendous advances have been made in neonatal care in this century. A discussion of essential services, as a result, has changed drastically, and now includes such issues as bonding and psychological health. One hundred years ago the discussion would have centered around infection and handwashing. Today, however, if the child is healthy and at low risk for

medical complications, it has easily met needs. The child's psychological needs become of prime importance. In this regard, certain consumer groups are stressing the importance of:

- the mother being relaxed, awake, and aware of what is going on during delivery;
- the mother having prolonged contact with her baby immediately after delivery;
- the father being involved; and
- the delivery being more home-like and less of an "operating room" environment.

Data from the Maine Division of Vital Records show that in 1970 there were 3.6 live home births for every 1,000 births, and in 1978 there were 15.8 home births for every 1,000 births. In 1979, 1.6% or 264 live births occurred outside of the hospital. *Chart Ic, page 21.*

The Task Force conducted a survey of 52 Maine physicians who deliver babies which revealed that 62% of them felt that homebirths are increasing. In addition, the 52 physicians polled felt that home births pose a medical problem for the mother and baby.

A solution to the demand for alternatives is to encourage hospitals providing obstetrical services to create an environment which is more home-like and promotes a change in the attitudes and practices of hospital staff and personnel. Although physical alterations in the hospital setting can be an impetus, it is more essential to create a psychological environment in which the family unit is to have available, at a moments notice, all the skills of modern medicine. This solution allows the best of both worlds.

The increasing complexity of diagnostic and therapeutic technologies has markedly increased the cost of health care. Health care institutions are initiating cost-effectiveness studies. The Task Force recommends that the initiatives in this regard be encouraged. Specifically, studies of the child bearing experience show that the standard admission procedure should be evaluated in relationship to the risk factors of family units. Early discharge and coordination with community based services for appropriatelu screened patients could result in a decrease in high cost of maternity care.

The Task Force estimates that the cost of developing birthing rooms will be a minimal expense to hospitals and will require, at the most, some redecorating costs.

Maternity Care Charts

*Chart Id.*

Resident Live Births By Selected Characteristics: 1979

| | Total Live Births | Out-of Wedlock | Under 2500 Grams | Congenital Anomalies | Mother under Age 20 |
|---|---|---|---|---|---|
| Maine Total | 16,435 | 2,083 | 851 | 240 | 2,441 |

| | No Prenatal Care | Not Born in Hospital |
|---|---|---|
| Maine Total | 390 | 264 |

Source: Division of Research and Vital Records, DHS.

*Chart Ie.*

Out-of Hospital Births 1970-1979

| YEAR | TOTAL BIRTHS | TOTAL BIRTHS OUT OF HOSPITAL | #/1000 |
|---|---|---|---|
| 1970 | 17837 | 65 | 3.6/1000 |
| 1971 | 17850 | 78 | 4.4/1000 |
| 1972 | 16269 | 67 | 4.1/1000 |
| 1973 | 15730 | 74 | 4.7/1000 |
| 1974 | 15110 | 72 | 4.8/1000 |
| 1975 | 15232 | 65 | 4.3/1000 |
| 1976 | 15046 | 84 | 5.6/1000 |
| 1977 | 16252 | 110 | 6.8/1000 |
| 1978 | 15919 | 251 | 15.8/1000 |
| 1979 | 16435 | 264 | 16.1/1000 |

Source: Division of Research and Vital Records, DHS.

## Newborn Care

### Problem Statement

The staff in small rural hospitals and non-hospital baby deliverers do not perform resuscitation often enough to maintain current and efficient resuscitation skills.

### RECOMMENDATION

1.12 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE THAT FINANCIAL SUPPORT IS AVAILABLE FOR CONTINUING EDUCATION OF BABY DELIVERERS REGARDING THE ADVANCES IN RESUSCITATION AND EARLY ACUTE CARE AND THAT SUCH CONTINUING EDUCATION BE REQUIRED IN ALL HOSPITALS WITH OBSTETRICAL SERVICES.

SECOND PRIORITY

### Rationale

Small hospitals deliver a significant percentage of Maine's babies, and in these settings, the high risk infant comes along infrequently. Skills exist to reduce the problems that can develop in these high risk situations, e.g., brain damage and death. These skills are utilized more frequently in the larger hospitals. The people who deliver babies outside of the hospital, and who care for infants in the smaller hospitals, should have repeated and frequent education in these skills so that they can respond to the occasional emergency in the best possible way, manage the sick infant in the first few minutes and, if necessary, send the infant off to specialized care. These skills are collectively known as newborn resuscitation, a form of cardio-pulmonary resuscitation (CPR).

A further support for the need of improving these skills in Maine's hospitals comes from the neonatal mortality statistics. As the number of babies who die decreases, the most common causes of death also changes. One of the causes that still remains is asphysia neonatoru, i.e., an infant who had not been resuscitated who could have been.

In 1973, 33% of the total neonatal deaths in the state were live born

babies unable to be resuscitated (died in less than 4 hours). In 1978, although there were fewer babies in this group, there still were 18 babies (33% of total deaths) who died because of this failure of resuscitation. *Chart I f*. In addition, the percent of babies dying in Maine with asphysia on their death certificates has increased from 11.8% of total neonatal deaths in 1973 to 14.8% in 1978. *Chart I g, page 25.*

The Task Force recommends that the financing of the education be through the Department of Human Services and provided directly by the regional network of neonatal nurseries. The approximate cost of training would be $45,000.

Problem Statement

Many of Maine's babies are born in small, rural hospitals or in hospitals that do not have intensive care facilities for newborns. Fifty percent of the high risk babies come unexpectedly from healthy, low risk pregnancies. The financial cost of long term convalescent care in a Level III hospital (e.g., neonatal intensive care unit) and the psychological cost of long term family and newborn separation is a problem for many Maine families.

RECOMMENDATION

1.13 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES SHALL ADVOCATE FOR A CHANGE IN THE THIRD PARTY PAYMENT MECHANISM TO ASSURE MORE ADEQUATE NEONATAL TRANSPORT FOR ALL MAINE CITIZENS REGARDLESS OF FINANCIAL STATUS OR GEOGRAPHIC LOCATION.

SECOND PRIORITY

Rationale

Access to specialized neonatal care is important in reducing neonatal mortality and morbidity. Because Maine is a large rural state, the specialized care services are centralized (i.e., in regional locations), and babies who need these services often require transportation to a central neonatal unit. The cost of the special care is covered by third party payers. The transport to and from this special care is not adequately provided for and the cost of it is not covered by many of the third party payers.

The 1980-81 Maine State Health Plan calls for Level II nurseries to develop transport services for the State. These services should be monitored by the State. The Department of Human Services should also work with third party payers to see that all Maine citizens have equal access to transportation to special neonatal services.

The convalescent transport or return trip from the nursery is also important. The convalescent babies cannot "pile up" in the special care nurseries using all of the available beds. At times there is not room for a sick baby in the specialized nursery. It is in the general population's best interest that the convalescent babies be quickly and efficiently returned to their home hospitals.

Convalescent transport is also important to the individual baby-parent unit. The psychological trauma of separation at this time in life and the disruption of bonding is best kept to a minimum.

The Task Force determined that a total of $9,000 would pay for ALL neonatal transport.

Newborn Care Charts

*Chart 1f.*

NEONATAL DEATHS <4 HOURS

| YEAR | NEONATAL DEATHS | UNABLE TO RESUSCITATE | % |
|---|---|---|---|
| 1978 | 54 | 18 | 33% |
| 1977 | 64 | 21 | 33% |
| 1976 | 69 | 21 | 30% |
| 1975 | 82 | 25 | 30% |
| 1974 | 111 | 27 | 24% |
| 1973 | 101 | 33 | 33% |

Source: Neonatal Intensive Care Unit, MMC.

*Chart 1g.*

DEATH CERTIFICATE WITH ASPHYXIA AS DIAGNOSIS

| YEAR | ASPHYXIA AS DX | TOTAL DEATHS | % |
|---|---|---|---|
| 1978 | 8 | 54 | 14.8 |
| 1977 | 7 | 64 | 10.9 |
| 1976 | 11 | 69 | 15.9 |
| 1975 | -- | 82 | -- |
| 1974 | 9 | 111 | 8.1 |
| 1973 | 12 | 101 | 11.8 |

Source: Neonatal Intensive Care Unit, MMC.

## Section I. Footnotes

1. Healthy People. The Surgeon General's Report on Health Promotion and Disease Prevention, 1979. U.S.D.H.E.W. Public Health Service Publication No. 79-55071. Pg.85

2. Ibid. Pg. 86.

3. Ibid. Pg. 21.

4. Ibid. Pg. 24.

5. Ibid. Pg. 24.

6. "Fact's 80", March of Dimes.

7. Op.Cit. Pg. 24.

Section II Children

Health Maintenance

Health Education

Accident Prevention

Mental Health

Children with Special Needs and Handicapping Conditions

Families with the Problem of Child Abuse and Neglect

Dental Health

## Section II. Children

### Introduction

The Task Force believes that the health of the parent intimately influences the health of the child. The parents' behavior, their emotional stability and the physical environment of the home can make the difference between a healthy child and a child with problems.

Efforts at early child health supervision and screening to discover health and health related problems (e.g., physical, emotional, dental) combined with the early identification of handicapping conditions and intervention for children with special needs are all necessary to promote the health of the children.

Once health problems are identified, early treatment and the alleviation of adverse conditions in the family that lead to child abuse and neglect must occur, so that the child's health can be maintained. In addition, the Task Force feels that the unfortunate toll of child deaths and injuries due to accidents can be avoided through single preventive measures undertaken by the family and community on behalf of the child.

Increased public education and awareness of those factors that most affect the child's health are the bases for the following recommendations.

# Health Maintenance

## Problem Statement

A substantial number of Maine's children, particularly among the poor and rural population, are not effectively reached by presently available health maintenance services. Presently available services often do not focus upon psychosocial, environmental, and developmental determinants of health.

## RECOMMENDATIONS

2.1 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DESIGNATE AN OFFICE WITHIN THE DEPARTMENT THAT IS MANDATED TO SET STANDARDS FOR CHILD HEALTH SUPERVISION; TO DETERMINE APPROPRIATE SCREENING TECHNIQUES; TO COORDINATE SCREENING EFFORTS; TO COLLECT DATA REGARDING CHILDREN'S SERVICES; TO SET GOALS; AND TO EVALUATE EFFORTS IN THIS AREA BASED UPON A BROAD DEFINITION OF HEALTH.

SECOND PRIORITY

2.2 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES INVESTIGATE MEANS OF ESTABLISHING A NETWORK OF HOME HEALTH VISITORS WITHIN THE STATE AIMED AT REACHING ALL CHILDREN WITHIN PARTICULAR LOCALITIES.

IMMEDIATE ACTION

## Rationale

### HEALTH MAINTENANCE

This recommendation recognizes the changing pattern of health problems of children in Maine. Traditionally, medical and organic diseases and conditions have been of utmost concern to the community of physicians, nurses and health practitioners seeking to reduce child mortality and childhood morbidity. Recently, greater emphasis has been placed upon the psychosocial, developmental and environmental aspects of child health. These determinants of health have become very important in defining the overall health status of children. Involvement in areas such as improved parenting skills, guidance

in child development, promotion of mother-child attachment behavior, health education in safety and nutrition and anticipatory guidance in childhood behavior are, today, more applicable to the prevention of health problems in children. We feel that early identification and intervention in these areas can effectively promote cognitive development in children, lessen the chance of child abuse and lower the accident injury rate for children, among other things. We further believe that the well child care system is the primary and most universal vehicle available to bring such information and intervention to families early in the lives of their children and at a time when that intervention will be most useful.

SCREENING

The concept of screening involves the application of specific tests to a population in an attempt to identify diseases or abnormal conditions at an early stage so as to be able to more effectively treat those conditions. Screening programs have most often been directed at detection of specific diseases (e.g., testing for PKU, urine screening for diabetes, or skin testing for TB). Recently, screening procedures have been developed for the early detection of environmentally based problems of a developmental or social nature. For example, tools now exist to detect abnormalities of the mother-infant relationship at an early stage, thus defining a group at high risk for later child abuse. In spite of available tools, however, these newer types of screening are not yet widely used.

There is little consensus in Maine as to what constitutes adequate health supervision and screening. The Health Assessment Standards 0-20 (HAS), published by the Division of Public Health Nursing are directed at existing services such as: EPSDT (Early Periodic Screening Diagnosis and Treatment of Medicaid eligible children), Head Start programs, School Health Programs, handicapped children served by the Division of Public Health Nursing, and Title V Preschool Clinics. The HAS is based on recommendations of the American Academy of Pediatrics, as applied to Maine. The Division of Public Health Nursing has the mandated responsibility to establish standards for community nursing services in communicable diseases, school health screening and programs for promoting the health of mothers and children. Although the HAS may be used by some physicians in private practice, the standards are not viewed by the Task Force as an overall policy statement from the Department regarding health supervision.

Screening for health problems occurs in a variety of settings. Most health supervision activities occur in physicians' offices. Health maintenance services are also delivered through the Public Health Nurses' child health conferences. These include screening services, health education, immunizations and referral for treatment. Medical screening of children covered under Medicaid is mandated by the EPSDT legislation. These programs are generally administered at the local level through community health agencies. In some cases, there is inadequate follow-up on problems discovered at screening, leading to insufficient treatment.

The content of health supervision visits for children is often limited to a search for the physical disease. We believe that this is an inefficient screening method for the most common health problems of childhood. Studies applicable to Maine indicate that the physical examination in the physician's office tends to be brief (10 minutes) and fairly stereotyped in style and content. It is typically focused on medical-physical concerns and the detection of organic diseases. It has been demonstrated that the physical examination has a fairly low yield in terms of detecting diseases in well children and that such services seem to have little effect on health outcomes as measured in terms of reduced mortality or morbidity.

However, many physicians, especially the newly trained pediatricians, can offer in an office setting the comprehensive services not limited to traditional medical care. This has always been the most efficient and least expensive way to deliver care and emphasizes to the patient and the family the concept of a medical home. A multitude of services can be initiated in the "medical home" and duplication or inappropriate referrals of service can be avoided as a result.

DATA

There is little or no data to indicate what proportion of children in Maine receive adequate child health maintenance services, from what source, or to estimate the comprehensiveness of the services received. There is no data specific to Maine regarding the content of health supervision visits to physicians' offices. There is inadequate information as to the overall health status of the children in the State. A recent immunization survey, although an important survey, provided only one general indicator of health status. The pediatrician/child population ratio has been estimated for the State and found not to meet existing national standards. The ratio would,

however, suggest that there are many under-served children, particularly in poor urban and rural areas. Studies outside of the State show that 10-20 percent of the population in a community do not relate to traditional health services due to conflicting priorities, lack of awareness of services, motivation, belief systems, and barriers to obtaining services. It is reasonable to assume that this also applies to Maine, although no specific data is available.

The data obtained from screening must be followed up or else it is useless. One of the problems with the EPSDT program has been the difficulty in assuring that abnormalities detected through screening are followed up. This is especially true of the child who becomes ineligible for Medicaid during the screening process. One way to promote follow-up is to incorporate the screening process into a comprehensive clinical setting where the other health supervision services are delivered. Screening should be cost effective. An evaluation component must be built into any screening program to ensure its continuing effectiveness.

HOME HEALTH VISITOR

The concept of a home health visitor is a combination of an innovative idea and the broadening of health maintenance responsibilities and activities on the part of many existing health care providers and agencies. The primary purpose of the home health visitor is to ensure that children have access to appropriate health care services (e.g., prevention and treatment) at an early age.

The Task Force recommends that the Department provide funding for several demonstration projects throughout the State. The Task Force is not proposing any specific model or program. Rather, we suggest that individual communities and locales can determine the most effective way to deliver health visiting services. The Task Force is aware that home visiting services may currently be provided by a variety of health and social service agencies and health practitioners including:

(a) private physicians with home visitors for newborns;

(b) outreach workers for EPSDT (Early Periodic Screening Diagnosis and Treatment);

(c) public health nurses, including staff of the Division of Public Health Nursing and of municipal and community agencies;

(d) homemaker-home health aides;

(e) home visiting performed by day care centers, Headstart programs, and programs for children with special needs; and

(f) home visiting by various extension agencies, social service programs and State Department Staff (DHS, DMHC, DECS) performing assessment functions, determining eligibility for services and providing therapeutic treatment.

Home health visiting programs have been widely used and have been successful in other parts of the country (i.e., Michigan, New York) and in other countries (i.e., Scotland, Holland).

The purpose of the Task Force's recommendation is to provide specific incentives for the development and/or expansion of health visiting services in a limited number of communities throughout the State. The Task Force's proposal is not intended to duplicate the services that are already being provided by public health nurses and others in many areas. Rather, the recommendation proposes a redefinition of well-child screening services and an expansion of the types of health personnel that can deliver these services.

The Task Force recommends that the Department entertain proposals to develop or expand home health visiting services in limited geographic areas of the State. Local health care providers, including physicians, community health agencies and/or public health nursing programs should be encouraged to develop proposals. Proposals should document the need for such a program in the area, and existing resources in the area, and should specify methods that will be used to develop the assessment and screening by and the coordination of funds for the home health visitors.

The Task Force recommends the following features be reflected in proposals for home health visiting:

1. The home health visitor would be a person of at least high school education.

2. Intensive supervision would be provided by a skilled and qualified health professional (i.e., physician, nurse, etc.).

3. Training for the home visiting staff would include or specify a particular course of training in areas such as child development, nutrition, accident prevention, assessment of parent-child interactions, basic parenting skills, preventive mental health, family emotional support and child advocacy.

4. The function of the home visiting program would be:
   (a) to bring children into the health system,
   (b) to assess family function, parent-child relationship, and developmental status of the child,
   (c) to provide health education and information,

(d) to teach parenting skills, child care and child development,

(e) to provide primary home-based preventive mental health services and emotional support,

(f) to act as family advocate within the health care system,

(g) to provide a liason with available health and health related resources.

5. The local agency administering the program would be responsible for specific program design and effective linkages of the program to other health agencies and providers.

The home visiting program as recommended, would be completely voluntary and would not be forced on any family against their wishes. All families would be offered supportive home services. They could choose to use the service when offered or avail themselves of it at a later time. The extent of involvement of the visiting service would range from minimal to considerable, depending upon the needs and desires of each family. The fact that the service is offered to all children in an area removes the potential stigma attached to programs just for the poor, those guilty of poor parenting or the mentally ill, etc.

The concept of a supportive home visitor is appropriate to our modern society with its pressures upon the family, including:

- a tendency toward single parent families, primarily due to an increasing divorce rate;
- the young age of parents;
- lack of extended family support systems; and
- isolation of the family within the community.

A major group of child health problems including accidents, poor nutrition, child abuse and neglect, school failure, mental health problems and delayed development, all have their origins in infancy and early childhood and are best managed by primary prevention. If not prevented, the later costs to the child, the family and society are high. Early and timely identification of real or potential problems is essential if intervention is to be effective in preventing disability. There is presently no effective way to predict at birth which children will develop these problems later on. The only effective screening system would be to assess the health needs of all children.

Presently available services often do not focus upon psychosocial, environmental, and development determinants of health. In addition, families often fail to consider such determinants when deciding whether to seek services.

Due to the nature of Recommendations 2.1 and 2.2, the Task Force was unable to determine the cost of the health maintenance program.

# Health Education

## Problem Statement

Children, without the knowledge of how their bodies function and how to keep them healthy, develop poor health habits and behaviors which are detrimental to their health and well-being.

## RECOMMENDATIONS

2.3(A) WE RECOMMEND THAT THE DEPARTMENT OF EDUCATIONAL AND CULTURAL REQUIRE THAT HEALTH EDUCATION BECOME A MANDATED PART OF THE PUBLIC SCHOOL CURRICULUM FROM K-12, AND THAT THIS EDUCATION SHALL EMPHASIZE LIFE STYLES AND ACTIVITIES THAT WILL HAVE A LONG-TERM EFFECT ON THE HEALTH AND HEALTH RELATED BEHAVIOR OF CHILDREN. THE CONTENT OF THE HEALTH EDUCATION COURSES SHOULD BE DECIDED BY LOCAL EDUCATIONAL BODIES. CURRICULUM SHOULD INCLUDE COVERAGE OF AT LEAST, BUT NOT LIMITED TO, THE FOLLOWING TOPICS AND BE PRESENTED IN A FORMAT APPROPRIATE TO THE AGE AND GRADE LEVEL OF THE CHILD:

- CHILD GROWTH AND DEVELOPMENT
- NUTRITION
- DENTAL HEALTH
- MENTAL HEALTH
- HEALTH CARE CONSUMER SKILLS
- FIRST AID INCLUDING CARDIOPULMONARY RESUSCITATION
- HARMFUL EFFECTS OF SUBSTANCE ABUSE, INCLUDING ALCOHOL, DRUGS AND TOBACCO
- HUMAN SEXUALITY AND REPRODUCTION
- PARENTING SKILLS

IMMEDIATE ACTION

2.3(B) WE RECOMMEND THAT THE UNIVERSITY OF MAINE DEVELOP A DEGREE PROGRAM AND COURSES FOR CONTINUING EDUCATION UNITS IN HEALTH EDUCATION SO THAT TEACHERS OF HEALTH CURRICULA ARE WELL QUALIFIED AND TRAINED. WE RECOMMEND THAT THE DEPARTMENT OF EDUCATION AND CULTURAL SERVICES DEVELOP A SEPARATE CERTIFICATION FOR HEALTH EDUCATION WHICH WOULD BE REQUIRED TO TEACH HEALTH.

SECOND PRIORITY

Rationale

Health education which provides children with adequate information relating to the development of health habits, life-styles and behaviors which are advantageous to their health is not routinely part of public school education. Nor is there appropriate training and certification in comprehensive health education available for educators who teach health. Although there have been some exemplary programs developed in several school districts across the state, not all children have access to the information they need to learn how to become healthy and stay healthy, or gain access to health and related services when they need them.

The Task Force recognizes that some children receive adequate education on health issues in the home. For those children, the health education curriculum will serve as a supplement to or reinforcement of their home learning. For other children who do not have access to adequate information from parents and families, the school curricula will provide them with a base of knowledge which will assist them in making responsible decisions regarding their health and well-being.

Changing lifestyles, including the increasing divorce rate, availability of drugs and alcohol, poor nutritional habits, and lack of exercise often have a detrimental effect on the physical health and emotional well-being of children. Much of the focus of current physical education curricula is on team sports in which the adult will no longer participate. A physical education course which teaches the child to continue physical activities and to stay fit will result in a healthier individual.

Recommendation 2.3 (A) proposes that all children be given the opportunity to participate in comprehensive health education programs over the twelve years they are in school. Programs at each grade level should be developed to provide information appropriate to the age level of the children and in a manner consistent with their ability to learn. Mechanisms for providing health education may be varied, including classroom instruction, field trips, development of resource materials, utilization of professionals in the field as resource people, and peer counseling for sharing factual information particularly at the junior-senior high level.

In adolescence, the peer group is of prime importance. Peer pressure can be used to enlist the interest and cooperation of adolescents, in order to most effectively prevent poor health and behavior that lead to serious injury and disabilities. As evidenced by the leading cause of death and injury to adolescents (i.e., motor vehicle accidents), reckless behavior and substance abuse are major problems. *See Recommendation 2.6 Rationale.*

Adolescents are not interested in preventive health care. They will be interested, however, in what will improve their body image. "Very few among them are going to get excited about nutrition as a factor in iron deficiency anemia and its sequelae of low energy and high proneness to infections. But give them solid information about which foods are likely to leave them scrawny or make them fat, or contribute to a clear complexion, or sound, good-looking teeth, and they will listen, absorb and act upon it. They will pour time and effort unstintingly into learning what they want to know, and into any task of personal hygiene that promises to make them more pleasing to themselves and more attractive to their friends." [1]

In order for health education to become a meaningful part of education, teachers must have adequate and appropriate training in the field of health education if they are to be effective health teachers. The University of Maine at Farmington offers a degree program in Community Health Education. A University brochure states that, "this program is designed for persons expecting to work in community settings as health educators." It goes on to state that, "the student in community health education will develop competence in first aid, patient education, preventive health care, health planning, health promotion, self care, community organization, environmental health and public health education methods." While it further states that graduates would be employable at school health offices as well as many other settings, it does not specifically address the education of teachers to provide good health education for children. Recommendation 2.3 (B) recognizes that one way of assuring minimum standards in the provision of health education is to require teachers to be certified in the area they will be teaching. Certification assures that a teacher has had basic instruction in the curriculum areas and in methods for teaching the information to children.

The Task Force estimates that implementation of the health education curriculum would cost each school $20,000 in personnel and operating expenses. The estimated resources required by the University system in the development of a degree program is $150,000.

# Accident Prevention

## Problem Statement

Accidents are the leading cause of death among children age 1-19, in Maine. There does not exist a coordinated, comprehensive statewide Accident Prevention Program.

## RECOMMENDATIONS

2.4(A) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES REVISE THE INFORMATION REQUIRED ON DEATH CERTIFICATES SO THAT APPROPRIATE STATISTICS CAN BE COLLECTED AS TO THE CAUSES OF ACCIDENTAL DEATHS, THE PLACE OF INJURY, AGE OF VICTIM AND THE RESULTANT MORTALITY INCLUDING SECONDARY CAUSES OF DEATH.

FIRST PRIORITY

2.4(B) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DEVELOP A METHOD TO COLLECT STATISTICS FROM EMERGENCY ROOMS ABOUT THE CAUSES OF ACCIDENTAL INJURY AND DEATH AMONG CHILDREN UP TO AGE 18, THE PLACE OF INJURY, THE RESULTANT MORBIDITY OR MORTALITY DUE TO THE ACCIDENT AND THE AGE OF THE VICTIM.

SECOND PRIORITY

## Rationale

Accidents are the leading cause of death among children in Maine. During the past ten years in Maine, 1310 children between the ages of 1-19 have died as a result of an accident. This averages to 131 children who died every year.

Fire is the number one killer of children under the age of five. However, by the age of six and throughout childhood to age nineteen, motor vehicle accidents kill more children than any other cause including illness and disease.

Twenty to thirty years ago it was appropriate to arm our children with defenses against disease and to develop programs that contributed to the

reduction of death and handicapping conditions from sickness. The prevention of disease must continue and immunization is still a keystone to our protection of childhood illness. However, we feel that the time has come to divert some of our resources to the prevention of accidents in the home, on the street and in places where children gather, to prevent the maiming and killing of our children. The data from the last decade provides us with only broad target areas. We must develop a plan for the reduction of child death and injury due to the accidents most prevalent here in Maine.

From 1970 to 1980, 162 children died as a result of fire and flames. Of these, 71 children were under the age of 5, 72 children were between 5 and 14 years of age and 19 were between age 15 and 19. During the last decade, motor vehicle accidents took the lives of 182 children, ages 5-14 and 514 adolescents, ages 15-19.

In a single year, 1979, the number of adolescents ages 15-19 who died as a result of motor vehicle accidents (60), equaled the total number of children all ages (63) who died that year from causes other than accidents, i.e., disease, infections, suicide and assault. An additional 19 children between 5-14 and 4 children under the age of five died in motor vehicle accidents in 1979, for a total of 83 child-deaths.

Although the numbers seem small, it is significant to note the death rates for children due to accidents. For example, based on average death rates for 1974-1977, approximately 49 adolescents (15-19) in every 100,000 adolescents died from motor vehicle accidents. The death rate for the entire population (all ages) due to motor vehicle accidents for 1976 was only 20.8 and for 1977 only 18.2 per 100,000 population. Teenagers (15-19) died as a result of all accidents at the rate of approximately 64 teens per 100,000 adolescents. Children between the ages of 5-14 died as a result of all accidents at a rate of more than 18 children per 100,000 in that age category and preschoolers died at a rate of nearly 27 per 100,000 children ages 1-4. Fire and flames killed more than 10 preschoolers for every 100,000 children between the ages of 1-4.

There is no escaping the fact that accidents kill more children than any other cause, and children are killed by accidents at a rate greater than any other population group.

An even greater number of children are injured by accidents. We do not know from the data available the total number of children injured but,

we do know:

- At least 4,441 children were injured in motor vehicle accidents in 1979, ages 0-19.

- In one year from June 1977-July1978, the Poison Control Center in Portland received 2,672 poisoning calls, in addition to 100 cases treated in hospital emergency rooms for a total of 2,772 children up to age 19 who were in some way involved in poisoning.

- Using the incidence of injuries obtained from the National Health Interview Survey for 1977, the number of persons injured in accidents in Maine under age 5, is 33,350. Of these, 540 injuries were sustained during a motor vehicle accident, 24,560 were in the home and 8,650 happened elsewhere. For children ages 5-14, 79,240 injuries were a result of accidents of all types. Motor vehicle accidents were the cause of 3,060; 35,030 happened in the home; and 42,300 occurred some place else.

The traditional maternal and child health system in Maine has not viewed accidents and the prevention of accidents among children as a top priority. Statistical information on accidents is gathered by a number of different sources. However, no one person brings all the information together in one place for the purpose of planning a comprehensive Accident Prevention Program. Compilation of data using the current sources is both cumbersome and time consuming and therefore subject to misinterpretation.

The number of deaths, age of the victim and the underlying causes are available from the death certificate as reported to the Department of Human Services. However, two problems exist that complicate the use of pertinent information from death certificates in the planning of a comprehensive primary prevention program.

First, not all information on death certificates is processed. We do not know, for example, what were the secondary causes of death and consequently, how that would influence the planning of an accident prevention program.

Second, to collect data on accidents as a cause of death, death certificates would have to be revised. We do not currently collect information on death certificates about the cause of the accident. We do know the general location of the accident both geographically and by place, i.e., home, farm, street, office, factory, etc. However, material available for this report did not show the location of the accident computed by the age of the victim. Consequently, we do not know where children are most often killed by accidents.

Determining the cause of accidents is a complex issue. The death certificate is the most central reporting mechanism for death-related information,

but injury sustained as a result of an accident would have to be collected elsewhere. At this time, data collection on accidents occurs in a variety of places without any centralized planning. For example:

- The number and age of persons injured from motor vehicles can be obtained from the Maine State Police, Traffic Accident Summaries.
- The Department of Transportation collects similar data.
- The State Fire Marshall is now able to collect the number of fire "incident related" injuries and fatalities.
- Patient-related information on burn injuries is collected by the Burn Center at the Maine Medical Center in Portland.
- A forthcoming study by the New England Regional Burn Program of the Shrine Institute will provide helpful statistics on Maine's burn victims.
- The Maine Poison Control Center can provide data on the number of calls regarding poisoning of children and the number of poison related cases treated at hospital emergency rooms.
- The Division of Research and Vital Records of the Department of Human Services collects accident related data for the purpose of reporting annual Maine Vital Statistics. The statistical information is available for planning and program development on request.
- Other efforts at data collection and information gathering involves the Bureau of Health Planning, the Division of Child Health, Health Systems Agency and project efforts such as the Emergency Medical Services Program.

Detailed information on accidents including drowning, falls, or inhalation accidents is not centrally collected or readily available.

The Task Force believes that the most appropriate and timely collection of accident information including the cause of the accident should occur in the hospital emergency room.

Due to the nature of activities that occur in the emergency room and the staffing and resource limitations of many small or overworked emergency rooms in Maine, data collection is a difficult and complicated issue. Also many minor injuries are treated in the doctor's office.

Some obvious difficulties with collecting emergency room data on accidents include: (1) the information will not necessarily be collected during admission in the emergency room if the person's life is at stake; (2) often the handwriting is illegible; (3) some hospitals have no Medical Records Division; and (4) if the patient is not admitted to the hospital or transferred to another location,

tracking becomes difficult.

As the current system exists, if a person from an agency, other than the hospital, retrieved the information it would necessitate reviewing complete client records. Confidentiality for the patient and for the hospital would have to be considered. Persons needing to be involved in the discussion of appropriate methodology of collecting accident data are: Maine Hospital Association, Maine Records Association and already existing data collection efforts.

The cooperation of the hospital and the emergency room staff would be imperative in the success of data collection and distribution of data in a statewide Accident Prevention Program.

The development of a method to collect information data in emergency rooms can be performed by existing staff. The cost of processing new data from death certificates is estimated at $16,500, including personnel and training in multiple cause coding.

Problem Statement

Fires and flames kill more children under the age of five than any other cause of death.

RECOMMENDATIONS

2.5(A) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES BE INVOLVED IN THE SUPPORT AND PASSAGE OF LEGISLATION REQUIRING EARLY WARNING FIRE DETECTION SYSTEMS IN RESIDENTIAL BUILDINGS.

FIRST PRIORITY

2.5(B) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES JOIN WITH THE FIRE MARSHAL'S OFFICE IN A MEANINGFUL PROGRAM OF PUBLIC EDUCATION AND INFORMATION ABOUT FIRE PREVENTION.

SECOND PRIORITY

Rationale

The most helpless of our children, those under the age of five, are killed by fires more than any other type of accident. With the exception of infants, children are killed by accidents more than any other cause of death. Sixteen (16) children under the age of five died as a result of accidents in 1979. During the last decade 236 children less than five years of age were fatal victims of accidents. An additional, untold number of children are injured and hurt as a result of fires. Current data sources do not reveal the number of injuries sustained during fires. The State Fire Marshal's office has developed this data capability, but accurate, current information is not available at this time.

During the last decade, 1970 to 1980, 162 children up to age nineteen died as a result of fire and flames. Of the child deaths due to fire (1970-1980) there were:

| Less than Age 5 | Age 5-14 | Age 15-19 |
|---|---|---|
| 71 | 72 | 19 |

The annualized death rate for 1974-1977 among children ages 1-4 was in excess of ten (10) children per 100,000 preschoolers in Maine.
In 1979 child deaths due to fire were:

| Total up to age 19 | Less than age 5 | Age 5-14 | Age 15-19 |
|---|---|---|---|
| 15 | 7 | 6 | 2 |

During a three year period, 1974-1977, the most predominant causes of fires were misuse of wood stoves and faulty oil burners and gas heaters. In a state where heating one's home sufficiently is both expensive and unavoidable, this data is not surprising. Contrary to every parent's fear, however, only two children died as a result of a fire caused by playing with matches. There were eight undetermined causes of fires during this same time period, one mattress fire and one fire started in an over-stuffed chair. The total fire deaths in the three year period among children up to the age of nineteen were forty-two (42) deaths in nineteen (19) individual fires. Even with this low number of fires per year, Maine is tied with the State of Georgia for number 10 of the top 10 in fire death rates nationwide. We have the highest fire death rate in New England.

The following chart shows the number and percentage of child deaths due to fire compared to the total number of fire deaths.

*Chart II a*

Comparison of Child Deaths Due To Fire and Total Fire Deaths

| | 1979 | 1978 | 1977 |
|---|---|---|---|
| Number of Child Deaths Due to Fire | 15 | 12 | 15 |
| Number of Deaths Due To Fire, All Ages | 53 | 48 | 40 |
| Percentage of Child Fire Deaths to Total Fire Deaths | 28.3% | 25% | 37.5% |

Among the most effective answers to the problem of death and injury due to fire are: (1) early warning fire detection systems and (2) public education on fire prevention. Both are exact and inexpensive ways to prevent fires and their resultant deaths among our children.

The causes of fires demonstrate the public's inattention to fire prevention. For example, the cause of a fire might have been inappropriate installation of a wood stove but as in the case of one rural fire in Maine, the fire exit was blocked by a home freezer. The subsequent deaths were caused by the inability to escape the fire. People need to be taught the value of smoke detectors, how to hold exit drills or how to maintain fire exits. A drive through any Maine town in the winter will show doors and fire exits sealed from the elements and pathways unshoveled and inaccessible. Additional causes of wood stove fires are poor chimneys, improper stove operation, inappropriate storage of ashes and dangerous rekindling with flammable fuels. All are preventable acts of human ignorance.

Maine is a rural state. Often it is difficult for fire-fighting vehicles to get to the scene of the fire, especially in the wintertime. Other states in New England and large cities have available water hydrants and ample fire-fighting equipment. This is not always true in Maine. At a time when municipal budgets are suffering, fire prevention has got to be the responsibility of the individual citizen.

In an interview with the State Fire Marshal's office, we found there <u>are</u> laws to require fire detection systems in wood-frame hotels serving more than 15 people. School, day care centers and residential treatment facilities

serving children have stringent fire regulations to prevent death and injury due to fires. If sufficient building codes were in place and better enforced throughout all of Maine, we would begin to see a positive impact on the fire rate over a period of years, according to the State Fire Marshal.

In fact, the Life Safety Code that governs most of the fire regulations in Maine, has an established requirement for "at least one approved smoke detector" in residential dwellings. Legislation requiring simple and inexpensive early warning fire detection systems, such as smoke detectors or heat sensors, in new or existing residential dwellings will have an immediate impact on the child death rate resulting from fires. Enforcement would be impossible at the state level, local municipalities and the individual would have to take the responsibility for upholding the law. Electrical inspectors in certain areas of Maine already require new residential dwellings to follow the specifics of the Life Safety Code. The Code states:

| | |
|---|---|
| 11-6.3.2 | Detection and Alarm |
| 11-6.3.2.1* | At least one approved smoke detector powered by the house electric service shall be installed in an approved manner in every dwelling unit. When activated, the detector shall initiate an alarm which is audible in the sleeping rooms. Exception: in existing construction approved smoke detectors powered by batteries may be used. |

According to the State Fire Marshal, this section on "one-and two-family dwellings" in the Life Safety Code has not been considered in the clarification and assistance by law. During the 109th Legislative session, legislation was submitted and later withdrawn that would require early warning systems in all NEWLY constructed residential dwellings. The legislation would also affect any substantially rehabilitated residence, the transfer of ownership of a family dwelling or the renting of apartments. As a result of a recently developed data collection system, the State Fire Marshal will be able to document the existence of smoke detectors and the performance of the detectors.

The Task Force believes that legislation should again be submitted to require residences in Maine to be protected by an early warning fire detection system.

We feel that the protection of Maine children far outweighs both the low cost of purchasing the systems and cost of enforcement.

The Task Force further believes that fires that kill our children can be prevented. A fire prevention effort would not only save the lives of children but also diminish the loss of property and dollars.

The most effective awareness campaign would come from the local community. Assistance for the public education campaign should come from the Department of Human Services in partnership with the State Fire Marshal's office. The combination of state and local efforts in schools, and in influencing people in their homes through the use of creative media, will promote the public awareness and education needed to prevent fires and the deaths to children due to fires.

Legislation requiring fire detection systems can be developed, the Task Force feels, by existing personnel. The cost and method of enforcement cannot be determined at this time. A public education campaign would require additional resources of approximately $20,000.

Problem Statement

Motor vehicle accidents kill and injure more children between the ages of 5 and 19 than any other form of accident.

RECOMMENDATION

2.6(A) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES PROVIDE LEADERSHIP IN THE SUPPORT AND PASSAGE OF LEGISLATION REQUIRING APPROPRIATE CHILD SAFETY RESTRAINTS FOR CHILDREN WHO ARE PASSENGERS IN MOTOR VEHICLES.

FIRST PRIORITY

2.6(B) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ADVOCATE FOR A CHANGE IN REGULATIONS AND POLICY SUCH THAT AUTOMOBILE SAFETY RESTRAINTS FOR CHILDREN BE MADE REIMBURSABLE ITEMS FOR ALL THIRD PARTY PROVIDERS INCLUDING MEDICAID, BLUE CROSS AND BLUE SHIELD, ETC. THE DEPARTMENT OF HUMAN SERVICES SHALL PROMOTE PRIVATE LOW COST RENTAL AND LOAN PROGRAMS OF CHILD CAR SAFETY RESTRAINTS THROUGHOUT MAINE FOR THOSE NOT COVERED BY THIRD PARTY PAYERS.

Rationale

Motor vehicle accidents killed fifty-nine (59) of Maine's teenagers ages 15-19, in 1979. Another sixteen (16) children (5-14) and four (4) of our most helpless children less than five years old died as a result of a motor vehicle accidents.

The statistics for the last decade are alarming. Between 1970 and 1980, 743 children of all ages were fatal victims of accidents involving motor vehicles. Of these:

534 were 15-19
91 were 10-14
80 were 5-9
47 were less than 5 years of age.

Even more startling is the number of children who were injured in motor vehicle accidents in ten years:

35,254 children all ages
26,473 ages 15-19
9,436 ages 5-14
2,963 less than 5 years of age.

In one year, 1979, 4,441 children were injured in automobile accidents. Seventy-two percent (3,190) were teenagers, 22% (985) were children ages 5-14 and the remaining 266 were young children under the age of five.

Of all the persons killed in motor vehicle accidents in 1979, 32.6% were children. In fact, throughout the last ten years the percentage of children killed out of the total fatalities has accelerated. In 1977, there were significantly fewer children killed than any other time in the last decade. Sixteen percent of all injuries and 23% of all fatalities in that year were to children.

*Chart IIb*

| | % of Children Killed Out of Total Fatalities | % of Children Injured Out of Total Injuries |
|---|---|---|
| 1979 | 32.6% | 32.8% |
| 1978 | 33.6% | 33.7% |
| 1977 | 23.4% | 16.0% |
| 1976 | 30.8% | 33.6% |
| 1975 | 35.8% | 34.3% |
| 1974 | 34.1% | 34.8% |
| 1973 | 32.0% | 33.7% |
| 1972 | 28.7% | 33.0% |
| 1971 | 29.1% | 31.6% |
| 1970 | 27.2% | 30.3% |

Although it is clear that automobile accidents are the leading cause of death among young people, the Task Force feels that the prevention of adolescent deaths due to accidents is far more complex than the use of seat belts. The causes of motor vehicle accidents involving adolescents has a great deal to do with their general behavior, sense of self-control and level of maturity. The development of defensive driving habits including:

- avoiding driving after drinking or riding with a driver who has been drinking,

- avoiding the use of mind-altering drugs,
- obeying traffic laws,
- using seat belts, and
- respecting the motor vehicle as a serious instrument of transportation rather than a weapon, a plaything or extension of ego (reckless "hot rodding"),

will help reduce the number of adolescents who die every year from motor vehicle accidents.

Prevention of automobile accidents requires changes in the behavioral patterns of many parents as well as young children. Frequently, accidents result from the poor judgment of parents who, for example, speed or drive after drinking--and from failure to teach proper precautionary measures to children.

A North Carolina study, not yet available for publication determined that children themselves are a contributing factor in the cause of automobile accidents. The action or behavior of the child in the automobile can interfere with the driving or distract the driver. A child that is not properly seated and carefully restrained by a seatbelt or car seat may fall out of the seat; grab the steering wheel; stand and obstruct the driver's view; move around in the car; or create excessive noise. Either these actions directly lead to a collision or the driver in attempting to assist or discipline the child, may lose control of the car.

The Federal Department of Transportation said recently that less than 10% of all children under the age of 10 are properly restrained in automobiles. In a telephone survey conducted in 1978 by staff of the Bureau of Safety in Maine's Department of Transportation, adults were asked if they requested or encouraged their children to use seat belts. Of the 2,068 persons interviewed, 33% said they did request or encourage children to use seatbelts. Sixty-five percent of those interviewed favored some sort of insurance incentive for seat belt use. The Highway Safety Plan for Fiscal year 1978, which discusses the Safety Restraint Usage Survey noted that the monetary gains were more of an incentive than the fact that 90% of child deaths and 78% of serious injuries in children in motor vehicles could be reduced by the use of seat belts and child safety restraints.

It has been proven that under identical conditions of speed and impact,

a child is more likely to be injured than an adult. An even more shocking revelation is that a baby held in mother's arms is not safe. Crash tests by the Insurance Institute for Highway Safety, using female and infant test dummies, have shown that the mother's body can become a battering ram, crushing the infant that she is holding.

The August issue of the Status Report of the Insurance Institute for Highway Safety reviewed a recent Michigan study investigating the performance of child restraints in serious crashes. The study concludes that child restraints provide excellent injury protection when properly used. However, the report stated that further work needs to be done to provide a more effective means of protecting children in side impacts. Of sixteen (16) detailed investigations of severe crashes and of the 17 children and infants in child restraints, "two sustained fatal impact injuries, both on side crashes involving severe intrusion of the occupant compartment by the impacting vehicle." "Sever of the children escaped with no injury whatsoever," even when restraints were improperly used.

In the eight frontal crashes studied, "the restraint systems investigated provided effective protection for their child occupants. Even in five severe frontal crashes, in which some of the adult occupants were either killed or seriously injured, the restrained children were only slightly injured, if at all."

Two stories from the study are impressive:

> *"In one of the crashes, a two-month old child was seated in a GM Infant Love Seat in the center front position of a 1976 Cadillac. The restraint's harness was unfastened, but the restraint itself had been anchored to the care seat with a lap belt. For unknown reasons, the care left the road and, in a very severe impact, smashed head-on into a large tree. The child was uninjured, but its unrestrained mother was killed."*

> *"In another very severe crash, a two-year old was harnessed in a GM Child Love Seat in the right rear seat of a 1976 Peugeot. The restraint had been secured with a lap belt, but its top tether had been improperly anchored. While traveling on a roadway with a 45 MPH speed limit, the car was struck head-on by an oncoming 1971 mustang that had crossed the center line. The child was uninjured, but two adults in the front seat suffered various fractures requiring hospitalization."*

Even in severe side crashes,

> *"A 16-month old child was harnessed in his forward-facing child restraint in the left rear seat. The restraint was fastened by a seat belt, although not according to manufacturer's instructions. The 1974 Toyota was struck on the left side (drivers side) by a pickup truck traveling about 50 MPH. The child's left arm was trapped between the restraint and the vehicle interior and broken, and the child received facial lacerations. The driver was fatally injured and two other occupants received minor injuries.*

Numerous barriers exist for the proper use of seat belts and child safety restraints:

- unappropriate installation,
- failure to anchor the child restraint to the seat,
- neglecting to fasten the restraint's harness system, thus failing to secure the child within the restraint itself,
- inadequate types of child carriers and seats,
- lack of attention by parents to the need for child restraints, and
- the expense involved in the purchase of the restraints.

Helpful information is available in purchasing the proper child safety restraint. New and revised federal standards require that child restraints protect children in frontal crashes up to 30 miles an hour. Additionally, federal regulations require the information about the height and weight of the child and installation instructions be on the manufacturers label.

Legislation requiring child restraints in automobiles, inexpensive purchase and loan programs and insurance incentives for the acquisitions of child safety restraints will increase their use.

The Task Force believes that when parents are appropriately informed that they will realize the importance of "buckling up" their children to reduce the likelihood of their child's death, dismemberment or severe handicap.

A program to develop a child safety restraints program would require approximately $21,000 in personnel time and operating expenses.

Problem Statement

Children sustain accidents in school buildings, on school buses, on school grounds, and at athletic contests and practices.

RECOMMENDATIONS

2.7(A) WE RECOMMEND THAT THE DEPARTMENT OF EDUCATION REVIEW AND REVISE CURRENT SAFETY REQUIREMENTS AND BETTER ENFORCE MINIMUM STANDARDS FOR ON-SITE FIRST AID EQUIPMENT IN EVERY SCHOOL BUILDING AND SCHOOL BUS IN MAINE, AND TO BE PRESENT AT EACH ATHLETIC CONTEST AND PRACTICE. THE DEPARTMENT OF HUMAN SERVICES SHALL ADVOCATE FOR SUCH CHANGES.

SECOND PRIORITY

2.7(B) WE RECOMMEND THAT THE DEPARTMENT OF EDUCATION DEVELOP AND ENFORCE POLICE THAT ASSURES THAT EACH SCHOOL BUILDING IS STAFFED WITH PERSONNEL TRAINED IN BASIC FIRST AID INCLUDING CPR (CARDIOPULMONARY RESUSCITATION) TECHNIQUES. POLICY SHALL ASSURE THAT ALL COACHES OF BOTH INTERSCHOLASTIC AND INTRAMURAL SPORTS WILL LIKEWISE BE TRAINED IN CPR AND BASIC FIRST AID. THE DEPARTMENT OF EDUCATION SHALL ASSURE THAT THESE PERSONNEL ARE SUFFICIENTLY TRAINED IN THE USE OF PRESENT AND NEW FIRST AID EQUIPMENT.

SECOND PRIORITY

Rationale

Very little data exists on the type, severity and frequence of child accidents in schools, on school grounds, in school buses and at athletic events. Parents and the children themselves have the most extensive knowledge of school-based accidents. In the experience of the parents, physicians and educators on the Task Force, these accidents do occur in a significant degree. In their opinion the accidents can best be treated with appropriate first aid equipment used by school personnel trained in their use and skilled in basic first aid procedures.

Existing standards regulating on-side first aid equipment is viewed by the Task Force as insufficient, in some cases antiquated, and ineffectively

enforced. Our children spend from six to eight hours a day either being transported to and from school, on school grounds or at school functions. School activities such as home economics, industrial arts, athletics and recess represent potential hazards for the child. The Task Force was unable to find evidence of updated and meaningful standards for first aid equipment and personnel training for the schools in Maine. Every effort should be made not only to prevent serious accidents but also to provide emergency treatment for the ever-present child accident, no matter the degree or severity.

It is difficult to estimate the resources needed to improve standards and first aid equipment, and to train personnel in modern techniques. The Task Force estimated approximately $50,000 statewide.

# SUPPORTING DATA

# FOR COMPREHENSIVE

# ACCIDENT PREVENTION PROGRAM

*Chart IIc*

Accidental Deaths among Children, By Type

Less than 5 years of Age.

| Type of Accident | Total number of child deaths 1970-1973 | Total number of child deaths 1974-1977 | Total number of child deaths, annually 1978 | 1979 |
|---|---|---|---|---|
| All types, Total | 119 | 91 | 10 | 16 |
| Fire and Flames | 29 | 34 | 1 | 7 |
| Motor Vehicle | 23 | 25 | 5 | 4 |
| Drowning | 16 | 13 | 1 | 2 |
| Inhalation/ Suffocation | 18 | 5 | 0 | 0 |
| Falls | 9 | 4 | 1 | 1 |
| Poisoning | 3 | 2 | 1 | 0 |
| All Other | 21 | 8 | 1 | 2 |

All other includes accidents caused by firearms, explosives, surgical complications, piercing or cutting instruments, electrical current, etc.

Source: Bureau of Health Planning of the Department of Human Services.

*Chart IId*

Accidental Deaths Among Children, By Type

| Type of Accident | Total number of child deaths 1970-1973 | Total number of child deaths 1974-1977 | Total number of child deaths, annually 1978 | 1979 |
|---|---|---|---|---|
| 5 to 14 years of age. | | | | |
| All types, Total | 186 | 144 | 35 | 31 |
| Fire and Flames | 29 | 27 | 10 | 6 |
| Motor Vehicle | 88 | 58 | 17 | 19 |
| Drowning | 31 | 25 | 4 | 4 |
| Inhalation/ Suffocation | 3 | 0 | 0 | 0 |
| Falls | 3 | 3 | 0 | 0 |
| Poisoning | 0 | 4 | 0 | 1 |
| All Other | 32 | 27 | 4 | 1 |
| 15 to 19 years of age | | | | |
| All Types, Total | 268 | 279 | 58 | 73 |
| Fire and Flames | 8 | 8 | 1 | 2 |
| Motor Vehicle | 190 | 214 | 50 | 60 |
| Drowning | 21 | 16 | 4 | 5 |
| Inhalation/ Suffocation | 1 | 0 | 0 | 0 |
| Falls | 6 | 1 | 0 | 1 |
| Poisoning | 6 | 7 | 0 | 0 |
| All Other | 36 | 33 | 3 | 5 |

Source: Bureau of Health Planning of the Department of Human Services

*Chart IIe*

Cause of Death in Children Age 1-19
1979

| Ages: | 1-4 | 5-9 | 10-14 | 15-19 |
|---|---|---|---|---|
| Disease and Infection | 10 | 12 | 11 | 12 |
| Suicide | 0 | 0 | 2 | 11 |
| Assault | 1 | 0 | 0 | 4 |
| Total | 11 | 12 | 13 | 27 |

Total All Ages: 63

Source: Vital Records

*Chart IIf*

Average Death Rates* 1974-1977
By Age and Type of Accident

| Ages: | 1-4 | 5-14 | 15-19 |
|---|---|---|---|
| Motor Vehicle | 8.13 | 7.42 | 49.29 |
| Fire and Flames | 10.46 | 3.45 | - - |
| Drowning | 4.65 | 3.20 | 3.68 |
| Inhalation/ Suffocation | - - | - - | - - |
| Falling | - - | - - | - - |
| Poisoning | - - | - - | - - |
| All Accidents | 26.72 | 18.52 | 64.26 |

*Rates per 100,000 in the age category

Source: Bureau of Health Planning

*Chart 11g*

Total Number of Child Deaths Due to Accident

From 1970 - 1979

| | Total number of child deaths 1970-1979 Less than 5 years | Total number of child deaths 1970-1979 5-14 years | Total number of child deaths 1970-1979 15-19 years | Total number of child deaths 1970-1979 All ages |
|---|---|---|---|---|
| All | 236 | 396 | 678 | 1310 |
| Fire and Flames | 71 | 72 | 19 | 162 |
| Motor Vehicle | 57 | 182 | 514 | 753 |
| Drowning | 32 | 64 | 46 | 142 |
| Inhalation/ Suffication | 23 | 3 | 1 | 27 |
| Falling | 15 | 6 | 8 | 29 |
| Poisoning | 6 | 5 | 13 | 24 |
| All other | 32 | 64 | 77 | 173 |

Source: compiled from Bureau of Vital Records

*Chart IIh*

Death Rate for Motor Vehicle Accidents in Maine

1976, 1977

All Ages

| Motor Vehicle Accidents | 1976 | 1977 |
|---|---|---|
| | 20.8 | 18.2 |

Source: SPO Statistical Report, August 1978
Maine Vital Statistics, 1976

Chart Source: HSA

*Chart IIi*

Number of Persons Injured* in Accidents By Age

Maine, 1977

| Age | Total Accidents | Class of Accident | | |
|---|---|---|---|---|
| | | Motor Vehicle | Home | Other |
| Less than 5 | 33,350 | 540 | 24,560 | 8,650 |
| 5-14 | 79,240 | 3,060 | 35,030 | 42,300 |
| Total | 112,590 | 3,600 | 59,590 | 50,950 |

*Number of persons injured in Maine is estimated using incidence of injuries obtained from National Health Interview Survey.

Source: NCHS, "Current Estimates from the Health Interview Survey." U.S., 1977. USDHEW.

Table Source: Draft Pediatric Care Program Plan prepared by Bureau of Health Planning and Development.

*Chart IIj*

Calls to the Poison Control Center By Age
Maine - June 1977 - July 1978

| Age | Poisoning Calls | Cases Treated in E.R. | Total |
|---|---|---|---|
| 5 | 2,252 | 44 | 2,296 |
| 5-15 | 267 | 20 | 287 |
| 15-20 | 153 | 36 | 189 |
| Total | 2,672 | 100 | 2,772 |

*Chart IIk* Summary of Motor Vehicle Accidents Involving Children Ages 0-19, 1970-1979

| | Total # of Traffic Accidents | Total # of Persons Killed | Total # of Children 0-19 Killed | Number of Children Killed by Age 0-4 | 5-9 | 10-14 | 15-19 |
|---|---|---|---|---|---|---|---|
| 1970-1979 | 280,069 | 2423 | 743 | 47 | 80 | 91 | 534 |
| 1979 | 29,578 | 242 | 79 | 4 | 7 | 9 | 59 |
| 1978 | 32,716 | 241 | 81 | 5 | 8 | 10 | 58 |
| 1977 | 32,183 | 218 | 51 | 3 | 1 | 4 | 43 |
| 1976 | 30,147 | 227 | 70 | 3 | 5 | 12 | 50 |
| 1975 | 26,672 | 226 | 81 | 11 | 5 | 10 | 55 |
| 1974 | 24,939 | 217 | 74 | 2 | 4 | 9 | 59 |
| 1973 | 24,950 | 247 | 79 | 4 | 13 | 6 | 56 |
| 1972 | 24,956 | 258 | 74 | 7 | 8 | 10 | 58 |
| 1971 | 26,698 | 271 | 79 | 3 | 18 | 11 | 47 |
| 1970 | 27,230 | 276 | 75 | 5 | 11 | 10 | 49 |

Source: Maine State Police, Traffic Program

*Chart 11k (cont.)*

| | Total # of persons injured | Total # of children 0-19 | Children injured by Age | | | |
|---|---|---|---|---|---|---|
| | | | 0-4 | 5-9 | 10-14 | 15-19 |
| 1969-1979 | | 35,254 | 2,963 | 4,252 | 5,184 | 26,473 |
| 1979 | 13,509 | 4,441 | 266 | 418 | 567 | 3,190 |
| 1978 | 14,267 | 4,808 | 299 | 470 | 654 | 3,385 |
| 1977 | 13,298 | 2,131 | 138 | 160 | 268 | 1,565 |
| 1976 | 13,198 | 4,438 | 299 | 446 | 571 | 3,122 |
| 1975 | 11,968 | 4,113 | 310 | 431 | 564 | 2,808 |
| 1974 | 11,662 | 4,061 | 314 | 443 | 528 | 2,776 |
| 1973 | 11,811 | 3,980 | 328 | 468 | 528 | 2,656 |
| 1972 | 11,510 | 3,803 | 318 | 429 | 489 | 2,567 |
| 1971 | 11,455 | 3,618 | 340 | 494 | 511 | 2,273 |
| 1970 | 11,488 | 3,479 | 351 | 493 | 504 | 2,131 |

# Mental Health

## Problem Statement

Maine children suffer needlessly from emotional problems and mental disorders, many of which could be prevented or alleviated through early intervention and efforts at primary prevention.

## RECOMMENDATIONS

THE TASK FORCE RECOMMENDS THAT THE FOLLOWING STEPS BE TAKEN TO STRENGTHEN MENTAL HEALTH SERVICES AIMED AT PRIMARY PREVENTION AND EARLY INTERVENTION FOR CHILDREN AND ADOLESCENTS IN MAINE:

2.8(A) THAT A COMMITTEE BE FORMED REPRESENTATIVE OF THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS AS LEAD AGENCY, AND IN PARTNERSHIP WITH THE DEPARTMENT OF HUMAN SERVICES, DEPARTMENT OF EDUCATIONAL AND CULTURAL SERVICES AND THE MAINE CRIMINAL JUSTICE PLANNING AND ASSISTANCE AGENCY (MCJPAA) TO DEVELOP THE CRITERIA AND PROVIDE SUPPORT FOR A SYSTEMATIC STATEWIDE INVENTORY OF CURRENT MENTAL HEALTH ACTIVITIES FOR CHILDREN AND ADOLESCENTS. THE CRITERIA SHALL INCLUDE COLLECTIVELY ESTABLISHED DEFINITIONS AND INDICES. THE INVENTORY SHALL INCLUDE THOSE EXISTING MENTAL HEALTH RELATED ACTIVITIES BEYOND THE TRADITIONAL SERVICE ORIENTED PROGRAMS.

IMMEDIATE ACTION

2.8(B) THAT THE COMMITTEE REVIEW AND ASSESS THE RESULTS OF THE INVENTORY, IN ORDER TO: DETERMINE THE GEOGRAPHICAL AND DEMOGRAPHIC AREAS LACKING IN APPROPRIATE MENTAL HEALTH ACTIVITIES FOR CHILDREN AND ADOLESCENTS; AND IDENTIFY, SECURE FUNDING SOURCES FOR, AND REQUEST PROPOSALS FOR THE PROVISION OF COMPREHENSIVE PREVENTION AND EARLY INTERVENTION SERVICES.

IMMEDIATE ACTION

2.8(C) THAT THE ALLIANCE OF THE THREE DEPARTMENTS AND MCJPAA RECOGNIZE, ENCOURAGE AND SOLICIT THE ASSISTANCE OF A COMMUNITY-BASED COALITION OF PROFESSIONALS, CONSUMERS AND INTERESTED CITIZENS TO PARTICIPATE IN THE ESTABLISHMENT OF PRIORITIES, THE MONITORING OF PROGRESS AND THE MAINTENANCE OF EFFORT IN THE PROVISION OF PREVENTIVE MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS.

IMMEDIATE ACTION

2.8(D) WE RECOMMEND THAT THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS USE ITS AUTHORITY TO INCREASE THE PROPORTION OF MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES THAT ARE PROVIDED BY COMMUNITY MENTAL HEALTH CENTERS (CMHC) BY REQUIRING IN THEIR CONTRACTS FOR SERVICE WITH THE CMHC'S THE FOLLOWING:

(1) THAT EACH COMMUNITY MENTAL HEALTH CENTER DEVELOP A CHILDREN'S SERVICES UNIT AND THAT A SPECIFIED PERCENTAGE OF FUNDS BE ALLOCATED TO THE CHILDREN'S SERVICES UNIT IN PROPORTION TO THE POPULATION OF CHILDREN OR AS MODIFIED BY THE STATEWIDE INVENTORY, AND

(2) THAT EACH CMHC PROVIDE A SPECIFIC DESCRIPTION OF THEIR CONSULTATION AND EDUCATION SERVICES AVAILABLE TO CHILDREN, FAMILIES, AND SCHOOLS, AS WELL AS OTHER CHILD-CARING AGENCIES.

IMMEDIATE ACTION

2.8(E) THAT THE ALLIANCE OF THREE DEPARTMENTS AND MCJPAA COMMIT PLANNING RESOURCES AND SOLICIT THE PARTICIPATION OF LOCAL COMMUNITIES IN THE DEVELOPMENT OF A UNIVERSAL PREVENTION PLAN FOR THE PREVENTION OF CONDITIONS AND CIRCUMSTANCES THAT HAVE AN ADVERSE EFFECT ON THE HEALTH, EDUCATIONAL, EMOTIONAL AND SOCIAL WELL-BEING OF MAINE'S CHILDREN AND ADOLESCENTS. THE PURPOSE OF THE PLAN WOULD BE TO ALLEVIATE THE EXISTING FRAGMENTARY COLLECTION OF PREVENTIVE AND TREATMENT SERVICES FOR CHILDREN SO THAT RESOURCES CAN BE MORE EFFECTIVELY USED TO SERVE THE CHILD IN NEED.

SECOND PRIORITY

Rationale

THE PROBLEM

When adults experience periods of frustration, uncertainty, and confusion they may do two things. First, they draw upon their inner strengths and resources, in order to cope with the crisis or pressure. Second, if their feelings are unclear and the solution to their problems beyond their control, they seek help. They may talk their problems over with an alert and sensitive friend, spouse or family member. They may seek the comfort and expertise of clergy or mental health professionals with whom they can be open and trusting.

In either case, the way they respond will depend on what they have learned as children. If their early conditioning by their parents was positive and supportive and their sense of self-concept and identity secure, they will be more prepared to cope with pressure and conflict.

When children encounter frustration, uncertainty and confusion, they must depend on their parents to seek help for them. They may not have the skills necessary to get their own help or to cope with their problems.

A child's learning can be both positive and negative, both implicit and explicit. The explicit learning comes from the direct teachings of parents, educators and friends. Children can learn conflicting values and ideas, but if they are emotionally secure and they have the skills to make decisions, they can choose for themselves what is right and wrong, good or bad. The implicit learning gained from observing the behavior of others, especially their parents, or from the mass-marketing approach of television and the media, will have a lasting effect on who they are and what they do. If a parent's behavior is inappropriate, much of the child's learning will be inappropriate. If the parent copes with stress by drinking too much, smoking too much, or striking out at the child or others, the child will model his or her behavior after the parent and may deal in similar ways with problems. If television repeatedly glamorizes overt sexual behavior, violence and substance abuse, the child may model his or her behavior after the television characters.

The cycle of child abuse and neglect provides valuable information about the way in which a child learns. Parents who were physically or emotionally abused or deprived during childhood often become victims of a tragic and recurring cycle of poor parenting. Studies have indicated that the primary

motivation for having children among parents who have a problem of child abuse or neglect is to have a "child" to receive the love, acceptance and nurturing that they did not receive as a child. The intense unmet needs of childhood, however, create unrealistic expectations of the child. The child is not capable of meeting these parental needs or expectations and is, therefore, viewed by the parent as a failure and as inadequate. The child accepts this view of him/herself and responds to future human contact as an emotionally and physically painful experience. For the child in this situation, the family relationships are very unsatisfying. The child begins a desperate search to have his or her needs met, often becoming involved in repeated destructive and unsatisfying adolescent and adult relationships. The search often leads them eventually to the solution of having a baby of their own to love and to meet their needs. Thus, the tragic cycle begins anew.

The cycle can be broken by early intervention to prevent a permanently damaged self-concept in the child. Primary prevention is successful when prospective parents are provided with support, information, and resources to meet their own needs as parents and the needs of their child. The alternative to prevention and early intervention is the continued cycle of deprivation and abuse.

The symptoms of delayed, inadequate or inappropriate learning among children are (a) the lack of impulse control, (b) the inability to delay self-gratification, and (c) the lack of future goal orientation. For many children and adolescents, their inadequate learning or socialization results in character disorders or social malfunctioning leading to:

- abuse of drugs or alcohol;
- truancy, school failure or learning problems;
- crime and delinquency;
- unwanted pregnancy and premature parenthood;
- inability to adjust, behavioral problems or reckless behavior;

As adults, inadequate learning and socialization may result in:

- divorce or family breakdown;
- an inability to maintain employment, be self-sufficient; or
- child abuse, neglect or exploitation.

The "first line of defense" for psychosomatic disorders is the child's family. The family, more than anyone else, influences the child's identity development and fosters the child's sense of security. The community also has a responsibility and an important role to play in the positive and healthy development of the child. Every person needs a sense of belonging. If that is attained in the early years of life--a sense of belonging to family, neighborhood, or community--the child becomes more secure in his or her relationships and interactions with the environment.

Unfortunately, many of the mental health problems of childhood are never adequately addressed as evidenced by the mental health needs and problems of adolescents in Maine.

The leading causes of death among adolescents, including motor vehicle accidents and suicide, are indicative of the adolescent's need to develop the skills necessary to make healthy decisions or seek help. Early detection of suicidal cases requires the skillful intervention of mental health professionals. Often they can recognize the severely depressed youth and those at odds with themselves and their environment. In the past five years, forty-seven (47) young people have committed suicide, including two children between the ages of 10-14. *Chart III* shows the annual toll of child-deaths by suicide:

| *Chart III.* | 10-14 | 15-19 |
|---|---|---|
| 1979 | 2 | 11 |
| 1978 | | 9 |
| 1977 | | 10 |
| 1976 | | 6 |
| 1975 | | 9 |

Other mental health related problems of adolescents are discussed in Section III, Adolescents.

In Maine, preventive and early intervention mental health services for children are severely lacking. In fact, beyond the traditional therapeutic services of private practitioners (psychiatrists, psychologists, family therapists and counselors) and mental health clinics and institutions, we do not know what is available for children in Maine communities. A review of the 1979-1980 budget for the Office of Children's Services in the Department of Mental Health and Corrections reveals that the $1.6 million budget, delivered

through approximately thirty purchase-of-service contracts provides:

- 0% for prevention
- 8% for early intervention
- 19% for family intervention
- 73% for residential treatment

An inventory of preventive and early intervention services would include the non-traditional mental health activities of organized church programs, municipal-sponsored activities, school-related programs, groups like the Boy Scouts of America and independent self-help efforts.

The Community Mental Health Centers have, historically, not viewed children as a priority target population. It is unclear what amount of their resources and programming are devoted to early intervention or treatment of children.

FIRST STEP

The inventory will provide clear information on what community services are available, how they are delivered, who they reach, how much they cost, and what effect they have. Criteria for the survey would be developed in part by the three departments of State Government involved in children's services and the Maine Criminal Justice and Planning Assistance Agency (MCJPAA). For the purpose of discussion, the following provides a definition and statement of purpose for the various levels of services to be assessed in a statewide inventory.

Primary Prevention
Definition and Purposes

Activities aimed at a total group of children, none of whom have yet been specifically identified as having mental health needs, or problems, but all of whom - like anyone else - have the potential for needing mental health services at some later period. Such a group of children could be general (e.g., all 4th Grade students) or "at risk" (e.g., all adopted children, children in single parent homes, etc.).

Primary prevention activities are intended to provide information and examples to children, family members, and significant others (teachers, friends, neighbors, non-mental health professionals, etc.) designed to help them become able to:

- prevent mental health problems from arising;
- identify mental health problems when they arise; and
- respond appropriately to mental health problems when they are identified, either through personal response or by seeking appropriate assistance.

## Early Intervention Definition and Purposes

Activities aimed at children who have been identified by mental health professionals as possessing certain characteristics, traits or qualities that may - if continued unchanged - increase the likelihood of later, more severe emotional or behavioral problems or needs.

Since these activities are provided early in the course of the condition, the observed behavior or trait will generally be mild or minor in nature, and the intervention required will be relatively non-restrictive. By the same token, though not in every case, the children receiving these services, or the benefit of these services, will generally be in the 0-10 year old age range.

Early intervention activities are intended to provide children, family members, and significant others with information and examples designed to help them become able to:

- recognize the targeted behavior or trait;
- modify or extinguish the targeted behavior or trait when it is recognized;

- eliminate the cause of the behavior or trait when possible; and
- direct the energy of the family unit to constructive ways of reducing the chances of the behavior or trait reappearing.

## Family Intervention Definition and Purposes

Activities aimed at children whose mental health needs, or problems, have eluded early intervention and have reached a level of frequency, complexity and/or intensity, such that the ability of the nuclear or extended family to continue providing care and nurturance to the child is in jeopardy.

Since the unsupported abilities of families to provide for children in need varies widely, so will the level of mental health needs that require family intervention vary from case to case.

Since the appropriate mental health intervention activities are being provided during a later stage, the intervention required will be relatively intensive and/or restrictive, though still not requiring long term residential placement away from the family unit. By the same token, though not in every case, the children receiving these services or the benefit of them will generally be in the 10-18 year old age range.

Family intervention activities are intended to provide children, family members and significant others with information and examples designed to help them become able to:

- recognize the mental health need, or problem;
- control and contain the resulting behavior or trait;
- recognize and understand the origins or causes of the behavior or trait;
- confront the behavior and begin to eliminate its causes and/or transform the behavior into one that is less frequent, less complex and less intense; and

- direct the energy of the family unit to constructive ways of reducing the chances of the behavior recurring.

**Residential Treatment**
**Definition and Purposes**

Services aimed at children whose emotional/behavioral needs have reached a level of frequency, complexity and/or intensity, such that their ability to function in their own or a substitute home environment even when provided with family intervention services is demonstrably absent.

Because of the complexity of the mental health needs addressed by residential treatment services, placements will normally be a year or more in duration and with the exception of planned home visits will be provided on a 24-hour-a-day, year-round basis.

Residential treatment services are intended to provide therapeutically planned group living situations within which educational, recreational, medical and socio-psychotherapeutic components are integrated for children whose presenting behaviors or traits preclude a less restrictive level of mental health service.

SECOND STEP

Following the inventory, the second step in strengthening preventive services for children is to review and assess the results of the inventory to determine which areas of the State ladk appropriate mental health activities for children. Mental health services may be available in some areas to one age group but not another. Or they may be limited by lack of resources and personnel. In order to fulfill the need for more or different services, the committee of department representatives and MCJPAA should develop new and additional resources as well as assess the appropriateness of current

expenditures and funding priorities. The committee would then develop requests for proposals to be made available to agencies, groups and organizations in the local communities.

THIRD STEP

Parents, consumers and members of local communities are the best resource for determining the needs of their children. A formal needs assessment can provide information on gaps of service and client need. But the participation of a coalition of consumers, professionals and interested citizens can help establish priorities, monitor the progress of activities and the maintenance of effort of existing mental health services. The committee should solicit the assistance of community-based coalitions and encourage their development in areas where they are lacking. A statewide coalition of similar structure could monitor the development of comprehensive prevention and early intervention services throughout the State.

FOURTH STEP

The network of Community Mental Health Centers is perhaps the most significant and accessible resource for mental health expertise in the majority of local communities in Maine. Financed by a combination of federal, state and private funds, they have provided limited treatment services to children. It is currently difficult to determine precisely how involved Community Mental Health Centers are in providing mental health services for children, or the adequacy of these services. These problems are due, in part, to (a) the absence of mutually agreed upon service definitions, and (b) the inadequacies of the existing management information system which is in its initial stages of implementation.

The Department of Mental Health and Corrections currently contracts with the eight CMHC's in Maine to provide a variety of services in the following general categories:

- inpatient care
- outpatient care

- transitional living
- partial hospitalization
- emergency community support
- consultation services to courts and other agencies
- other consultation and education

It is not known the extent to which these activities involve services for children and their families.

The Task Force feels that the most appropriate method to assure the delivery of children's services by CMHC's is through the contractual agreements with the Department.

Many of the CMHC's provide consultation and education services on behalf of children to schools and community agencies. It is unclear to the Task Force, however, what direct effect these services have on children. Consultational education services are difficult to evaluate and must be defined more clearly in relation to the mental health needs and problems of children in Maine.

Preschool programs, child care agencies and private programs for children with special needs require consultation and training services from mental health professionals at a reasonable cost. CMHC's should be a resource for these programs.

Requiring the establishment of Children's Services Units (CSU) staffed and funded in proportion to the number of children in need in the area, will guarantee a more thorough delivery of mental health services to children. The inventory of mental health services for children will provide a basis for determining the fair and equitable proportion of community mental health services to children. Funding for the CSU's should come from a reallocation of existing resources or through a realignment of funding priorities.

## FIFTH STEP

The purpose of this fifth step would be to assure that preventive health services and treatment for children are available in local communities throughout the State, and that the system for delivering these services ensures that the mental health needs and problems of children are appropriately addressed. The concept of the Universal Prevention Plan is to bring together in a joint

planning effort at the local level, agencies, programs and other providers of mental health services for children. Information gained through the statewide inventory and the work of the coalition would be instrumental in assisting and providing direction for these local planning efforts.

Fragmentation and the lack of coordination are two major obstacles which stand in the way of efforts to develop a system of preventive mental health services for children in Maine. At the state level, almost all state agencies concerned with children and youth have specific legislative mandates involving prevention. Yet, there is currently little communication or cooperation between these agencies, as evidenced by the absence of joint policy development and program planning activities. The office of Alcohol and Drug Abuse seeks to prevent substance abuse. The Department of Human Services provides or funds a variety of services aimed at preventing child abuse and neglect. The Maine Criminal Justice Planning and Assistance Agency is involved in efforts to prevent juvenile crime and delinquency. The Department of Mental Health and Corrections is expected to prevent mental illness. The Department of Educational and Cultural Services is charged with preventing truancy and drop-outs.

The categorical and fragmented nature of mental health services delivered at the community level means that children with specific mental health needs and problems do not always have access to appropriate services. If a child "acts out" in a public, community setting, he or she will most likely become a juvenile justice client. If significant acting out occurs in school, the child may become a drop-out or a special education student. If the acting out occurs in the home, the child may become a community mental health client or a protective services client. Yet in each of these cases, the client is the SAME child and the behavior frequently the SAME behavior. The treatment of choice is frequently the SAME treatment and effective and appropriate prevention techniques--had they occurred--would have been the SAME.

The Universal Prevention Plan would assist community agencies and mental health providers in developing specific action plans for addressing these problems of duplication and lack of coordination in the delivery of mental health services for children.

The Task Force believes that the development of a mental health inventory of children services and the subsequent policy development and planning will

require minimal resources. Personnel and travel costs for the paraprofessionals to conduct the survey is estimated at $6800. The amount of new resources for new and additional services is unknown at this time. CSU's in Community Mental Health Clinics will require a reallocation and reprioritization of existing resources.

## Children with Special Needs and Handicapping Conditions

### Problem statement

Only 35% of Maine children under five years of age who have handicapping conditions or developmental problems receive adequate services. No single Department or agency within State Government has a clearly assigned responsibility to assure that these children are identified and receive appropriate health and educational intervention.

### RECOMMENDATIONS

2.9(A) WE RECOMMEND THAT THERE BE DEVELOPED WITHIN STATE GOVERNMENT A CLEARLY DEFINED POLICY OF EARLY AND ONGOING IDENTIFICATION AND INTERVENTION ON BEHALF OF CHILDREN WITH SPECIAL NEEDS AND HANDICAPPING CONDITIONS.

IMMEDIATE ACTION

2.9(B) WE RECOMMEND THAT THE DEPARTMENTS OF HUMAN SERVICES, MENTAL HEALTH AND CORRECTIONS, AND EDUCATIONAL AND CULTURAL SERVICES CONTINUE TO SUPPORT, ACTIVELY IMPLEMENT, AND PLAN FOR STATEWIDE EXPANSION OF A COORDINATED DELIVERY SYSTEM FOR SERVICES TO PRESCHOOL HANDICAPPED CHILDREN, AND FURTHERMORE THAT LEGISLATION BE DEVELOPED TO REDUCE THE AGE LIMIT TO BIRTH FOR THIS SYSTEM.

SECOND PRIORITY

### Rationale

Based on current population estimates and an estimated 12% prevalence figure for handicapping conditions, approximately 3,160 children between the ages of three and five have handicapping conditions or developmental problems which would benefit from early intervention. According to figures in an annual child count from the Department of Educational and Cultural Services, only 1,287 of these children were receiving services as of December 1, 1979. Additionally, the report lists 21,581 children age 6-17 receiving services, but they have no data concerning specific medical services received by these children. An additional problem exists in that there are no data for the number of children between the ages of birth to three.

The Division of Child Health in the Department of Human Services keeps records of children served by its crippled children's program. However, the

State Pediatric Care Program Plan (PCPP) cites an estimate that only 8% of the estimated population of handicapped children are actually served through Crippled Children's Services.

A joint report of the Commissioners of Human Services, Mental Health and Corrections, and Educational and Cultural Services, cites a 12% estimated prevalence figure for preschool handicapping conditions, based on the results from seven preschool pilot programs. The same report points out that over half of the estimated 3,610 children in the 3-5 age range who require early intervention are excluded from preschool services by at least one of several factors;

(a) income eligibility,

(b) specific disability eligibility,

(c) geographic location in the State, and

(d) lack of sufficient programs.

Sufficient research now exists to document the effectiveness of early intervention in reducing or removing the impact of handicapping conditions on the development of young children. Intervention with children under the age of five usually requires a combination of medical, psychological, social, and educational services which are provided through a variety of community agencies and resources. Both federal and state legislation complicates the issue of service delivery to this population by fragmenting responsibility and payment resources through various categorical programs assigned to several different bureaus or departments within state government. The regulations for administering these programs are frequently overlapping and/or conflicting.

Because each of three state departments currently has some part of the responsibility and funding resources for identification and intervention, a policy needs to be developed which clarifies and defines each department's role and its relationship to the services for which the other two departments are responsible. In order to assure that all children with special needs and handicapping conditions are provided with appropriate services as early as possible, this policy should define the nature and extent of State Government commitment to early identification and intervention, and support the concept of a coordinated delivery system.

A system for coordination has already been established through federal grants and previous legislation, and piloted in seven areas of the State. The

state level committee makes grants to local coordinating committees at the regional level for implementation of state initiatives in four areas:

(1) screening for children,

(2) diagnosis and evaluation,

(3) provision of direct services, and

(4) local planning.

This system, with the support of the three departments, has begun to successfully coordinate existing resources and planning efforts at the community level, in order to assure that a comprehensive array of services are available to all children between three and five years of age with special needs or handicapping conditions, regardless of the type or degree of handicap or the family's financial situation. This pilot effort to date provides a model for statewide implementation and a downward extension of coordination and service delivery to children from birth. The data from the pilot effort and a description of the history and development of this coordinated delivery system can be found in a series of three reports to the State Legislature, entitled Early Education for the Handicapped, December 1977, December 1978, and January 1980.

Recommendation 2.9(A) will require no new resources in the development of a policy statement. The best estimate the Task Force could provide for Recommendation 2.9(B), an expansion of a coordinated delivery system, is $711,000 for 15 sites at approximately $48,000 per site. This will meet the maximum number of 0-5 year olds identified as in need of services. This estimate is based on the resources necessary to support the existing network of seven (7) sites.

Families with the Problem of Child Abuse and Neglect

Problem Statement

Child abuse continues to be a problem of significant proportions which threatens the health and safety of children in Maine.

RECOMMENDATIONS

2.10(A) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES AND THE DEPARTMENT OF PERSONNEL MAKE THE NECESSARY CHANGES IN THE STATE PERSONNEL SYSTEM TO ENSURE THE HIRING, TRAINING AND MAINTENANCE OF WELL QUALIFIED STAFF IN THE AREA OF PROTECTIVE SERVICES AND SUPPORT SERVICES.

IMMEDIATE ACTION

2.10(B) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DEVELOP MECHANISMS TO ENSURE COMPLIANCE WITH CURRENT ADMINISTRATIVE POLICIES AND TO IMPROVE REPORTING AND ENFORCEMENT OF THE EXISTING CHILD ABUSE AND NEGLECT STATUTES.

SECOND PRIORITY

2.10(C) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE THAT A NETWORK OF IMPROVED SUPPORT SERVICES FOR CHILDREN AND THEIR FAMILIES WITH THE PROBLEM OF CHILD ABUSE AND NEGLECT BE PROVIDED THROUGHOUT THE COMMUNITIES OF MAINE. SERVICES INCLUDE COUNSELING, DAY CARE, TRANSPORTATION, HOMEMAKERS, ETC.

FIRST PRIORITY

Rationale

In 1979, over 4,000 new cases (i.e., families) received protective services from the Maine Department of Human Services. Experts on the true incidence of child abuse and neglect estimate that only one in four cases of abuse and neglect ever get reported. For Maine, this means approximately 32,000 children a year are victims of abuse and neglect. At least six Maine children died in the last two years as a result of child abuse and/or neglect.

Violence in the home is not limited to young children but extends to older children and spouses. Thirty-seven percent (37%) of the abuse and neglect victims, in a recent study of 1979 reported cases, were adolescents between the ages of 12-17. The report, conducted by the Department of Human Services and the American Humane Association, Children's Division, reviewed about 75 percent (3200) of all child abuse and neglect reports for 1979. They found that 1,342 individual adolescents were abused or suffered from major deprivation, out of a total of 3,600 individual victims.

National incidence rate estimates indicate that over 50 percent of married women in the United States will be beaten by their husbands. In Maine, a network of five family shelters provides lodging and supportive services to victims of domestic violence. During calendar year 1979, 965 individual families were served in the shelters, including 552 children under the age of 18.

The cost of child abuse and neglect to the individual and society is immeasurable as evidenced by (a) the unrealized potential of a damaged child; (b) the cost of medical care, special education and services to children permanently damaged; (c) the common history of abuse or neglect in runaway youth and adolescents living on the "streets"; (d) the common history of child sexual abuse of young prostitutes; and (e) the common history of severe abuse or deprivation in the lives of the prison population.

Maine's public and private resources and capability are currently inadequate to respond to a problem of this magnitude.

## THE MAINE DEPARTMENT OF HUMAN SERVICES

The Department is required by law to receive and investigate all reports of child abuse and neglect. Thus, the Department has a major role in attempting to address the problem of abuse and neglect and to provide, as resources allow, services to protect children and maintain family integrity.

Although the Task Force does not make recommendations specific to the area of domestic violence, we strongly urge the Department to assume a leadership role in developing resources for the prevention and treatment of domestic violence.

The Department's ability to deal effectively with child abuse and neglect depends in part on the effectiveness of protective personnel. There are,

however, many problems in hiring, training and retraining skilled and qualified staff. State personnel regulations often make it difficult to hire talented staff due to the emphasis on in-house promotions and career ladders. The personnel system does not allow for career development within child protective services. This often means that a worker must leave the field to receive advancement even if he or she is accomplished at the work and satisfied with the position. The personnel system also is not responsive to the overwhelming stress of performing child protective jobs which creates worker "burn-out" among supervisors and staff. This problem is exacerbated by the fact that the supervisory ratio often leaves the best worker feeling unsupported.

Training of Department staff has been improved but needs to be developed into a comprehensive career training program for child welfare workers. Workers should be trained in working with multi-problem families.

The organizational structure of the Department influences services to families with a problem of abuse and neglect. Standards of practice and the quality of services provided vary from region to region. These differences are not attributable to regional differences such as geographic area and population, but to differences in administrative policies and practices.

The Task Force applauds the Department's improvements in the protective service program, including:

- the establishment of a 24 hour system to receive and respond to reports;
- a doubling of staff to handle the more than doubled caseloads requiring services;
- increased staff training;
- education for potential or mandated reporters of child abuse and neglect; and
- a greater effort to form a partnership with community agencies.

Nevertheless, the Task Force feels that a mechanism to ensure policy compliance, improved reporting and better enforcement of existing child abuse and neglect statutes carried out by trained, qualified personnel would greatly improve the State's ability to fulfill its mandated responsibilities.

## THE ROLE OF THE COMMUNITY

Child abuse and neglect is an insidious, pervasive problem with a bleak history which may never be completely eradicated! The Task Force believes, however, that the incidence of abuse and neglect can be substantially reduced with appropriate prevention and early intervention services. A network of health and social services in the community to strengthen the family and to provide appropriate supports for families with problems of abuse and neglect is essential. Programs should strive to reinforce parent-child relationships that allow the family to function as an independent unit.[2]

There has been an overall improvement in the response of communities and their commitment of resources to the problem of child abuse and neglect. Improvements that have been made in some areas of the State include: (1) expanded coordination among service providers, (2) increased reporting by citizens and local service providers, and (3) a greater willingness to work with families with a child abuse problem.

A review of the reporting data shows that friends and relatives are the first to report child abuse and neglect, followed by self-reporting and reporting by the police. Problems remain, however, with enforcement of the reporting statute, as evidenced by under-reporting by professionals who work with families. These professionals are often unaware of the reporting requirements or are unwilling to become involved with the problem.

This is obvious, for example, when it is discovered that a seriously abused child referred by a relative has been seen by a physician or hospital emergency room.

## AVAILABILITY OF COMMUNITY SERVICES

The community faces another problem in providing preventive and supportive services to families with the problem of abuse and neglect. There are insufficient resources in many communities to support basic preventive and supportive services. The problem is complicated by the fact that health and social services programs are often forced to compete with each other for limited resources. This competition represents a major obstacle to improved coordination

among agencies around the problem of child abuse and neglect.

Treatment services often receive priority funding over preventive and supportive services, largely because of the current lack of resources with which to address the crisis needs of children in abusing families. In addition, the problems of evaluating the effectiveness and cost-effectiveness of preventive programs often pose a major obstacle to efforts to develop preventive and support services. Many of the State's resources are necessary for the support of the Department's protective service program and enforcement of child abuse reporting. Policymakers have the difficult choice of whether, and at what level, to fund treatment and enforcement services versus preventive and supportive programs which may result in longer term cost savings. The State's current financial and economic conditions suggest that there will be few, if any, resources increases available to address the problem of child abuse and neglect.

The development of prevention programs will, therefore, require a redefinition of priorities for the allocation of existing resources. In Maine, the existing resources are spread so thin that the reallocation of resources is not always a viable alternative.

Improved coordination and increased communication among community programs including the efforts of volunteer organizations will promote the effective use of scarce resources. Because of the fragmented, categorical nature of funding services, many community programs operate in isolation from one another. Formal linkages between programs and coordinated referral mechanisms could improve the delivery of comprehensive services to multi-problem families.

The ever-increasing problem of child abuse and neglect is at times overwhelming to the staff person who is inexperienced and poorly trained in dealing with families having problems of child abuse and neglect. This is particularly true in the diagnosis and treatment of the child. Often child development and psychological assessments are not conducted or are unavailable for children experiencing abuse and neglect. Child abuse prevention and treatment demands that we handle multiple problems simultaneously, in ways that are tailored to the unique needs of individuals.[3]

Screening is often unavailable as part of routine individual care for problems assiciated with (1) disturbed parent-child relationships, (2) the parents' lack of child care skills, (3) the parents' unrealistic expectations

of the child and self, and (4) other indicators of potential child abuse and neglect. Many health professionals often prefer to ignore a potential problem of abuse or neglect, rather than pursue a definitive diagnosis as they do with most other health problems.

There are a number of preventive programs that have been proven to be effective, including:

- Education programs for young people and adults designed to impart information on child care, child development, basic needs of children, disciplinary methods, and where to go for help. *Recommendation 2.3*

- Home health visiting programs for all new mothers (a) to increase their skills in caring for the new baby, (b) to reduce stress created by infants with special problems, (c) to provide information and advice on parenting, child care, nutrition, (d) to provide screening for children's health and development, and (e) to bring the child into the health care system. *Recommendation 2.2*

- Support groups for parents to provide mutual support assistance in overcoming the problem of child abuse and neglect (i.e., Parents Anonymous).

- Child day care to provide respite care so that the parent can spend time away from the child and work more directly on mental health and other issues. As support for the child, day care can involve the child in healthy socialization and in development activities, and can acquaint the child with positive adult role models. *Recommendation 3.5*

- Counseling and mental health supports. *Recommendation 2.9*

A great deal of prevention can be done in the hospital and in the schools. During and after the delivery of the baby, procedures which enhance parent/infant bonding are not adequate or accessible to most families. *Recommendation 1.11* Schools can influence the behavior of children by providing education and information in developing life skills to deal with anger, frustration and responsibility.

Implementation of many of the other recommendations in the Task Force report concerning community efforts and the coordination of service delivery, would have a positive effect on the problem of child abuse and neglect.

The Task Force cannot estimate the cost of Recommendation 2.11. Cost implications of personnel changes, compliance and enforcement and a network of improved community support services should be examined prior to implementation. The Task Force feels strongly that the benefits of preventing child abuse and neglect far outweigh the cost of delivering preventive and support services.

# Dental Health

## Problem Statement

Dental disease affects more children in Maine than any other known disease or affliction.

## RECOMMENDATIONS

2.11(A) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES EXPAND ITS CURRENT PRESCHOOL EDUCATION PROGRAM TO PROVIDE FINANCIAL ASSISTANCE TO PRE-SCHOOL SETTINGS FOR DENTAL HEALTH EDUCATION ACTIVITIES.

SECOND PRIORITY

2.11(B) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES EXPAND ITS CURRENT SCHOOL DENTAL HEALTH PROGRAM TO PROVIDE FINANCIAL ASSISTANCE TO PUBLIC AND PRIVATE SCHOOLS FOR DENTAL HEALTH EDUCATION ACTIVITIES.

FIRST PRIORITY

2.11(C) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES INVESTIGATE THE COSTS AND BENEFITS OF PROVIDING FLUORIDE SUPPLEMENTS TO CHILDREN UP TO AGE 6 WHO LIVE IN FLUORIDE-DEFICIENT AREAS OF MAINE, AND WHOSE PARENTS CANNOT AFFORD SUCH SUPPLEMENTS.

SECOND PRIORITY

## Rationale

Dental disease is the most prevalent health problem afflicting Maine children and adolescents. It has been estimated that "99 percent of the United States population over age 10 has had dental disease at one time or another." [4] Dental disease includes dental decay (caries), diseases of the bone and soft tissue (periodontal disease), improper meeting of the upper and lower teeth (malocclusion), cancers associated with the oral tissues and other diseases of the oral cavity. [5] In children, major oral health problems include decay, premature loss of teeth, damage to teeth through accidents and mal-occlusion. [6]

Dental disease alone is not a life threatening condition. It can, however, cause pain, sickness and physical and emotional discomfort. It may affect all physical systems of the body. Dental problems can lead to poor nutrition and gastrointestinal problems because of inability to chew food properly and speech impediments. [7] For children, poor dental health can afflict their psychological and social well-being.

Tooth decay is irreversible. Decay can destroy the tooth, once it has begun. Treatment can slow down the decay through removing the decay and filling the tooth but frequent recurrence often leads to loss of tooth.

Various studies throughout the last decade, although none were statewide or comprehensive, have indicated that dental disease is a serious, widespread problem among Maine people. Factors such as geographical location, nutrition, education and income determine the degree of severity of dental disease. Dental disease is particularly prevalent among low income families who lack the resources to obtain preventative dental care and early treatment, and persons who do not consider dental care a high priority.

For children, the prevention of dental disease is both critical and inexpensive. By the age of two, when all the primary teeth have erupted and are functioning, half the country's children have at least one decayed tooth. Upon entering school, the average child has three decayed teeth and by age 15, eleven teeth are decayed, filled or missing. [8] There is no reason to believe Maine children are different. In fact, it has been stated that Maine has the worst dental decay in the country. A study conducted by the Maine Department of Human Services between 1965 and 1975 found that about one quarter of the total permanent teeth examined were carious. Another third were found to have been filled previous to the examination. [9] These conditions are unnecessary, given what is known about the prevention of dental disease. Decay has three requisites: a susceptible tooth, a population of certain bacteria in the mouth, and certain foods, particularly sugars, to encourage bacteria. Prevention, therefore, must be aimed at minimizing bacterial growth and improving the diet through appropriate education and information. The American Dental Association feels that:

- increased fluoridation,
- steadily improving dental techniques,
- greater utilization of dental services by an increasingly aware public, and
- an improved economic situation,

can assure good dental health.

At current prices, every dollar invested in prevention can save about $65 in treatment costs.

ON EDUCATION

The years in a child's life when habits are being formed are the most effective time to provide them with dental health education, which includes (a) dental hygiene (proper brushing and flossing techniques) and (b) proper nutrition (health snacking habits). The preschool setting and school system serves as a place where positive reinforcement, as well as proper instruction of good oral health care, can take place. Almost every school system in Maine provides some degree of health education for its students, although there is great variety in quality and extent. Current dental health activities are directed at grades K-6. Of the 125,000 children enrolled in 1979-1980, 23,000 or approximately one-fourth participated in an organized dental education program.

Dental health education programs are often supervised by hygienists and dental health educators and implemented by the classroom teacher. There is little information on the nature of many health education programs and the qualifications of the people delivering them. This is especially true of the preschool population. Although many Headstart Programs and day care centers are involved in a limited health education program sponsored by the Office of Dental Health, countless other preschool programs could benefit by state assistance. The cost to the Department of dental health education is extremely low, approximately $2.00 per public school student and $1.00 for preschoolers per year.

FLUORIDE SUPPLEMENTS

Although fluoridation of public water supplies often sparks controversy and conflict, it is one of the most effective - and well-documented - cost effective preventive measures known for reduction in dental decay. By making teeth less susceptible to decay through increasing resistance to the action of bacteria-produced acid (it may have an anti-bacterial effect as well), optimal level fluoridation of drinking water can prevent 65 percent of decay that would otherwise occur. [10]

Maine faces a particular problem of low levels of naturally occurring fluorides in the water supplies, statewide. To date, there are 72 Maine communities that have fluoridated their water supplies.

Where community water supplies are not fluoridated, or where there is no central source of drinking water, as in many rural areas of Maine with private wells, there are several methods that could be used:

(1) fluoridating school drinking water, but this method does not reach the preschool or child when school is closed;

(2) fluoride mouth rinses, but they require regular continued use, shown to produce 35% decay reduction;

(3) dietary fluoride supplements given conscientiously from birth, on a daily basis, are close to fluoride water in protection and effectiveness; and

(4) fluoride, applied directly to teeth twice a year by a dental professional in a school program or dentist's office, also is effective, as is daily use of an appropriately formulated fluoride toothpaste. [11]

Of these approaches, fluoride supplements are nearly as effective as fluoridated drinking water and are the least expensive alternative.

The Task Force feels that the Department should investigate the cost effectiveness, cost benefits and the number of children under age 6 in need of fluoride supplements. A determining factor of need should be the parents' ability to pay, to assure that supplements reach children in greatest need.

## Section II. Footnotes

1. A Guide to Adolescent Health Care, EPSDT, U. S. Department of Health and Human Services.

2. A Community Plan for Preventing Child Abuse, A Wingspread Report. The Johnson Foundation. Racine, Wisconsin, 1979. Pg. 3

3. Ibid. Pg. 4

4. Dental Health Plan for 1979, Maine Department of Human Services. Office of Dental Health Education. Pg. 12

5. Ibid. Pg. 17

6. Ibid

7. Healthy People. The Surgeon General's Report on Health Promotion and Disease Prevention, 1979. U.S.D.H.E.W. Public Health Services Publication No. 79-55071. Pg. 11

8. According to Maine Dental Health Council, Earle W. Pulsifer, D.M.D., Chairman.

9. Dental Health Plan. op cit. Pg. 10

10. Healthy People.

11. Dental Health Plan. op cit. Pg. 13

## Section III Adolescents

Adolescent Health

Adolescent Pregnancy

## Section III. Adolescents

### Introduction

The debate that took place among Task Force members about adolescents and where they belong in a report on Maternal and Child Health is indicative of the status of adolescents in our society as a whole.

We, as adults, never seem to know where they fit.

Are they children? Do they belong with that segment of society which is dependent on adults for their decision making, instruction and care? Or are they grown up enough to make their own decisions, seek their own learning and take care of themselves? The answers to those questions are complex and difficult. The Task Force does not have all the answers. The questions have to be considered in the following context:

- the adolescent within the family unit,
- the adolescent as an individual,
- the adolescent within various age groupings, e.g., ages 10-12, 13-15, 15-17, 17-19.

The broad spectrum of years called adolescence (10-19) can best be considered between childhood and adulthood. Adolescents are told they are too old for certain behavior and too young for other. They are, in one word, "tween-agers."[1]

The Task Force decided in their early deliberations to view adolescents, first in the context of all children from birth to age 19, or until they became pregnant or gave birth. Then the needs of the child-mother or adolescent at risk of pregnancy (sexually active) would be addressed in reference to all mothers and women of childbearing age. The Task Force theorized that in the post-pregnancy or post-childbirth period, the adolescent reverts back to a child, with many of the same needs as all other adolescents. Thus, the target group, children, would include the adolescent once again.

However, by the end of their research, it became evident to the Task Force that the needs, problems and issues of adolescence, many of which are related to the pressures and uncertainties of their "between-ageness" required separate and distinct attention by policymakers, parents and the public at large.

The following recommendations address the distinctness of issues specific to adolescence, both with regard to their general health needs and their needs specific to their sexuality, sexual behavior and parenting.

It is significant to note, however, that all of the other recommendations in this report will affect and influence the adolescent in some way:

e.g., they and their children as in recommendations:

| | |
|---|---|
| 2.1 | Child Health Maintenance Standards |
| 2.8 | Mental Health Care |
| 2.3 | Health Education Curriculum |
| 2.4-2.7 | Accident Prevention Program |
| 2.11 | Dental Health Care |
| 2.9 | Children with Sepcial Needs |
| 2.10 | Families with the Problem of Child Abuse and Neglect. |

they and their pregnancies, as in recommendations:

| | |
|---|---|
| 1.1 | Perinatal Program |
| 1.7 | Early Prenatal Care through AFDC |
| 1.11 | The Birthing Experience |
| 1.10 | Continuing Education in Obstetrics |
| 1.8 | Promotion of Prenatal Care |
| 1.9 | Perinatal Educator Conference |
| 1.2-1.6 | Family Planning and Contraceptive Services. Commitment, payment for, public education training and the development of an action plan. |

and they and their babies:

| | |
|---|---|
| 1.12 | Continuing Education in Resuscitation |
| 1.13 | Neonatal Transport |
| 2.2 | Home Health Visitor. |

## Adolescent Health Care

### Problem Statement

Adolescents face numerous barriers to health care. Among these are the availability and appropriateness of health care specific to their needs. In addition, accessibility to health care is limited by certain legal restraints and the adolescent's lack of money and transportation.

### RECOMMENDATION

3.1 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES CONVENE A WORKING GROUP TO ADDRESS THE SUBJECT OF ADOLESCENT HEALTH SERVICES.

THE WORKING GROUP SHALL CONSIST OF PARENTS, ADOLESCENTS, ATTORNEYS, MEMBERS OF THE PUBLIC WITH RESPONSIBILITIES FOR MEDICAL CARE, MENTAL HEALTH CARE, SOCIAL SERVICES AND EDUCATION FOR ADOLESCENTS AND DEPARTMENT STAFF WHO WORK IN THE AREA OF CHILD WELFARE AND CHILD HEALTH.

IN AN EFFORT TO ASSURE MEDICAL COUNSELING AND EDUCATIONAL SERVICES TO ADOLESCENTS, TO REMOVE THE BARRIERS THAT ADOLESCENTS FACE IN ACQUIRING HEALTH SERVICES, TO PROTECT THE RIGHTS OF PARENTS AND TO ENCOURAGE PARENTAL RESPONSIBILITY FOR THE HEALTH CARE OF THEIR ADOLESCENTS, THE WORKING GROUP SHALL BE CHARGED WITH THE RESPONSIBILITY OF DEVELOPING LEGISLATION AND POLICIES AFFECTING RELEVANT STATE AGENCIES AND SERVICES INVOLVED IN ADOLESCENT HEALTH.

IMMEDIATE ACTION

Rationale

AVAILABILITY, ACCESSIBILITY AND APPROPRIATENESS OF HEALTH CARE FOR ADOLESCENTS

The health care of adolescents goes beyond the treatment of a particular health problem or disease. Adolescents require an holistic approach to their health care needs; one that brings together all of the components of the fragmented health care delivery system.

Adolescents' health problems are often a result of behavior, self-confidence and self-respect, and their lack of information. This is evidenced by the following:

- Fifty-three (53) adolescents ages 15-19 die as a result of motor vehicle accidents every year. Two in every 100 are injured. (Based on average last decade).
- Suicide is the second leading cause of death among children ages 10-19 years.
- Obesity and anemia are two adolescent health problems resulting from poor nutrition and insufficient diets.
- 552 adolescents (10-19) were treated for sexually transmitted diseases (e.g., gonorrhea) in 1979.
- 2,441 adolescent females gave birth during 1979.
- 3,150 adolescents went for pregnancy tests during 1979. (Estimates from Family Planning Association).
- 316 adolescents 18 and under were admitted to drug and alcohol abuse programs in Maine in 1979-1980.

Scores of other teenagers address these problems every day but they are not reflected in the statistics available.

Prevention of health problems and comprehensive health care that includes (a) emotional counseling, (b) nutritional information, (c) education and counseling in sexuality, reproduction and genetics, (d) screening and treatment of sexually transmitted disease, and (e) information on substance abuse, contraception and pregnancy termination have, historically, not been part of the traditional medical model of health care. However, physicians are a natural link to a multitude of services in the community that address adolescent health needs, such as mental health care agencies, family planning agencies, drug and alcohol rehabilitation programs, venereal disease clinics, prenatal clinics and learning disabilities programs. Fragmentation of the family and the individual's needs could be reduced through a more coordinated and integrated approach to total health needs. Adolescents do not have the skills necessary to negotiate the many disconnected and scattered programs and agencies available to them. Unfortunately, few physicians provide the appropriate linkages to services for adolescents.

In fact, Maine lacks physicians with specialized training in adolescent health who recognize the complex psychosocial health needs of the teenager. There are few others, including pediatricians, who accept adolescents as clients. The issue is, where do adolescents get their health care?

The pediatrician who has been seeing the adolescent since birth may find the relationship with the teenager's parent a complicating factor when addressing the sensitive areas of adolescent sexual behavior or substance abuse. Confidentiality in health care is of primary importance for the adolescent. Many adolescents do not view the pediatrician as the appropriate physician for their sexuality or psychosocial health needs. Many adolescents are not seen by a physician and do not get regular health care until their sexual activity has led to pregnancy or to the birth of a child. Many adolescents who go to Family Planning Clinics for their contraceptive services consider that medical check-up as their only primary health care.

For adolescents who have left their families at an early age and/or dropped out of school, primary health care is of little importance. Delivery of primary health care to these adolescents becomes increasingly complex and difficult. These adolescents, often labeled "street kids," "unreachables" or "emancipated," reject the traditional medical system as the establishment the way they reject other institutions (i.e., family, school). They do not seek medical care until they are severely ill. Only then will they find

their way into a hospital emergency room or to a "storefront medical clinic," if available. As with all adolescents, access to health care is further complicated by the lack of money, certain legal barriers and transportation to and from the health care provider.

Some methods of providing medical care, mental health care, counseling and educational services and health-related social services needed by adolescents to cope with the social and emotional pressures they face include:

- locating the health prevention and treatment programs more closely to schools or concentrated populations of adolescents;
- providing education and information services in medical offices during the office visit by persons trained in adolescent needs;
- providing separate physician waiting rooms or specific office hours for adolescents;
- recognizing the effect of peer influence and developing ways in which adolescents could be informed and trained to provide appropriate, positive health information to each other;
- working with families to help them resolve the conflicts of adolescent behavior, and parental responsibility for adolescent health care;
- providing outreach services to get the adolescent into a health care delivery system and/or providing public education and information on the importance of health care, e.g., prenatal and postpartum care for pregnant adolescents;
- identifying a person or agency in the community to act as a source of help and to assume responsibility for coordination and continuity of health care for the adolescent.

The latter method is endorsed by the American College of Obstetricians and Gynecologists (ACOG) statement of policy on adolescent reproductive health care. According to ACOG, the elements of a comprehensive program for individuals entering their reproductive years should include health, education and social services. The adolescent's entry into a health care system is dependent on whether the adolescent is sexually active and whether adolescent parenthood becomes the choice. The College supports a special program focus for adolescents in public and private health programs. Their emphasis is on follow-up support. If adequate follow-up is not implemented, the adolescent who seeks immediate services is lost to continued preventive and

supportive health services and care. Someone needs to assure the follow-up. Education for adolescents who are not yet sexually active is the ideal entry point for health services. Failing that, steps should be taken to assure that continuity of care follows a negative or positive pregnancy test, a request for contraception, an abortion, or the birth of a child. Such supportive services require a multidisciplinary team approach by the community of health care providers to provide comprehensive assistance to young people.

## OTHER ISSUES AND PROBLEMS FOR THE WORKING GROUP TO CONSIDER

Another area of concern to the Task Force is the adolescent's attitude that government will "take care" of them. This is evidenced by the fact that many adolescents who become pregnant perceive the welfare system as an effective and "plentiful" source of financial support for themselves and their babies. This misconception is brought on by their lack of information and immature sense of economic support. The working group needs to address this issue and consider ways of better informing the adolescent of the economic realities of parenthood.

The Task Force requests that the working group assess and define the relationship between the Statewide Service Provider Coalition on Adolescent Pregnancy and the Department of Human Services. Public and private community agencies serving adolescents who are at risk of pregnancy, pregnant, or who are teen parents have joined together to form a coalition addressing the issue of adolescent pregnancy. They have developed a strategy to provide a comprehensive approach to the problem of adolescent pregnancy. The Task Force feels that there needs to exist a recognition on the part of government that for many years a number of private agencies throughout the State have been providing resources towards the resolution of adolescent pregnancy issues. There does not need to be a new program created for dealing with adolescent pregnancy. There are numerous resources available in the communities which could be enhanced by appropriate linkages and shared support. The Coalition's strategy for working with adolescents who are pregnant or who are parents involves referrals, coordination and mutual support.

In addition to the relationship between the Department and the Coalition, the Working Group shall consider and promote the involvement of adolescents,

parents of adolescents, the clergy, the Legislature, medical practitioners and educators who are not members of the Coalition in the resolution of the problem of adolescent pregnancy.

## ADOLESCENTS AS POOR ACHIEVERS

For the adolescent who drops out of school, access to health care is a problem. Based on secondary school enrollment, the Department of Educational and Cultural Services estimates that:

- in 1971-1972, 3,273 children dropped out of school or 5.3% of the total enrollment (68,786);
- in 1976-1977, 3,949 or 5.4% dropped out of school. Enrollment that year was 73,669.

These students could not receive the education and information provided in a health education curriculum (*see Recommendation 2.3A*) throughout the established educational system. Without a high school education, their opportunities for economic stability and advancement become limited. Many of these students, especially those who quit school for reasons other than employment or marriage, are more vulnerable to the health problems identified as "street" related, i.e., drug and alcohol abuse, mental health problems, early pregnancy and parenthood. The Task Force recognizes the vulnerability of these youth and suggests that the Working Group address ways in which to keep children in school.

The child who is a poor achiever early in his or her school years and faces repeated school failures is more likely to drop out of school. If a concentrated effort were made by school officials and educators to identify these children early in their school experience, special assistance could be provided to meet their emotional and educational needs. Unfortunately, unless the poor achiever acts out behaviorally or has an identified severe learning problem, he or she may be lost in the system's attempt to provide for the more difficult or needy student. The Task Force also recognizes the lack of preparation specific to child development required for many Maine school teachers. The Task Force feels that teachers in Maine should be required to take at least one Child Development course and one Health Education course in order to teach in Maine.

THE SELF-CONCEPT OF THE ADOLESCENT

A significant issue that the Working Group on Adolescent Health shall address is the problem of the adolescent's sense of self, self-confidence and self-respect. Much of the adolescent behavior (motor vehicle accidents, suicide, school drop outs, early pregnancy and parenthood, drug abuse) that is having an adverse affect on their health is a result of the way the adolescent feels about himself or herself.

The development of one's own identity takes place over the period of a lifetime. The developmental stages from birth through adolescence is the most critical life period for the evolution of self-identity, self-value and self-worth.

The parent plays the most influential and vital role in the child's development of ego and identity. It is the parent's responsibility to perform this function. However, the child's environment, including other family members, peers and the community contribute to the development of the child's identity. They too, have a responsibility to assist in the development of a positive, healthy self-image for their child.

For the adolescent, the period of time beginning with the onset of puberty until the age of nineteen, is full of confusing messages about their identity. Adolescents fluctuate from their familiar feelings of childhood to their strange new feelings of puberty.

Broadly speaking, there are three stages of adolescent behavior.[2]

> 10-14. Although some young girls enter menarche as early as age 9, the ages of 10-14 represent the time of central struggle for adolescents to get comfortable with their rapidly changing bodies. The adolescent is acutely aware of others but unclear about what is expected of him or her.
>
> 15-17. Physical changes begin slowing down in this period but psychosocial changes accelerate. There is mental and emotional turbulence and rebellion. The adolescent makes claims of independence and pronounced triads against the demands of society. However, in the midst of the acting out, the experimentation and the talking out, there comes a brief but firm grip on a sense of self.
>
> 17-19. By late adolescence the beginning of stabilization of identity struggles take place. There is a feeling of becoming more predictable, better able to think about the future...even plan for it and for some, take tentative steps toward it.

Sometimes, however, the community, the schools and parents expect maturity and control over emotions, social behavior and thought processes that the adolescent may not yet be able to provide.

The Task Force suggests to the Working Group that they consider ways in which the environment negatively reinforces the behavior of adolescents. Examples of ways in which the environment influences adolescent behavior are:

- the sex, drug, alcohol, tobacco oriented advertising on television and radio and through the use of rock and roll music;
- the lack of available job and career opportunities for adolescents;
- the spiraling divorce rate which has created a large population of children growing up in single parent families. (In 1979, 3,623 divorces involved children under 18; 3,646 in 1978; 3,374 in 1977; 3,311 in 1976; and 3,543 in 1977).
- the lack of attention paid to the noteworthy accomplishments of adolescents and the over-emphasis of negative behavior, e.g., drug and alcohol abuse, teenage pregnancy, juvenile crime.

The Task Force also suggests that the Work Group study ways to involve the clergy, the schools, and the service providers in adolescent health in assisting parents in the promotion of a positive self-concept in their children.

The Task Force estimates $7,600 in additional resources will be required for operating costs for the working group during one year.

## Adolescent Pregnancy

The Task Force believes that there are a number of educational and health services that may be important in providing the adolescent with the resources necessary to postpone pregnancy and parenthood. These include:

- education on reproduction and sexuality;
- education on the responsibilities and demands of parenthood;
- the availability of contraceptive services for sexually active adolescents and those at risk of repeat pregnancies;
- the availability of and accessibility to primary health care;

- the promotion of a positive self-image for male and female adolescents; and most importantly,

- a stable, secure, positive family life.

The issue of prevention of pregnancies among adolescents is discussed in more detail in Section I, Women in the Childbearing Years and Section II, Health Education Curriculum.

For those adolescents who are pregnant and give birth to a child, the following recommendations reflect the thoughts and concerns of the Task Force.

Problem Statement

One out of every seven live births in 1979 was to a teenager from the age of menarche to age 19. Teenagers are medically, economically and emotionally at high risk for pregnancy complications which have an adverse effect on their health and the health of the babies.

RECOMMENDATION

3.2(A) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES PROMOTE THE ACCESSIBILITY OF PRENATAL CARE FOR ADOLESCENTS BY TAKING THE FOLLOWING STEPS:

(1) THE DEPARTMENT SHALL WORK WITH THE COMMUNITY HEALTH CARE PROVIDERS IN THE DEVELOPMENT OF POLICIES THAT ACTIVELY SUPPORT THE PARTICIPATION OF THE FAMILY IN THE HEALTH CARE OF THE ADOLESCENTS. HEALTH CARE PROVIDERS SHOULD REFER THE PREGNANT ADOLESCENT TO APPROPRIATE COUNSELING SERVICES FOR SUPPORT AND ASSISTANCE IN COMMUNICATING WITH HER FAMILY;

(2) THE DEPARTMENT SHALL ASSIST AND PROMOTE THE PROVISION OF SPECIFIC TRAINING IN THE INVOLVEMENT OF THE FAMILY FOR PERSONNEL WHO ARE IN THE POSITION OF COUNSELING PREGNANT ADOLESCENTS;

(3) THE DEPARTMENT SHALL PRESENT AND ADVOCATE LEGISLATION THAT WOULD MAKE PRENATAL HEALTH CARE AVAILABLE TO ADOLESCENTS WITHOUT REQUIRING THE CONSENT OF THEIR LEGAL GUARDIAN.

IMMEDIATE ACTION

3.2(B) WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE PAYMENT FOR PRENATAL CARE SERVICES FOR ALL WOMEN UP TO 18 YEARS OF AGE REGARDLESS OF THEIR FAMILY LIVING ARRANGEMENT; THIS ONLY AFTER ALL OTHER OPTIONS FOR PAYMENT HAVE BEEN EXHAUSTED.

FIRST PRIORITY

Rationale

THE MAGNITUDE OF THE PROBLEM

Despite efforts to prevent adolescent pregnancy, there are many teenagers who will become pregnant, not choose to terminate pregnancy and deliver a child. In Maine in 1979, there were 2,441 live births to adolescents from the age of menarche to age 19. Girls aged 15-16 gave birth to 358 children and 24 births were to children under age 15. There were 995 out-of-wedlock births among teens in 1979. Fifty-nine percent (59%) of the live births to girls aged 17 and under were out-of-wedlock.

The Task Force believes that the health and social risks for all teenagers, regardless of age and marital status, begins at the point of pregnancy. Although the medical risks to adolescents is most serious under the age of 17, the emotional, economic and educational problems of teenage parenting can affect all pregnant adolescents. Early marriages often lead to divorce.[3] Eight percent (8%) of all substantiated cases of child abuse and neglect in Maine in 1979 involved teen parents.[4] As of October, 1978, 45 percent of all mothers receiving AFDC had been teenagers at the time they

delivered their first child.[5] Of the live births occurring* in Maine in 1979, 3,144 had less than 12 years of education.[6]

## THE NEED FOR AND IMPORTANCE OF PRENATAL CARE

Prenatal health care promotes healthy mothers and healthy babies. Early prenatal care as soon as the female thinks she is pregnant can signal many of the medical risks associated with pregnancy and childbirth. Of the known conditions accounting for low birthweight babies,** one-half of the risks can be predicted in the first prenatal visit. Obstetrical complications such as bleeding, infections, multiple pregnancies and premature rupture of the mother's membranes can be discovered early in pregnancy. Maternal health problems of heart, liver or kidney disease, diabetes or high blood pressure are identifiable conditions during pregnancy.[7]

Maternal behavior influences the health of the baby. Smoking has been

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*Live births occurring in Maine represent less births than resident live births. Births occurring in Maine does not include those residents who gave birth outside of the boundary of Maine, for example, while traveling or in a Canadian or New Hampshire border hospital. In 1979, there were 16,435 resident live births but only 15,812 live births occurring in Maine.

Source: Statistics from the Division of Research and Vital Records.

**Low birthweight is the most common birth defect of all that plagues newborn children. It is the cause of the greatest number of deaths in the first year of life and is the major cause of disability in childhood. Learning disabilities and behavioral problems are also linked to low birthweight.

Low birthweight means the infant fails to grow sufficiently in the womb, possibly from poor nutrition, insufficient oxygen or other adverse conditions. In contrast to premature babies that are born too soon, low birthweight babies' organs have had time to mature but are exceedingly small.

Source: March of Dimes, Fact's 80.

linked to stillbirths, spontaneous abortions and premature births.* Chronic alcoholism, drug addiction and poor maternal nutrition before and during pregnancy leads to low birthweight babies. Early prenatal care including prenatal diagnosis, emotional and nutritional counseling, supplemental vitamins, information about maternal behavior including substance abuse and routine medical care can augment the positive health outcome for mother and baby.

For adolescents, early prenatal care is imperative but because of the emotional and social turmoil involving the pregnancy (e.g., admitting for the first time to her parents that she is sexually active, confronting her own desires for the pregnancy, etc.) and the subsequent delays in decision making about the pregnancy, adolescents do not receive early prenatal care.

The degree of physical maturation of the adolescent (especially age 17 and under) is a factor in the level of risk in the pregnancy. The adolescent's body may still be in need of many of the same nutrients required by the baby. This is especially true for repeat pregnancies in the adolescents. She may not give her body time between pregnancies; there may be increased losses of nutrient reserve and further strain on overall health.[8] A minimum of two years between pregnancies is preferable.[9]

Adolescents who indulge in drugs, alcohol, and tobacco and have poor nutrition significantly increase the risk for themselves and their babies. Emotional, social and economic stress can further complicate the physical risks. A 1977 study conducted by Rose-Marie Louten and Richard A. Cook entitled, "Teenage Pregnancy in Maine" asserts that the unwed teenage mother is

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*A baby born ahead of schedule (3-12 weeks early) and whose organs have not matured sufficiently is premature. The baby may have problems breathing, have inadequate heart action and control of body temperature and blood sugar.

Premature labor is the most common complication of pregnancy. The cause is not usually known. Nearly half of all infant deaths are associated with prematurity. The death rate in Maine according to researchers Louten and Cook, is thirty times greater among premature infants than among mature infants.

Source: March of Dimes, Fact's 80.

more at risk for premature or low birthweight babies than the married teen mother. A review of the 1972-1974 birth statistics shows that the 18 and 19 year old unwed mothers had more premature infants than 18 and 19 year old mothers. Louten and Cook speculated that the younger, unwed mothers usually remained at home and were being cared for by their parents, thus decreasing the risk of prematurity due to illegitimacy. The older, unwed teenage mothers, living independently, faced a high risk of premature births due to their inability to provide for themselves.

According to further research by Louten and Cook, the percent of low birthweight infants born to girls less than 17 years of age is reported twice as great as the rate of low birthweight infants born to women age 25-29. The fact remains, however, that even among teenage mothers, the ratio of low birthweight drops in proportion to the adequacy of prenatal care.[10]

The following recent statistical information provides a basis for understanding the importance of early prenatal care for adolescents.

FACTS:

- Teenage parents have the highest infant (first year of life) mortality rate, based on 1975-1978 data. *(See chart IIIa, page 112)*
- Teenage parents have the second highest neonatal (up to 28 days) death rate, based on 1975-1978 data. Second only to women over 35. *(See chart IIIb, page 113)*
- Teenage parents have the highest post-neonatal (between 28 days and one year of age) death rate based on 1975-1978 data. *(See chart IIIc, page 114)*
- It is important to note that the infant and neonatal death rates have been steadily decreasing for the past forty years. From 1976 to 1977, the number of neonatal deaths decreased by 13.9 percent, and infant deaths declined by 7.3 percent.
- Teenage parents in 1978 had the highest percentage of low birthweight babies than any other age category (18-34 and 35+) including women over 35. *(See chart IIId, page 115)*
- Teenagers in 1978, 17 years and under, had more low birthweight babies born out-of-wedlock than married teenagers. This is in contrast to the other two age categories (18-34, 35+). *(See chart IIId)*
- In 1979, 96 percent of the live births to teenagers under 15 were born out-of-wedlock. Fifty-seven percent of the births to 15-17 year olds and 32 percent of the births to 18 and 19 year olds were out-of-wedlock. Each of these is higher than in any of the other five age categories. *(See chart IIIe, page 116)*

- Four (4) of the teens, 15 and younger, were having repeat pregnancies and gave birth to their second child.

- Seventy-four (74) 16 and 17 year olds were having their second child, five (5) were having their third child and one (1) 17 year old had her fourth child in 1979. *(See chart IIIf, page 117)*

- In 1979, 390 Maine women who gave birth reported no prenatal care during their pregnancy or 2.4 percent of all live births. *(See chart IIIg, page 117). Note: The incidence of women with no prenatal care reported is decreasing.*

- According to 1977 data available from the National Center for Health Statistics, 20.9 percent of the pregnant women in Maine did not obtain prenatal care in their first trimester.

- The number of live births to teenagers as a percentage of total live births has been decreasing steadily. *(See chart IIIh, page 118).* We will not know until more accurate data is available and after the 1980 census is completed, whether this is due to a decrease of adolescents in the total population or an increase in abortions.

BARRIERS TO PRENATAL CARE FOR ADOLESCENTS

Adolescents have difficulties in obtaining early prenatal care primarily because:

(a) their lack of motivation,
(b) their lack of knowledge of the importance of prenatal care,
(c) their reluctance to acknowledge their pregnancy,
(d) their indecision about pregnancy termination,
(e) their lack of transportation to health care,
(f) their lack of finances, and
(g) the need for parental consent.

The Task Force feels that Recommendations 3.2(A) and 3.2(B) will remove the latter two barriers to prenatal care.

Currently, the law provides the adolescent with clear legal access to family planning services, abortion, and to treatment for a sexually transmitted disease and drug abuse. The law is not so clear with legal access for prenatal care. Some providers of medical services refuse to provide prenatal care without parental consent. In the opinion of the Task Force, denying the adolescent similar access to prenatal care is inconsistent and inappropriate.

The adolescent may attempt to keep the pregnancy a secret until such time that either her problems are resolved or she can no longer hide the pregnancy. Unfortunately, by that time, vital prenatal care during the first trimester has not been provided.

In order to protect the rights of the family and individual family members, the Task Force recommends a two-fold approach to family involvement. First, the provider of prenatal care, and/or persons working with the adolescent, should be trained in the skills necessary to help the pregnant adolescent confront and involve her parents. Secondly, each prenatal care provider should then assist the adolescent in any way he can in involving her parents in the decisions regarding the pregnancy and childbirth.

The Task Force recognizes that many adolescents, regardless of their living situation, may not have the means to pay for prenatal care. In some cases parents cannot or will not pay. Therefore, a "last resort" payment mechanism is needed to remove the financial barrier to prenatal care.

Operating costs for Recommendation 3.2 are limited to the expenditures necessary for training (i.e., step 2 of 3.2A).

Problem Statement

Certain barriers exist that prevent adolescents from considering adoption as an alternative to parenthood.

RECOMMENDATION

3.3 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES, WITH THE ASSISTANCE OF RELATED PROFESSIONALS AND CONSUMERS, CONDUCT AN IN-DEPTH STUDY RELATIVE TO:

(A) THE AVAILABILITY OF ADOPTION SERVICES FOR PREGNANT ADOLESCENTS;

(B) THE APPROPRIATENESS OF ADOPTION SERVICES FOR PREGNANT ADOLESCENTS;

(C) THE BARRIERS FACED BY PREGNANT ADOLESCENTS AND TEEN PARENTS IN THE CONSIDERATION OF ADOPTION.

SECOND PRIORITY

Rationale

Adoption services are necessary for those adolescents seeking adoption for their babies. However, adoption services are limited in many areas of Maine.

In general, there exists an adoption stigma that says to the girl, "you don't love your baby," and view the adoption agencies as "taking babies away." The decision for adoption is a difficult one for a pregnant woman. Most adolescents, in fact, keep their children. In the experience of Task Force members, the young adolescent does not normally have the capacity to view the adoption as in the best interest of the child. Older adolescents are more likely to view adoption as an option to parenting. There are few public relations done that promote the love and sacrifice necessary to release a child to adoption. Parents that have experienced adoption are a good resource for others making the decision. A great deal of support from professionals and the adolescent's family and friends is necessary to follow through with the adoption decision.

Other barriers to successful adoption include the complex legal process and compliance with the "Father's Rights Law."

The Task Force concluded that there were sufficient problems to warrant further investigation into the adoption issue for adolescents.

The Task Force estimates that a study of adoption can be conducted with existing resources within the Department.

Problem Statement

Pregnant adolescents and teenage parents have difficulties staying in school or returning to school for their education.

RECOMMENDATION

3.4 WE RECOMMEND THAT THE DEPARTMENT OF EDUCATIONAL AND CULTURAL SERVICES DEVELOP A FORUM FOR SCHOOL PERSONNEL TO REVIEW AND REVISE SCHOOL POLICIES TO ENSURE THAT PREGNANT ADOLESCENTS RECEIVE APPROPRIATE COUNSELING SERVICES TO KEEP THEM IN SCHOOL AND/OR TO HELP THEM RETURN TO SCHOOL.

SECOND PRIORITY

Rationale

Vocational and educational training and advocacy for the adolescent to continue her education is a necessary support for the well-being of the teenager and teen parent and child. The support from the school system is discretionary and is dependent upon individual administrations. Pregnancy is not considered a medical problem, so tutoring is not an automatic or mandatory service. In policy, the pregnant teen becomes an adult when she gives birth, and is thereby "emancipated" from the public school system. If the pregnant adolescent is motivated and asks for help, she can receive tutoring and necessary special attention to continue her schooling throughout her pregnancy. However, many of the pregnant teens have low self-images, are poor learners, are unmotivated and often have difficulty reading. Furthermore, tutoring isolates and segregates the adolescent who requires socialization and development of social skills.

The Task Force requests that the Department of Educational and Cultural Services sponsor a forum in which school personnel, including guidance counselors and administrators, can review and revise their school policies affecting pregnant adolescents so that adolescents can receive the help necessary to continue their education.

**In the opinion of the Task Force, a forum to review school policies can be conducted with existing resources.**

Problem Statement

Teen parents require care for their child to enable them to return to school or vocational training or to go to work. Many pregnant adolescents and teen parents lack sufficient skills in parenting, child care and child development to enable them to be caring, responsible and loving parents.

RECOMMENDATION

3.5 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES PROMOTE THE SELF-SUFFICIENCY OF ADOLESCENT PARENTS AND THE PREPARATION FOR PARENTHOOD FOR PREGNANT ADOLESCENTS AND TEEN PARENTS BY:

(1) ASSESSING THE AVAILABILITY OF CHILD DAY CARE SERVICES FOR INFANTS OF TEENAGE PARENTS; AND

(2) DEVELOPING FUNDING SOURCES FOR COMMUNITY BASED CHILD DAY CARE PROGRAMS WHICH PROVIDE TRAINING IN CHILD CARE AND PARENTING SKILLS FOR PREGNANT ADOLESCENTS AND TEEN PARENTS.

SECOND PRIORITY

Rationale

The teen parents must have someone to care for their child while they are at work, in school or receiving training. Two barriers to child day care for adolescent parents are (1) money to pay for the child day care and (2) the availability of someone to care for their child. Child day care costs between $35 and $50 per week for full time care. Most teenagers are not financially able to pay for their child care. The Department of Human Services purchases free, low cost and fee-for-service child day care for clients who are eligible for Title XX funded day care. However, these slots are limited to Department protective clients, and on a first-come-first-serve basis. They are also unavailable in many Maine communities. Additionally, if the adolescent receives Aid to Families with Dependent Children (AFDC), they may "pay" for their day care through an AFDC disregard mechanism. This means that the expense of day care is included as a work-related expense. For the working adolescent this is not always a "dollar for dollar" benefit to them.

Even if the adolescent can pay for the service, there are limited places to care for the child. There is no center-based infant day care in Maine. Currently, the Department is investigating the possibility of developing a license for center-based infant day care. The alternative to center-based care is the licensed family day care home. In addition, many parents in Maine seek neighbors, extended family members or friends to care for their child. These people may or may not be licensed.

The Task Force concludes that a day care program, either center-based or home-type that is licensed to care for infants, could perform the function of training the adolescent as well. Many young adolescents have had little or no training in preparation for parenting, child care and child development. This lack of training leads to difficulties in coping with the needs

of the child. In some cases, it can lead to child abuse and neglect. If the adolescent, with her baby, could attend training sessions in a preschool environment conducted by trained and experienced persons, she would learn first-hand how to take care of her baby. Pregnant adolescents could be assigned to preschool or day care programs for the same purpose. Some day care programs in Maine provide this service, but it is neither coordinated, publicized or available statewide.

The costs of developing a training program for teen parents and pregnant adolescents is difficult to determine. The costs of infant day care are high die to the intense needs of the infant. The Task Force estimates that a program to serve 40 teen parents, 40 infants and 40 pregnant adolescents (120) would require $250-300,000.

Problem Statement

There is no single person or office within State government that is identified as responsible for adolescent health care or the issue of adolescent pregnancy. This has contributed to problems of coordination and leadership in the development and distribution of services and programs to address issues related to adolescent health.

RECOMMENDATION

3.6 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DESIGNATE ONE PERSON TO ACT AS THE ADVOCATE FOR ADOLESCENTS IN DEALING WITH PROGRAMS ADDRESSING ADOLESCENT ISSUES.

THIS PERSON WOULD HAVE THE FOLLOWING SPECIFIC RESPONSIBILITIES:

(A) TO PROMOTE COMMUNICATION BETWEEN THE PROVIDER AGENCIES SERVING ADOLESCENTS, PHYSICIANS AND MEDICAL PERSONNEL, SCHOOLS, CHURCHES AND THE COMMUNITY;

(B) TO THOROUGHLY EXAMINE ISSUES, PROBLEMS AND THE STRATEGIES FOR RESOLUTION OF THE PROBLEM OF ADOLESCENT PREGNANCY IN MAINE;

(C) TO OVERSEE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE GOVERNOR'S TASK FORCE ON MATERNAL AND CHILD HEALTH PERTAINING TO ADOLESCENT PREGNANCY;

(D) TO ADVOCATE FOR THE ADOLESCENT AND HIS OR HER FAMILY WITHIN THE GOVERNMENTAL AGENCIES AFFECTING THEM AND THROUGHOUT THE NETWORK OF COMMUNITY SERVICES;

(E) TO PROVIDE A CLEARINGHOUSE FOR INFORMATION ON COMMUNITY SERVICES, PROGRAMS, AND RESOURCES FOR ADOLESCENTS;

(F) TO SERVE AS A FULL MEMBER OF THE STATEWIDE SERVICE PROVIDER'S COALITION ON ADOLESCENT PREGNANCY;

(G) TO ASSIST AND COMMUNICATE WITH THE WORKING GROUP ON ADOLESCENT HEALTH IN AREAS OF MUTUAL INTEREST AND CONCERN.

FIRST PRIORITY

Rationale

Two major health related problems confront the adolescent.

(a) the adolescent, in general lacks the decision-making skills necessary to determine the service available to meet whatever problems arise (e.g., poor health, threat of pregnancy or venereal disease, drug abuse, nutrition problems, emotional disorder);

(b) the medical, mental health and maternal and child health related services are not provided, either locally or regionally, in a comprehensive, coordinated manner. (For further discussion, see Section IV, Administration and Coordination of MCH Services in Maine).

For many adolescents and for most adolescent problems, the parent can be expected to negotiate the maze of health services required by the adolescent. For the adolescent who is unable to depend on his or her parent for their needs (e.g., from fear of retaliation, or parents refusal or lack of sufficient resources to help) the need for social service assistance is even more crucial.

A "one-name, one-number" mechanism within State Government would provide parents and adolescents with an advocate who can effectively represent their needs. The advocate would provide a clearing house of information and resources for adolescents and parents. Thus their search for health care services and programs would be easier.

The advocate would perform a similar function for service providers. Many of the problems of fragmentation of services for adolescents stem from the service provider lacking a process to communicate with each other or to develop cross-referral mechanisms. Medical personnel, including physicians, nurses, and health practitioners, schools, churches, private and publicly endowed service agencies, are often too busy, over-worked and lacking in resource to spend the necessary time and energy to coordinate their services and referrals.

The Statewide Service Provider Coalition, a group of public and private community agencies who have joined together to address the issues of teenage pregnancy, has taken significant steps to improve agency to agency communications. The Coalition could assist the adolescent advocate in the development of strategies to approach the issue of adolescent pregnancy on a statewide basis and would be in a position to support the agency to agency linkages necessary for a more comprehensive, coordinated system of health services in the communities.

Active involvment with the physician community can assist in meeting the needs of adolescents and their families. The Advocat's primary responsibility would be to define and remove the barriers to health services and to participate in the development of State policies, resource allocations, legislation and service provider program planning.

Personnel and travel costs for the advocate are estimated at $20,500.

SUPPORTING DATA

SECTION III

ADOLESCENTS

*Chart III a.* Infant Deaths by Age of Mother
Maine 1975-1978 (Resident Data)

| Age of Mother | Year | | | | 1975-78 Total | Age-specific Infant Mortality Rate[a] |
|---|---|---|---|---|---|---|
| | 1975 | 1976 | 1977 | 1978 | | |
| <15 | 1 | 0 | 1 | 0 | 2 | * |
| 15-19 | 49 | 33 | 34 | 34 | 150 | 14.16 |
| 20-24 | 68 | 64 | 55 | 63 | 250 | 10.43 |
| 25-29 | 47 | 41 | 43 | 41 | 172 | 9.07 |
| 30-34 | 16 | 14 | 14 | 20 | 64 | 9.62 |
| 35+ | 7 | 6 | 5 | 3 | 21 | 9.75 |
| TOTAL | 188 | 158 | 152 | 161 | 659 | 10.55 |

* Rate not computed due to small number of events.
[a] Rates expressed per 1,000 live births within an age category.

Source: Maine Department of Human Services,
Bureau of Health Planning and Development,
December, 1979.

*Chart 111b.* Neonatal Deaths by Age of Mother
Maine 1975-1978 (Resident Data)

| Age of Mother | Year | | | | 1975-78 Total | Age-specific Neonatal Mortality Rate[a] |
|---|---|---|---|---|---|---|
| | 1975 | 1976 | 1977 | 1978 | | |
| <15 | 1 | 0 | 0 | 0 | 1 | * |
| 15-19 | 30 | 22 | 14 | 13 | 79 | 7.46 |
| 20-24 | 45 | 45 | 39 | 39 | 168 | 7.01 |
| 25-29 | 32 | 28 | 35 | 32 | 127 | 6.70 |
| 30-34 | 12 | 11 | 8 | 11 | 42 | 6.31 |
| 35+ | 6 | 5 | 5 | 2 | 18 | 8.36 |
| TOTAL | 126 | 111 | 101 | 97 | 435 | 6.97 |

* Rate not computed due to small number of events.
[a]Rates expressed per 1,000 live births within an age category.

Source: Maine Department of Human Services,
Bureau of Health Planning and Development,
December, 1979.

*Chart IIIc.* Post-Neonatal Deaths by Age of Mother
Maine 1975-1978 (Resident Data)

| Age of Mother | Year | | | | 1975-78 Total | Age-specific Post-Neonat. Mortality Rate[a] |
|---|---|---|---|---|---|---|
| | 1975 | 1976 | 1977 | 1978 | | |
| <15 | 0 | 0 | 1 | 0 | 1 | * |
| 15-19 | 19 | 11 | 20 | 21 | 71 | 6.70 |
| 20-24 | 23 | 19 | 16 | 24 | 82 | 3.42 |
| 25-29 | 15 | 13 | 8 | 9 | 45 | 2.37 |
| 30-34 | 4 | 3 | 6 | 9 | 22 | 3.31 |
| 35+ | 1 | 1 | 0 | 1 | 3 | 1.39 |
| TOTAL | 62 | 47 | 51 | 64 | 224 | 3.58 |

* Rate not computed due to small number of events.
[a]Rates expressed per 1,000 live births within an age category.

Source: Maine Department of Human Services,
Bureau of Health Planning and Development,
December, 1979.

*Chart IIId.*

VITAL STATISTICS

1977

Resident live births to mothers by low birth weight, legitimacy and age

| | | 1500 | | 1500-2500 | |
|---|---|---|---|---|---|
| | | # | % | # | % |
| 17 years and under illegitimate | | 5 | 1.2 | 35 | 8.1 |
| 17 years and under married | | 1 | .2 | 24 | 6.4 |
| 17 years and under | Total | 6 | .7 | 59 | 7.3 |
| 35 years and over illegitimate | | 2 | 4.2 | 1 | 2.1 |
| 35 years and over married | | 6 | 1.2 | 29 | 6.0 |
| 35 years and over | Total | 8 | 1.5 | 30 | 5.6 |
| 18-34 years illegitimate | | 20 | 1.4 | 91 | 6.2 |
| 18-34 years married | | 97 | .7 | 537 | 4.1 |
| 18-34 years | Total | 117 | .8 | 628 | 4.3 |

Source: Division of Research and Vital Records, Department of Human Services

*Chart IIIe.*

Resident Live Births
Maine 1979

| Age of Mother | Out of Wedlock | Total | % |
|---|---|---|---|
| under 15 | 23 | 24 | 96 |
| 15-17 | 437 | 766 | 57 |
| 18-19 | 531 | 1651 | 32 |
| 20-24 | 712 | 6191 | 12 |
| 25-29 | 241 | 5097 | 5 |
| 30-34 | 109 | 2176 | 5 |
| 35-39 | 23 | 454 | 5 |
| 40+ | 6 | 73 | 8 |

Source: Division of Research and Vital Records,
Department of Human Services

*Chart 111f.*

Resident live births by age and order of children.

| Age | Live births that were the First Child | Second Child | Third Child | Fourth Child | 1979 Total |
|---|---|---|---|---|---|
| under 15 years | 23 | 1 | | | 24 |
| 15 years | 96 | 3 | | | 99 |
| 16 | 215 | 17 | 1 | | 235 |
| 17 | 368 | 57 | 4 | 1 | 432 |
| 18 | 546 | 123 | 12 | | 686 |
| 19 | 695 | 235 | 20 | 3 | 965 |

Source: Division of Research and Vital Records,
Department of Human Services

*Chart 111g.*

| | Total Resident Live Births | Total out-of-wedlock | No Prenatal care | Under 2500 grams |
|---|---|---|---|---|
| 1975 | 15,232 | 1496 | 841* | 867* |
| 1976 | 15,046 | 1531 | 782* | 830* |
| 1977 | 16,252 | 1780 | 572* | 883* |
| 1978 | 15,919 | 1944 | 410 (2.6%) | 831 |
| 1979 | 16,435 | 2083 | 390 (2.4%) | 851 |

*Based on live births occurring in Maine, only, i.e., fewer total births.

1975 - 460 less than resident live births
1976 - 527 less than resident live births
1977 - 663 less than resident live births

Source: Division of Research and Vital Records,
Department of Human Services

*Chart IIIh.*

| | Total Births | % of Total Teen Births |
|---|---|---|
| 1972 | 16,269 | 19.4 |
| 1973 | 15,639 | 19.2 |
| 1974 | 15,100 | 18.0 |
| 1975 | 15,232 | 18.9 |
| 1976 | 15,046 | 17.4 |
| 1977 | 16,252 | 16.6 |
| 1978 | 15,919 | 15.8 |
| 1979 | 16,435 | 14.9 |

Source: Bureau of Health Planning and Development, Department of Human Services

## Section III. Footnotes

1. A Guide to Adolescent Health Care, HEW, Health Care Financing Administration. Pg. 1
2. Ibid. Pg. 10
3. Division of Research and Vital Records, Department of Human Services
4. Ibid
5. Ibid.
6. Ibid.
7. Facts '80. March of Dimes
8. Louten and Cook.
9. Facts '80. March of Dimes
10. Ibid.

## Section IV The Administration of Maternal and Child Health Services in Maine

Policy Development and Program Planning

Coordination of Maternal and Child Health Programs at the Local and Regional Level

Financing of Maternal and Child Health Services

Administrative Policy Decisions

# Section IV. The Administration of Maternal and Child Health Services in Maine

## Introduction

There is no comprehensive maternal and child health program or service delivery system in Maine. As defined by the Task Force, a comprehensive maternal and child health program or system includes programs and services to address the physical, emotional and developmental problems and needs of Maine's women in their childbearing years and their children. The Task Force found, in assessing maternal and child health programs, resources and services, that authority, responsibility and accountability for maternal and child health is currently dispersed among diverse agencies within state government. Locally, there are few, if any, mechanisms for ensuring that maternal and child health services are available or that they are delivered in a coordinated service delivery system.

The Task Force has identified at least three major reasons for the absence of a comprehensive maternal and child health strategy in Maine. First, the administrative and programmatic requirements of the numerous federal and state categorical funding services for maternal and child health inhibit the development of a coordinated, comprehensive maternal and child health system.

Secondly, there is currently no policy development or planning process for maternal and child health within state government in Maine to establish or implement a comprehensive maternal and child health program.

And finally, the Task Force has found that the coordination of maternal and child health services locally or regionally is a problem of significant proportions that has not received adequate attention by policy makers. Many of these problems, however, stem from the limitations imposed by categorical funding sources and are compounded by the absence of policy goals and programmatic and administrative strategies for improving maternal and child health in Maine.

The following sections summarize the Task Force's major findings and conclusions regarding the administration and coordination of maternal and child health services in Maine.

## POLICY DEVELOPMENT AND PROGRAM PLANNING

The development of a more comprehensive approach to meeting maternal and child health needs in Maine will require a coordinated policy development and program planning process with State Government in order to ensure that the broadly defined health needs of families are adequately addressed. Such a process must encompass all of the diverse categorical programs and agencies which serve families. In addition, the principal goals of coordination - to eliminate the duplication of services and to ensure that needed services are available - can only be achieved through a commitment at the top levels of

policy decision-making to specific administrative mechanisms and strategies for coordinating policy development and program planning for maternal and child health. A specific goal of this policy development and planning process would be to develop specific incentives and sanctions to encourage coordination in the delivery of maternal and child health services at the state and local levels.

Currently, there is no comprehensive or coordinated policy development process for maternal and child health in Maine. No single agency or organizational unit of State Government currently has the responsibility or mandate for coordinating policy development and program planning for maternal and child health in Maine. Although the Department of Human Services has undertaken some important policy development and program planning initiatives in the context of its Title V program, there is no single agency or document which clearly defines goals and priorities and programmatic and administrative strategies for addressing maternal and child health problems and needs which cut across categorical programs and agencies (e.g., child abuse, failure to thrive). Other specific barriers or constraints which must be overcome in the development of a comprehensive policy development and program planning process for maternal and child health in Maine, include:

- the numerous and often conflicting requirements of categorical funding sources for maternal and child health and related programs and services;
- the absence of any specific administrative mechanisms for intra- and interdepartmental policy development and planning around maternal and child health;
- the lack of administrative leadership and clearly defined organizational and administrative authority to initiate policy development and program planning in maternal and child health;
- inadequate data with which to analyze health problems and needs and assess current services and resources;
- the lack of sufficient or adequate evaluation of current maternal and child health and related programs and services; and
- the lack of citizen and community participation in and support of maternal and child health.

RECOMMENDATION

4.1 WE RECOMMEND THAT THE COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES FORM A SPECIAL WORK GROUP CONSISTING OF THE DEPUTY COMMISSIONER OF HEALTH AND MEDICAL SERVICES, THE DEPUTY COMMISSIONER OF SOCIAL AND REHABILITATION SERVICES AND BUREAU DIRECTORS AND PROGRAM MANAGERS TO COORDINATE POLICY DEVELOPMENT AND PROGRAM PLANNING AROUND MATERNAL AND CHILD HEALTH AND RELATED SERVICES AND PROGRAMS.

THE GROUP SHALL HAVE AS ITS PRIMARY TASK THE PREPARATION OF AN ANNUAL PLAN FOR MATERNAL AND CHILD HEALTH WHICH;

- IDENTIFIES, DESCRIBES AND PRIORITIZES THE HEALTH AND HEALTH RELATED PROBLEMS AND NEEDS OF WOMEN OF CHILDBEARING AGE, THEIR CHILDREN AND FAMILIES; AND WHICH
- OUTLINES PRIORITIES FOR RESOURCE ALLOCATION AND;
- SPECIFIES INTRA-DEPARTMENTAL RELATIONSHIPS AND STRATEGIES FOR PROGRAM DEVELOPMENT AND COORDINATION.

FIRST PRIORITY

Rationale

A vital step in the development of policy, planning and programming for maternal and child health in Maine is to prepare a statewide plan. The Department of Human Services should assume a leadership role in developing a statewide plan for maternal and child health.

The Task Force found that program planning and development is not an integrated part of any coordinated policy development process in the Department of Human Services. Program planning in the Department of Human Services and in the two other Departments is done categorically with little or no coordination among categorical programs. Although these programs may have somewhat different purposes and functions - the family-oriented programs and services funded under Title XX are aimed at the income and social support needs of families, while Title V is concerned with health and health related problems and needs of families. The people these programs serve or intend to serve are, in many cases, the same.

The absence of coordinated planning and program development results in significant duplication of services and in a fragmentation of the service delivery system. In addition, there are no adequate mechanisms currently for engaging in intra-departmental planning and program development activities which would integrate specific categorical programs and services. Such integration is essential for ensuring that the limited human service resources

that exist in this State are targeted at priority problems and populations. Much of the duplication and fragmentation of services that exists at the local level is attributable to the absence of a policy development, planning and program development strategy at the state level.

The Task Force estimates staff time and resources necessary for the Working Group to be $3,000.

RECOMMENDATION

4.2 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES (DHS) ESTABLISH A MATERNAL AND CHILD HEALTH POLICY AND REVIEW COMMITTEE FOR THE PURPOSE OF:

(A) MONITORING POLICY DEVELOPMENT AND PLANNING ACTIVITIES FOR MATERNAL AND CHILD HEALTH AND HEALTH RELATED PROGRAMS WITHIN THE DEPARTMENT OF HUMAN SERVICES. SPECIFIC FUNCTIONS SHOULD INCLUDE:

1. REVIEWING ANNUAL PLANS FOR ALL MATERNAL AND CHILD HEALTH ACTIVITIES INCLUDING POLICIES AND PLANS DEVELOPED BY THE DEPARTMENT OF EDUCATIONAL AND CULTURAL SERVICES (DECS) AND THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS (DMHC) AFFECTING THE TARGET POPULATIONS. EXAMPLES OF THE PLANS WITHIN DHS ARE: TITLE XX PLAN, STATE PUBLIC HEALTH PLAN, STATE HEALTH PLAN, ETC. THE REVIEW SHALL INCLUDE:
   a. A REVIEW OF THE GOALS AND OBJECTIVES OF THE AGENCIES INVOLVED;
   b. AN ASSESSMENT OF THE HEALTH AND HEALTH RELATED NEEDS OF MAINE'S WOMEN OF CHILDBEARING AGE AND THEIR CHILDREN, AND EVALUATION OF THE PRIORITY SETTING MECHANISMS WITH REGARD TO PROGRAM AND SERVICE ACTIVITIES; AND
   c. A REVIEW OF THE PROJECTED EXPENDITURES AND FUNDING LEVELS OF MATERNAL AND CHILD HEALTH AND MATERNAL AND CHILD HEALTH RELATED FUNDS.
2. DEVELOPING AND SUBMITTING AN ANNUAL REPORT TO THE COMMISSIONER OF HUMAN SERVICES WHICH EVALUATES THE STATUS OF MATERNAL AND CHILD HEALTH AND OF PROGRAMS AND SERVICES AIMED AT IMPROVING MATERNAL AND CHILD HEALTH.

(B) PROMOTING PUBLIC AWARENESS AND PUBLIC PARTICIPATION IN MATERNAL AND CHILD HEALTH AND MATERNAL AND CHILD HEALTH RELATED ACTIVITIES BY,

1. BUILDING A CONSTITUENCY OF PUBLIC SUPPORT FOR THE HEALTH AND HEALTH RELATED PROBLEMS AND NEEDS OF MAINE'S WOMEN OF CHILD-BEARING AGE AND THEIR CHILDREN.
2. PROVIDING ADVOCACY ON BEHALF OF WOMEN OF CHILDBEARING AGE AND THEIR CHILDREN.
3. ENCOURAGING COMMUNICATION AND COOPERATION AMONG THE EXISTING LOCAL/COMMUNITY/REGIONAL COUNCILS AND COMMITTEES WHO SHARE SIMILAR GOALS AND OBJECTIVES WITH RESPECT TO MAINE'S WOMEN OF CHILD-BEARING AGE AND CHILDREN.
4. ENCOURAGING INNOVATIVE REGIONAL/LOCAL/COMMUNITY INITIATIVES AIMED AT COORDINATING AND INTEGRATING MATERNAL AND CHILD HEALTH AND MATERNAL AND CHILD HEALTH RELATED SERVICES.
5. EXPANDING THE AVAILABILITY AND USE OF VOLUNTEER SELF-HELP EFFORTS, SPECIFICALLY IN THE AREA OF PATIENT EDUCATION

SECOND PRIORITY

Rationale

There is currently no comprehensive policy development or planning process for maternal and child health in Maine. The fact that such a process is also absent at the federal level makes the task not only more difficult but also more necessary. It is impossible to achieve coordination of service delivery at the state and local levels without a commitment and mechanism formally established at the top levels of adminstrative policymaking.

Currently, there is a lack of clarity and comprehension of state policies and programmatic priorities regarding maternal and child health. The responsibility for policy development, planning, and program development is not clearly defined in the present governmental structure. Furthermore, the lack of accountability and leadership for policy development and implementation of an overall maternal and child health strategy is compounded by the categorical, fragmented funding base for maternal and child health services.

The Policy and Review Committee would assure policy development, planning and program development in maternal and child health. Membership of the Policy and Review Committee would include:

1. Providers of maternal and child health and maternal and child health related services,
2. Consumers,
3. Representatives from identified community volunteer efforts, and
4. Legislators

The ommittee will be staffed by individuals with responsibilties for policy development and program planning within the Department of Human Services (e.g., Division of Child Health, Bureau of Resource Development). Staff assistance from the Departments of Education and Mental Health and Corrections should be available to the Committee on an "as needed" basis.

The Task Force estimates a cost of $16,000 including the use of existing personnel for a Policy and Review Committee, annually.

RECOMMENDATION

4.3 WE RECOMMEND THAT THE COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES EVALUATE AND CLARIFY THE ROLE, FUNCTIONS, AND RESPONSIBILITIES OF THE VARIOUS ORGANIZATIONAL UNITS WITHIN THE DEPARTMENT WHICH ARE RESPONSIBLE FOR MATERNAL AND CHILD HEALTH PROGRAMS AND SERVICES. SPECIFIC STEPS THAT SHOULD BE CONSIDERED ARE:

(A) EVALUATING THE FEASIBILITY AND DESIRABILITY OF CONSOLIDATING PROGRAMMATIC AND ADMINISTRATIVE AUTHORITY AND RESPONSIBILITY IN A SEPARATE AND SINGLE ORGANIZATIONAL UNIT WHICH WOULD ENCOMPASS ALL MATERNAL AND CHILD HEALTH PROGRAMS, SERVICES AND ACTIVITIES. SPECIFIC PROGRAMS/ORGANIZATIONAL UNITS THAT SHOULD BE EXAMINED, INCLUDE:

- PROGRAMS, SERVICES AND ACTIVITIES CURRENTLY UNDER THE DIVISION OF CHILD HEALTH
- PUBLIC HEALTH NURSING
- EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
- IMMUNIZATION SERVICES
- DENTAL HEALTH
- FAMILY PLANNING

- HEALTH FOR UNDERSERVED RURAL AREAS AND RURAL HEALTH INITIATIVES, ACTIVITIES AND PROJECTS.

(B) EXAMINING THE FEASIBILITY AND DESIRABILITY OF ELEVATING THE ORGANIZATIONAL UNIT RESPONSIBLE FOR THESE MATERNAL AND CHILD HEALTH PROGRAMS, SERVICES AND ACTIVITIES TO A BUREAU LEVEL AGENCY.

IMMEDIATE ACTION

Rationale

The goal of this recommendation would be to create within State Government a single agency that would take a lead role in and/or be directly responsible for policy development, planning, program development, implementation and management for maternal and child health programs in Maine. There is currently no agency of State Government with such a mandate or with the organizational and political stature to assume such a mandate effectively.

The consolidation of maternal and child health programs, services and activities into a single organizational and administrative unit is necessary for coherent and consistent policy, planning and program development and implementation in maternal and child health. The Task Force feels that the creation of such an agency would significantly improve communication among the various organizational units of State Government currently responsible for maternal and child health policy and programs. This would also serve to enhance the State's ability to manage those programs effectively and efficiently.

Issues and problems related to maternal and child health in Maine and the State's maternal and child health program have very little visibility within State Government, the Legislature or in the public. These issues are not viewed as a priority. Part of the reason for this lack of visibility is the absence of any identifiable and/or active constituency in the public for maternal and child health issues and programs.

The current organizational position of the State's maternal and child health program is important. As divisions answering to a Bureau Director who in turn answers to a Deputy Commissioner who is responsible to the Commissioner, the Divisions of Child Health and Public Health Nursing clearly lack the stature or authority to assume the leadership role that is necessary to begin to develop a comprehensive, statewide maternal and child health program that coordinates and integrates categorical programs, services and activities

in the Department of Human Services and in the other two departments. The Task Force feels that elevating the Division of Child Health to the bureau level would significantly improve that unit's ability to make the public, legislators and other units of State Government aware of maternal and child health issues, problems and programs. The reorganization outlined in this recommendation would also provide the State's maternal and child health program with the mandate, responsibility and authority for pursuing many of the administrative and programmatic initiatives outlined in this report.

The Task Force feels there are no new cost resources necessary for implementation of Recommendation 4.3.

RECOMMENDATION

4.4 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ASSURE THE APPROPRIATE AND TIMELY COLLECTION OF MATERNAL AND CHILD HEALTH DATA FOR USE IN POLICY DEVELOPMENT, PROGRAM PLANNING AND PROGRAM MANAGEMENT. STEPS TOWARD PROPER COLLECTION OF DATA FOR THESE PURPOSES SHOULD INCLUDE THE FOLLOWING:

(A) THE CONSOLIDATION OF ORGANIZATIONAL UNITS RESPONSIBLE FOR THE COLLECTION AND ANALYSIS OF HEALTH DATA; AND

(B) A THOROUGH EVALUATION OF THE STATE'S PLANNING, DATA COLLECTION AND DATA ANALYSIS CAPABILITY RELATIVE TO MATERNAL AND CHILD HEALTH INCLUDING:

- AN ASSESSMENT OF THE OVERALL MATERNAL AND CHILD HEALTH DATA NEEDS FOR PROGRAM PLANNING AND MANAGEMENT;
- AN ASSESSMENT OF THE ADEQUACY OF EXISTING HEALTH AND HEALTH RELATED DATA SOURCES AND DATA COLLECTION SYSTEMS;
- AN EVALUATION OF THE QUALITY AND RELEVANCE OF EXISTING DATA AS WELL AS THE APPROPRIATENESS OF CURRENT USES OF THOSE DATA; AND
- AN EVALUATION OF THE APPROPRIATENESS AND ADEQUACY OF EXISTING STAFFING LEVELS IN THE AREA OF PLANNING AND DATA COLLECTION AND ANALYSIS AND/OR OF THE UTILIZATION OF SUCH PERSONNEL IN RELATION TO MATERNAL AND CHILD HEALTH PROGRAMS AND ACTIVITIES.

FIRST PRIORITY

Rationale

Effective planning, administration and management of maternal and child health services and programs cannot take place without accurate data regarding the health status, needs and problems of the target population. A brief assessment by the Task Force identified the following problems with respect to data collection and utilization:

1. existing data collection systems are not relevant to maternal and child health data needs;
2. available data is not appropriately analyzed or presented in a timely fashion;
3. there is no overall coordination of data collection and utilization activities in the health area;
4. data available from vital statistics is often inaccurate due to problems of processing the data;
5. the role and responsibilities of the Bureau of Health Planning and Development in assisting in collecting and analyzing health data relevant to maternal and child health are not clearly defined.

The estimated resources for a thorough evaluation of the State's data planning, collection and analysis capabilities would involve approximately $10,000 either in new staff or subcontracting.

RECOMMENDATION

4.5 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES BE RESPONSIBLE FOR THE DEVELOPMENT OF AN ONGOING, UNIFORM SYSTEM FOR EVALUATING MATERNAL AND CHILD HEALTH PROGRAMS AND ACTIVITIES.

SECOND PRIORITY

Rationale

Currently there is not sufficient attention paid to the need for an overall system of monitoring and surveillance of maternal and child health. This includes an ongoing analysis of health status, health care utilization, adequacy and accessibility of resources and quality of care. In addition, the Department of Human Services' capability for evaluating maternal and child health programs and

services needs to be strengthened. The Task Force supports the plans for a health survey to determine major health problems and target populations, but suggests that an evaluation of problems relating to health delivery systems also be conducted to identify barriers that exist to the effective and efficient utilization of maternal and child health programs and services.

The recent development and implementation of a grants monitoring system for Title V funds administered by the Division of Child Health is a beginning step and prime example of an effective evaluative mechanism.

The development of an evaluation capability of maternal and child health would cost an estimated $19,000.

## THE COORDINATION OF MATERNAL AND CHILD HEALTH PROGRAMS AND SERVICES AT THE LOCAL AND REGIONAL LEVEL

The development of a coordinated comprehensive maternal and child health program and service delivery system in Maine must be based on a partnership between State Government, citizens and health care providers in local communities throughout the State. The development of such a system is complicated by the lack of coordination and integration of programs and services at the local level and by the lack of involvement and participation of citizens.

Maternal and child health services in the local and regional communities consist primarily of:

a) primary care services provided by physicians and private practioners on a fee-for-service basis;

b) inpatient and ambulatory medical care services provided by hospitals and private physicians and funded by fee-for-service and third party payors (i.e., insurance companies or Medicaid);

c) community nursing services and clinics delivered by state public health nurses and community nursing agencies funded by Title V, other federal and state grant-in-aid programs and private funds;

d) nutrition services available through the Women, Infants and Children's supplementary feeding program (WIC) and through nutrition services provided in hospitals or other health settings;

e) certain maternal and child health and crippled children's services which are available on a statewide basis (e.g., newborn intensive care, clinics for physically handicapped children, genetic counseling and diagnosis), funded in part by state, federal and local dollars;

f) numerous health-related social, mental health and educational services (e.g., homemaker-home health aides, counseling for developmentally delayed day care for special needs children, etc.) available either locally or regionally. These are funded in part by state and federal government and local sources.

The components of a comprehensive maternal and child health program involve, by definition, a range of disciplines and professionals to deliver the services. Such a multi-disciplinary system can never be provided by a single agency, but must be established with the cooperation and communication of many agencies, joined together by a well-defined strategy and policy.

The current service delivery system for maternal and child health is not well-defined and is complicated by numerous categorical funding sources and service definitions. It also lacks consistency in quality and in the availability of services. There is no rational overall design in terms of the inter-relationships of its component parts.

The uncoordinated collection of agencies and programs is perplexing for both the providers and the policymakers, but more so for the maternal and child health client. Clients are often faced with multiple agencies with similar functions, duplicative intake systems and no single place for entry into a comprehensive maternal and child health system. For example, there are currently few mechanisms for ensuring that the AFDC mother who takes her developmentally delayed child to a day care center has access to the public health nursing services in the community. In the absence of formal mechanisms for coordinating intake and referral, the client is usually forced to negotiate the maze of services and programs alone.

The Task Force noted several important though isolated examples around the state of local initiatives to coordinate, integrate and advocate for child and family services. These efforts include: the Androscoggin County Community Coordinating Committe, the Franklin County Children's Task Force, the Maternal and Child Health Council of Bangor, the Cumberland County Child Abuse and Neglect Council and others. Certain coordinating activities are conducted on a statewide basis by specific service area organizations such as Maine Day Care Directors Association, Homemaker-Home Health Aide Council, Family Planning Association, etc.

Despite these isolated efforts, however, the Task Force concluded that,

- Leadership for promoting the coordination and integration of maternal and child health services and activities is not adequate to meet the needs of clients either at the state, regional or local levels.

- Linkages between agencies, although they are made by individual service providers, are not made consistently and are not formalized enough to avoid serious coordination problems and may result in significant duplication of effort.

- There appears to be very little integration of basic social services and public health services at the local level to facilitate and improve access to these services for the maternal and child health client.

RECOMMENDATION

4.6 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES ACTIVELY PROMOTE AND ASSIST THE FORMATION AND DEVELOPMENT OF LOCAL AND REGIONAL COMMITTEES WITH THE FOLLOWING PURPOSES, FUNCTIONS AND RESPONSIBILITIES:

1. TO PROMOTE AND ADVOCATE FOR MATERNAL AND CHILD HEALTH AT THE LOCAL LEVEL;
2. TO ESTABLISH FORMAL INTER-AGENCY MECHANISMS FOR NEEDS ASSESSMENT, PROGRAM PLANNING, DEVELOPMENT AND IMPLEMENTATION WITH THE AIM OF COORDINATING AND INTEGRATING HEALTH AND HEALTH RELATED PROGRAMS AND SERVICES AT THE LOCAL LEVEL FOR MOTHERS, CHILDREN AND FAMILIES;
3. TO PROVIDE A POTENTIAL MECHANISM FOR OBTAINING LOCAL INPUT INTO THE POLICY AND PROGRAM DEVELOPMENT PROCESS AT THE STATE LEVEL;
4. TO ADVOCATE FOR ADDITIONAL LOCAL FUNDING FOR MATERNAL AND CHILD HEALTH; AND
5. TO DEVELOP ADDITIONAL LOCAL RESOURCES FOR MATERNAL AND CHILD HEALTH THROUGH THE DEVELOPMENT OF "NON-SERVICE" APPROACHES TO THE DELIVERY OF MATERNAL AND CHILD HEALTH SERVICES, INCLUDING THE USE OF VOLUNTEERS AND OTHER COMMUNITY RESOURCES.

IMMEDIATE ACTION

Rationale

In the absence of local or regional health departments, the Task Force concluded that the Department of Human Services should provide whatever technical or financial assistance is necessary to develop and support local planning and service delivery initiatives. These local efforts should focus on assessing maternal and child health needs and the adequacy of existing programs and services in the local or regional area. The Task Force anticipates that such local efforts have the potential for:

- reducing the duplication of services and resultant costs;
- integrating programs and services;
- decreasing reliance on categorical state and federal funds; and
- facilitating and improving access for clients to maternal and child health services.

Local and regional efforts would complement policy and administrative initiatives at the state level aimed at developing a statewide maternal and child health program.

The resources necessary for the promotion of local efforts, the Task Force estimates, would involve one part-time existing staff person (approximately $10,000) or the efforts could be contracted out at a cost of $15,000.

## THE FINANCING OF MATERNAL AND CHILD HEALTH SERVICES IN MAINE

The level of funding for maternal and child health in Maine and the categorical nature of Title V and the other major sources of funding represent serious obstacles to the development of a comprehensive, statewide maternal and child health program. Currently the level of federal and state funding is inadequate to support a comprehensive statewide maternal and child health program. There are, as a result, significant disparities across the State in the availability and quality of services.

Administrative and programmatic requirements imposed by the numerous categorical sources of funding for maternal and child health also represent significant impediments to the development of a coordinated, comprehensive network of maternal and child health services. The health and health related problems and needs of women of childbearing age and children are addressed in all three of the major departments of State Government. The programs and services are funded and/or delivered by a multitude of state bureaus and divisions. Similarly, maternal and child health services are provided locally by numerous public and private agencies and other human service providers. The fragmentation of responsibility and authority for the delivery of maternal and child health services is in large part attributable to administrative and programmatic requirements imposed by categorical federal and state funding services for these state and local agencies and other private providers.

A limited analysis revealed at least 12 different sources of funding for maternal and child health and related programs and services. As noted in *Chart IVa page 139* most funding for these services is shared by federal and state governments with public and private funds being provided locally. In Maine, health (medical) services for women and children are paid for predominately by consumers through third-party payments to physicians, hospitals and other private providers. Publicly provided or funded maternal and child health services represent a small proportion of the total amount of maternal and child health and related funds.

Responsibility for administering public funds for maternal and child health and related programs and services is dispersed among numerous organizational units within the three departments of State Government. The multiplicity of funding sources and state and federal administrative agencies makes coordinated policy development and program planning especially difficult, though a sorely needed, task. Improving the coordination of maternal and child health programs and services and eliminating duplication in these services will require careful attention to the creation of specific administrative and financial strategies which provide sanctions and incentives for state and local agencies and other providers to perform coordinating activities. While a comprehensive policy development and program planning process is critical for defining basic goals

and programmatic and administrative strategies for maternal and child health, these goals and strategies can only be implemented effectively through specific policies and administrative strategies for coordinating the use of federal, state and local funds for maternal and child health and related programs and services.

Problem Statement

State and federal resources for maternal and child health activities are limited in Maine.

RECOMMENDATION

4.7 WE RECOMMEND THAT THE COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES INITIATE AN ANALYSIS OF POTENTIAL ALTERNATIVE USES OF TITLE XIX (MEDICAID) FUNDS IN THE DEVELOPMENT OF EXPANDED RESOURCES FOR PREVENTIVE HEALTH AND HEALTH RELATED ACTIVITIES AIMED AT WOMEN OF CHILDBEARING AGE AND CHILDREN.

SECOND PRIORITY

Rationale

The health problems encountered by women, mothers and children and the additional service needs for this population have been identified in prior recommendations in this report. The Task Force has consistently attempted to respond to the limited availability of state funds in a responsible fashion. Many service needs and programs were not considered by the Task Force due to their high cost and potential drain on maternal and child health and related resources. It was determined that with few exceptions, it is generally not possible to generate resources needed to assure the health of mothers and children through reductions in funding of existing programs.

A review of current and recent resource development efforts by various divisions and bureaus of the Department of Human Services has led the Task Force to conclude that the work of the Intertitle Transfer Committee established by the Commissioner should be pursued in relation to several specific maternal and child health related activities. The Committee was established to review and recommend appropriate transfers of funding sources.

The Task Force recommends that similar activity be conducted by the establishment of an Intertitle Transfer Committee more closely related to maternal and child health. Such analysis should be carried out with the involvement of private physicians and health practitioners and contract agencies; should encompass services, settings and reimbursable staff; and should result in implementation of Title XIX changes which assume some costs now met with Title V funds and other maternal and child health related resources.

Although the Task Force is aware of federal interpretations that restrict the availability of Medicaid funding for several services which are not customarily under the direct supervision of physicians, we feel that the State does have additional latitude in its definition of qualified health care providers. Specifically, there are additional home health, public health nursing, and personal care services currently funded by Title V which would conceivably be absorbed by the Medicaid program and maximize use of federal funds. The current allocation for the Division of Child Health, in being included in the State's Medicaid match request, does not adequately inform or involve legislators regarding current service levels and health needs of Maine's mothers and children.

The Task Force is aware of the fact that many high-risk pregnancies and infant deaths occur outside of the categorically or Medicaid eligible population. However, there are indications that many unmet maternal and child health care needs exist for this low income population. To be included in an analysis of Title XIX are many of the prevention and early intervention activities outlined in:

- Recommendation 1.1, The Components of a Perinatal Program,
- Recommendation 2.4-2.7, Components of a Comprehensive Accident Prevention Program,
- Activities for

  Children, Recommendations 2.1-2.1

  Newborns, Recommendations 1.12, 1.13

  Children with Special Needs, Recommendation 2.9

  Children and Families with the Problem of Child Abuse and Neglect, Recommendation 2.10

  Adolescents, Recommendation 3.2

  Women at Risk of Unplanned, Unwanted Pregnancies, Recommendations 1.2-1.6

  Mental Health, Recommendation 2.8.

As an example of potential Medicaid involvement which was not addressed by the original Intertitle Transfer Committee, the provision of mental health services to children and adolescents in non-family foster home settings is an area where other states seem to be making much more use of Medicaid. During the public hearings throughout Maine, the Task Force was asked to include other specific examples of potential services, programs and items to be considered for inclusion under Medicaid:

(a) the services of a licensed nutritionist,

(b) prenatal vitamins and iron supplements,

(c) therapeutic services (physical therapy, occupational therapy, speech therapy and family therapy) provided in a non-traditional setting, and

(d) perinatal education (including childbirth, child care, parenting, and child development) provided by a certified educator in non-traditional settings (e.g., in the customary fee-for-service settings).

Problem Statement

Program accountability and program planning in maternal and child health is encumbered by the lack of sufficient financial information.

RECOMMENDATION

4.8 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES EXAMINE AND REVISE ITS BUDGET AND FINANCIAL CONTROL SYSTEMS TO ASSURE THE PARTICIPATION OF PROGRAM MANAGERS IN THE BUDGET DEVELOPMENT AND REVIEW PROCESS FOR MATERNAL AND CHILD HEALTH.

SECOND PRIORITY

Rationale

The Task Force discovered an insufficient amount of administrative and management personnel and resources to enable the managers of various maternal and child health programs to obtain and utilize program-specific fiscal information. Generally, the information is available to bureau and division

directors and program managers (specifically, Child Health and Public Health Nursing) on a line-item basis rather than detailed program information. As a result, administrators are unable to determine the relative costs of activities aimed at specific populations or helath needs. For example, the task of assessing the cost-benefits of genetic screening programs is impossible as long as related expenditures cannot be distinguished from EPSDT expenditures. Another example is the variation in (a) contracted services, (b) direct provision of services by the State, and (c) linkage with locally funded public health nursing services. Currently it is impossible for the Division management to assess the comparative costs for activities carried out under these three alternative approaches, to plan for cost-effective program development, or budget for similar activities in under-served areas.

It is possible for the Department's Budget Control System to provide program specific fiscal data through its account, activity, character and object specificity. If necessary, the Department's data processing unit should be consulted regarding possible enhancements of the budgeting system. Regardless of the resolution process, the relative unavailability of program or contract specific expenditure data is clearly a problem for Public Health Nursing and Child Health administrators, with administrative limitations in program accountability and planning arising as a result.

The Task Force feels this recommendation requires no new resources.

Problem Statement

The Aid to Families with Dependent Children (AFDC) and Medical Assistance Programs in Maine do not provide adequate incentives towards employment and towards self-sufficiency and self-support for the families who receive AFDC.

RECOMMENDATION

4.9 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES INVESTIGATE METHODS OF DETERMINING ELIGIBILITY FOR AFDC AND MEDICAL ASSISTANCE BENEFITS THAT PROVIDE INCENTIVES TO WORK AND SELF-SUFFICIENCY.

FIRST PRIORITY

Rationale

Approximately 40,000 of Maine's children and their mothers* are dependent on Aid to Families with Dependent Children (AFDC) as a basic economic support and supplement to their income. Without AFDC, these children would undoubtedly face severe economic deprivation causing adverse effects on their health and well-being. Seventy-five percent of the AFDC recipients are children. In addition to AFDC, Medicaid pays for primary care visits to physicians, hospitalization, medication and certain other necessary health services for children. However, the AFDC enables the child to have the necessary food, clothing, shelter and opportunities which promote healthy children. In some cases, the economic security alleviates pressures that bring about emotional and physical abuse and neglect of the child.

However, AFDC is not the panacea envisioned by many non-recipients.

The cash supplement available to children and eligible families is equal to 67.5 percent of the cost of living for 1973 or $280 per month for two (2) children and one parent.

The measure of standard of living in 1973 is seven years old and was developed prior to double-digit inflation. An increase of even one percent, to 68.5 percent would yield only an additional $4.00 per month or $1.33 per week for one mother and child. Without the health supports from Medicaid, the Task Force predicts children would certainly experience poor health conditions.

The second aspect involves the disincentives of categorical and medical assistance. Two-parent families with both parents in the home and no source of income are not eligible for AFDC. For some families who face periodic and long-term unemployment, this means they must separate as a family unit in order to receive state categorical assistance. State policy influences this decision and can be reversed by an administrative decision.

Certain economic disincentives exist in AFDC and Medicaid assistance. The woman who obtains employment will find her AFDC eligibility affected and her cash supplement reduced. Although she is allowed work-related deductions such as child care, transportation, uniforms, etc., the increase in assistance through these deductions does not always equal, dollar for dollar, the loss in cash benefits. For women who can find only less than full-time work and/or

*In some cases where care and custody is with the father, he is eligible instead of the mother.

minimum wage jobs that are dull and demanding, it is sometimes not worth the effort to go to work. Often other health and social services are curtailed by an increase in salary or loss of AFDC eligibility. The compounded loss of benefits and services act as a disincentive to work toward self-support.

The Medicaid and Medically Needy programs often require the clients to incur debts in order to obtain eligibility and receive benefits. In other cases, the provider and service setting requirements of Medicaid promote institutionalization and encourage high cost medical care rather than cost savings and self-sufficiency.

The Task Force feels that all of the disincentive within the AFDC and Medical Assistance programs should be examined and revised to promote self-sufficiency, economic stability and family continuity.

The resources necessary for developing a new system of eligibility determination are available within the Departments. The cost implications of a change in eligibility determination depends on the type of method used. Costs involved in the method are unknown at the time.

## Chart IV (a)

| Selected funding sources | Source of funds | State Administrative Agency | Basic goals/Purposes | MCH Related Program/Services | Target Population |
|---|---|---|---|---|---|
| Title V | Federal<br>State | Department of Human Services (DHS) | To reduce infant mortality<br>To promote health of mothers and children<br>To provide crippled childrens' services | Perinatal program<br>Genetic disease program | Women and families in childbearing years, infants and children, newborns |
| WIC | Federal | DHS<br>Division of Child Health (DCH) | To provide nutritional and food supplements | Food and nutritional information | Eligible women, infants and children |
| EPSDT | Federal<br>State | DHS<br>Division of Public Health Nursing | To provide early screening and treatment of health conditions | Early, periodic screening and treatment | Eligible Title XIX children, including adolescents |
| 314D | Federal<br>State | DHS<br>Bureau of Health | For the support of basic public health services | ----- | |
| Title XIX | Federal<br>State | DHS<br>Bureau of Medical Services | To promote health insurance coverage of health services and items | Health insurance for service and reimbursable items of wide variety | Eligible women and children, including adolescents |
| Title XX | Federal<br>State<br>Local (public and private) | DHS<br>Bureau of Resource Development | To promote self-sufficiency, self-support<br>To prevent abuse, neglect exploitation and institutionalization of dependent individuals | Child protective day care, homemaker, family planning, transportation, programs for alcoholics, drug abusers, the blind, mental retardation, mental health, and nutrition | Adults and children:<br>• in care and custody<br>• at risk<br>• in jeopardy<br>Low income families and individuals |
| Title X | Federal<br>State<br>Local (public and private | Family Planning Association (FPA) | To promote family planning | Family planning and counseling, education examinations, pregnancy tests and contraceptives | Women of childbearing age and adolescents |
| Special Education | Federal<br>State<br>Local (public and private) | Department of Education and Cultural Services (DECS) | To provide educational opportunities to children with special needs and handicapped conditions | Education, treatment and counseling | Children (3-5) (5-20) |

| | | | | | |
|---|---|---|---|---|---|
| Mental Health/ Mental Retardation | Federal<br>State<br>Local (public and private) | Department of Mental Health and Corrections (DMHC) | To prevent mental health disease<br>To provide treatment for the emotionally disturbed and the mentally retarded individual | Mental health counseling<br>Institutional treatment<br>Community treatment | All individuals, all ages |
| Private | Self pay<br>Municipal government<br>Private foundations<br>Private donations | N/A | N/A | Physician and hospital services, etc.<br>Local health agencies, e.g., City of Portland, Community Health Services; York County Health Services<br>Variety of services including certain Title XX, Title V, and Title X services. Also certain health related organizations-Cystic Fibrosis Foundation, Anorexia Nervosa, Shrine Institute for Burns | Women, infants, children, adolescents and families |
| Other Federal Grant-in-Aid | Federal | Varies | Varies | Variety of services including certain Title XX, Title V, and Title X services. Also certain health related organizations-Cystic Fibrosis Foundation, Anorexia Nrevosa, Shrine Institute for Burns | Women, infants, children, adolescents and families |
| Other State (Legislative) | State | DHS<br>DECS<br>DMHC<br>FPA | Varies | Many of the above, including Office of Dental Health | Women, infants, children, adolescents and families |

## ADMINISTRATIVE POLICY DECISIONS

The following recommendations are based on the findings of the Task Force through their research and involvement with the public. Policy decisions on the part of administrative units within State Government are required for effective and successful implementation of the recommendations.

### Problem Statement

The family faces many outside pressures and distractions that interfere with the needs of family members and the family unit. One of these disruptions is the demands of the workplace.

## RECOMMENDATION

4.10 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES, DEPARTMENT OF EDUCATIONAL AND CULTURAL SERVICES, DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS AND DEPARTMENT OF PERSONNEL CONDUCT A STUDY OF EFFECTIVE AND INNOVATIVE APPROACHES TO ALLOW THE WORKING PARENT MORE TIME WITH HIS OR HER FAMILY. INCLUDED IN THE APPROACHES SHALL BE "FLEXTIME" AND JOB SHARING. THE STUDY SHALL INCLUDE AN IMPLEMENTATION PLAN FOR THE STATE EMPLOYEES AND THE CONSIDERATION OF SAME FOR THE PERSONNEL IN CONTRACTED AGENCIES.

SECOND PRIORITY

### Rationale

The family, regardless of definition (e.g., single parent, two parent, substitute parent), remains the basic source of nurturing, learning and support for the child. The family, therefore, requires time for the physical, emotional, social and educational needs of its family members. Time is needed for bonding during the child's early years, for spiritual and moral development, and for working out the intricacies involved in the educational and social development of the child.

Maine is the poorest state in the nation according to two reports issued in 1979.[1] The cost of living and maintaining a family in Maine is among the highest in the country. This economic situation places great demands on the adults in a family. For most two parent families in Maine and for nearly all single parent families, this situation means the adults must work to provide sufficient income for the family unit.

For parents, the time at work and supporting the family unit distracts from the time needed by individual family members, especially children. A sick child, a child with problems in school or a child with discipline or behavioral problems requires immediate attention from the parents. For many parents in industrial-type employment or minimum wage jobs, time to take a sick child to the doctor or provide the necessary care to bring the child back to health means loss of pay for loss of work-hours.

For many children, especially adolescents, the time the parent is at work means unsupervised spare time. It is theorized that an abundance of spare time subjects the child to pressures resulting in unacceptable behavior, e.g., crime, delinquency, early pregnancy. One method of coping with the problems of time away from the family is to adjust the work schedule to the child's needs.

The Task Force is aware of the fact that certain industries and corporations in Maine and in other parts of the country and the Federal Government have experimented with the options of job-sharing for parents and the adjustment of work hours.

The Task Force feels that a study and implementation plan for governmental employees in Maine could provide an excellent model for other Maine industries. Ultimately, many of the families of Maine would benefit from the governmental model.

The Task Force urges state government to realize that the support of the family goes beyond the economic needs. Support from the workplace can contribute to the success of family life in Maine.

The Task Force feels a study can be conducted with existing resources.

Problem Statement

Transportation is a major barrier to the accessibility of needed maternal and child health services throughout Maine.

RECOMMENDATION

4.11 WE RECOMMEND THAT THE COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES REQUIRE EVERY NEW AND EXISTING MATERNAL AND CHILD HEALTH PROGRAM AND CONTRACT BE REVIEWED TO DETERMINE THE ACCESSIBILITY OF THE PROGRAM BASED ON TRANSPORTATION PROBLEMS AND, WHERE POSSIBLE, A STRATEGY FOR ALLEVIATING SUCH PROBLEMS BE DEVELOPED.

FIRST PRIORITY

Rationale

In nearly every town and community in Maine, individuals must face the problem of transportation to and from services, programs and agencies. This is particularly true of women and children who do not have the economic means to purchase their own transportation.

At every public hearing of the preliminary Task Force recommendations, persons spoke on the difficulty of the accessibility of services due to transportation problems.

Seventy-five percent of Maine is rural. According to recent reports, Maine is the poorest state in the country. These two factors complicate the delivery of health services to Maine citizens. Many services have attempted to utilize a "van-type" mobile operation for the delivery of their services. Private physicians have modified office hours and provided more outreach activities to get people to health services. Still others have attempted to make transportation available for clients, either by paying for transportation costs or providing transportation directly. The method of alleviating the transportation problem depends on the type of service, the resources of the target population and the geographic area to be served. Many of Maine's small towns and cities face similar difficulties despite the density of the population.

The Task Force feels that the most responsible way in which State Government can address the massive transportation problem is to review each maternal and child health program and service for the client's accessibility to the service. Many programs and contracted agencies already address the problem, but more recognition should be given to the problem by the Department of Human Services.

The Task Force has determined that no costs are involved in setting policy. Funding transportation aspects of proposals will require consideration during the review of the proposal.

Problem statement

Open competitive bidding for contracts to provide health and social services to women, children and their families without a thorough assessment of the quality of the service will result in potential abuses of the service delivery system.

RECOMMENDATION

4.12 WE RECOMMEND THAT THE DEPARTMENT OF HUMAN SERVICES DEVELOP A STATEMENT OF POLICY ON STANDARD-SETTING AND QUALITY CONTROL OF THE HEALTH AND SOCIAL SERVICES ACQUIRED FOR CHILDREN AND THEIR FAMILIES THROUGH THE PURCHASE-OF-SERVICE CONTRACTS.

SECOND PRIORITY

Rationale

Competition in most every aspect of American society is deemed important and a critical aspect of our free enterprise system. It is, according to most economists, a guarantee of quality products. However, competition in the area of health and social service delivery will not guarantee a quality "product" will be delivered to the vulnerable clients seeking the service. Consumer education in the selection of a service to meet human need is not as advanced as it is in the area of commercial products and the environment. Much of the vulnerability of the clients in need of service relates to their inability to make decisions due to the health, psychosocial and economic pressures they are experiencing.

The Department has a responsibility to assure clients quality services (i.e., homemaker, child day care, family planning, transportation, nutrition, mental health and mental retardation). Many of the current contracted health

and social services are mandated by other agencies or standard-setting organizations. In some cases, adoption of those standards would suffice in assuring quality control.

The 1980-1981 plan for the expenditure of Title XX services says the following:

*OPEN COMPETITIVE PROCESS*

> *The Maine Human Services Council, an advisory body to the Bureau and other human services agencies, has recommended that all Title XX funds be awarded on an open competitive basis.*
>
> *The Bureau currently utilizes competitive bidding when: (1) new monies are available for new or expanded services, (2) individual agencies drop out of the Title XX system, thus freeing up funds, and (3) for supportive services proposals to the regional offices of the Department. The Bureau has made significant progress towards the development of an open competitive process for all Bureau administered funds.*
>
> *Work to date includes clarification of program area objectives in relation to the five Title XX goals. These objectives are being applied to priority target populations of the Bureau. In addition, a detailed contract format is finalized and written criteria for review of proposals submitted according to this format are developed.*
>
> *The Bureau currently projects that the open competitive process will be applied to a three year cycle of funding for each program area, with three or four program areas coming up for review each year. Full implementation of this system will be possible by January 1, 1981.*

Evaluation as defined in the Title XX Plan is "to provide policy and program managers with the information necessary to make the best possible decisions. Evaluation is an integral part of the management process which continually identifies need, plans and implements appropriate programs, and evaluates these programs." In addition to fiscal reporting and monitoring, a program review can be requested from the Division of Evaluation and Planning in the Bureau of Resource Development (BRD). It consists of "interviews with the agency director and a sample of the staff and review of the Title XX regulation, BRD policy, when applicable, and good management practice."

The Division of Licensing in the BRD comes closer to assessing quality of service than any other departmental mechanism. They license child day care centers, foster homes and placement agencies based on a combination of state and federal guidelines. However, the Task Force suggests that a truly open competitive bidding process would require closer scrutiny and definition of standards for the quality of service.

An evaluation of services which measures whether the agencies are performing as they promised they would, whether the services are having the intended effect, and what services are most cost effective, does not necessarily mean the client is getting the optimum in quality of services. It may mean the Department is meeting its program goals and objectives. It is most difficult to measure human need and, understandably, difficult to measure the growth and change in human need as a result of a health or social service. This is especially true of preventive or early intervention services.

The adoption or development of minimum standards of care, minimum qualifications of service personnel and an effective monitoring and surveillance system is the most effective and responsible guarantee of quality service for the client.

The Task Force suggests that costs involved in setting policy can be assumed by existing resources.

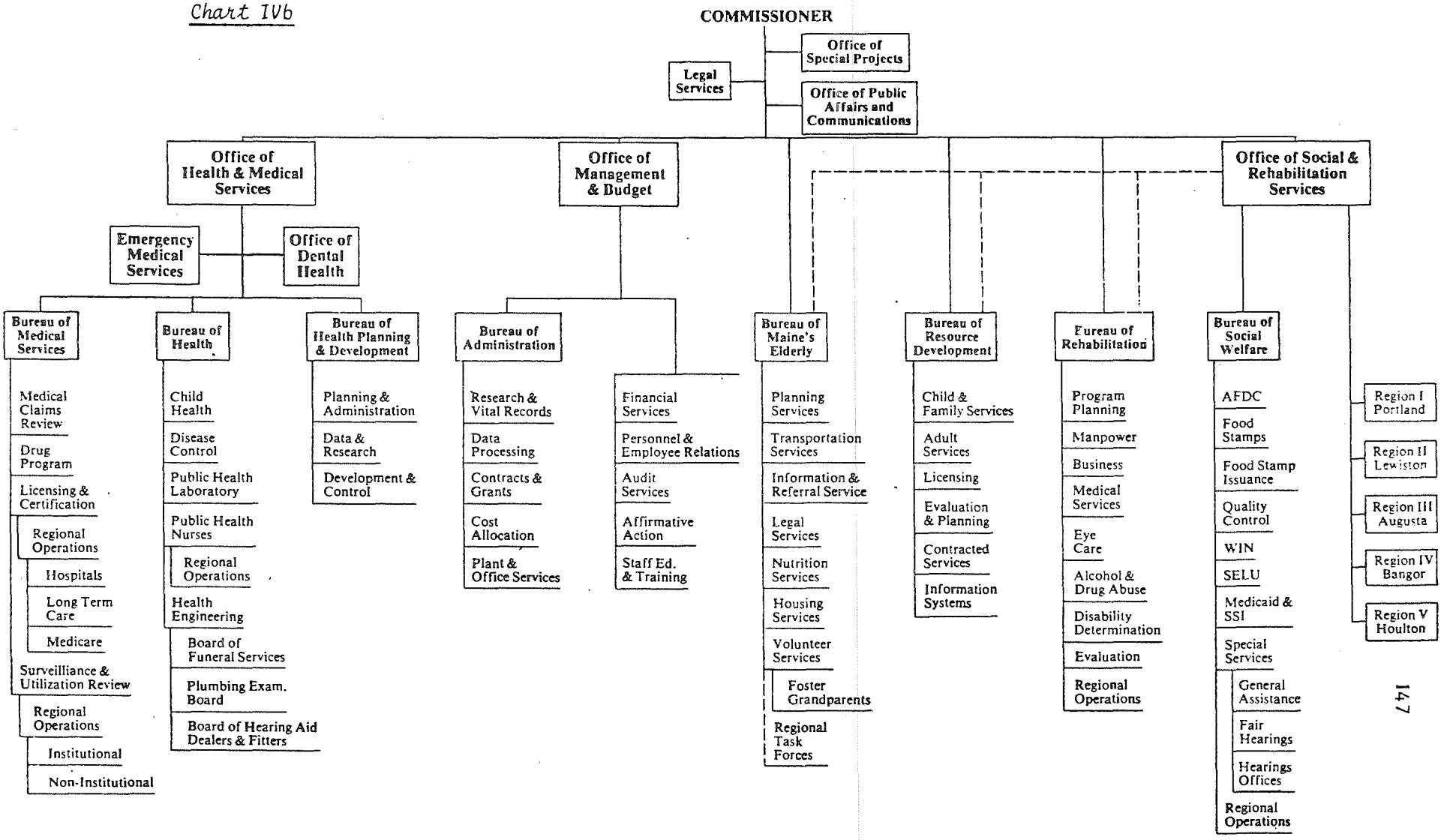
STATE GOVERNMENT

ORGANIZATIONAL CHARTS

FOR SECTION IV

# Maine Department of Human Services
Organizational Chart
November, 1979

Chart IVb

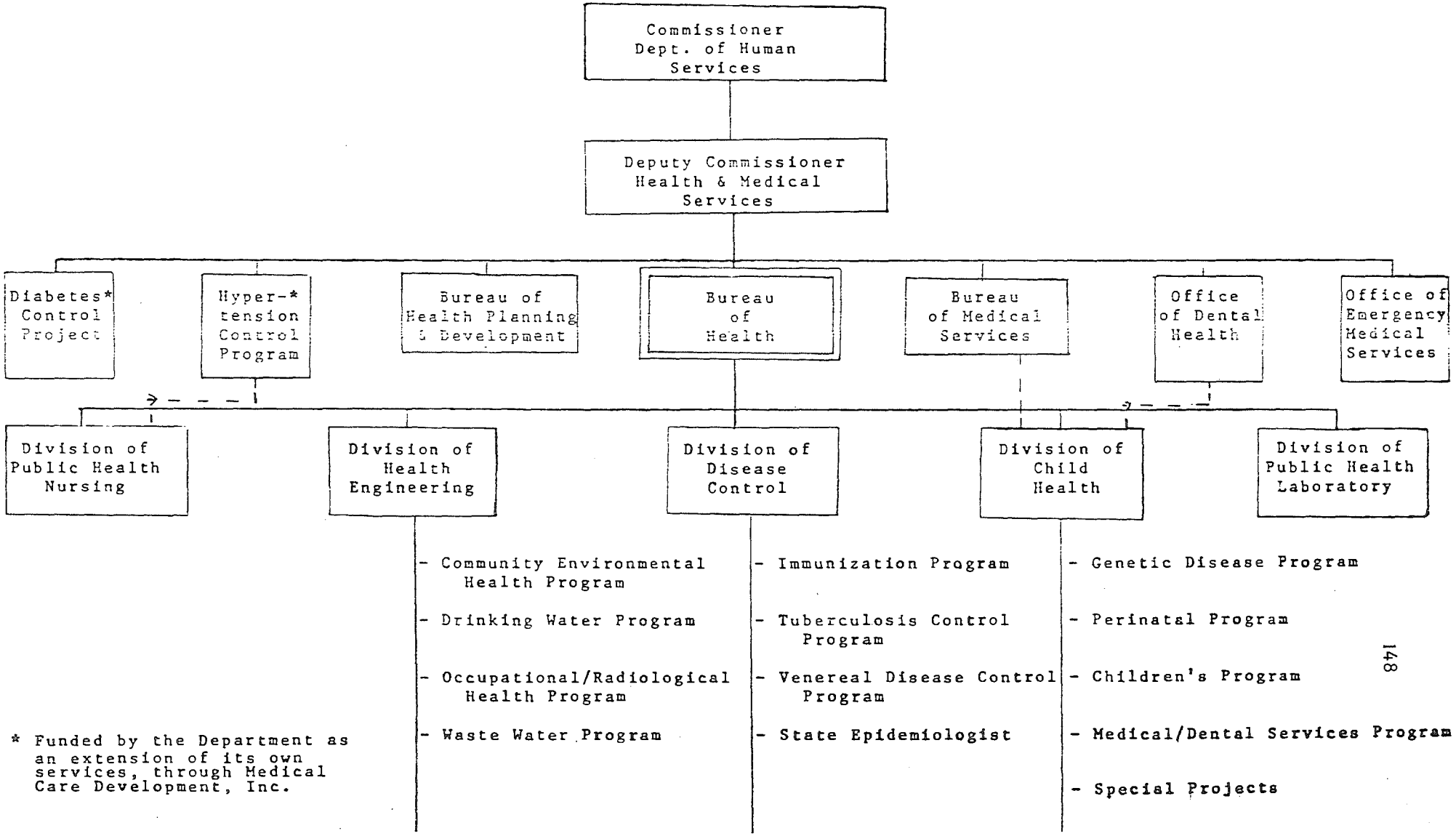


BUREAU OF HEALTH

ORGANIZATION CHART

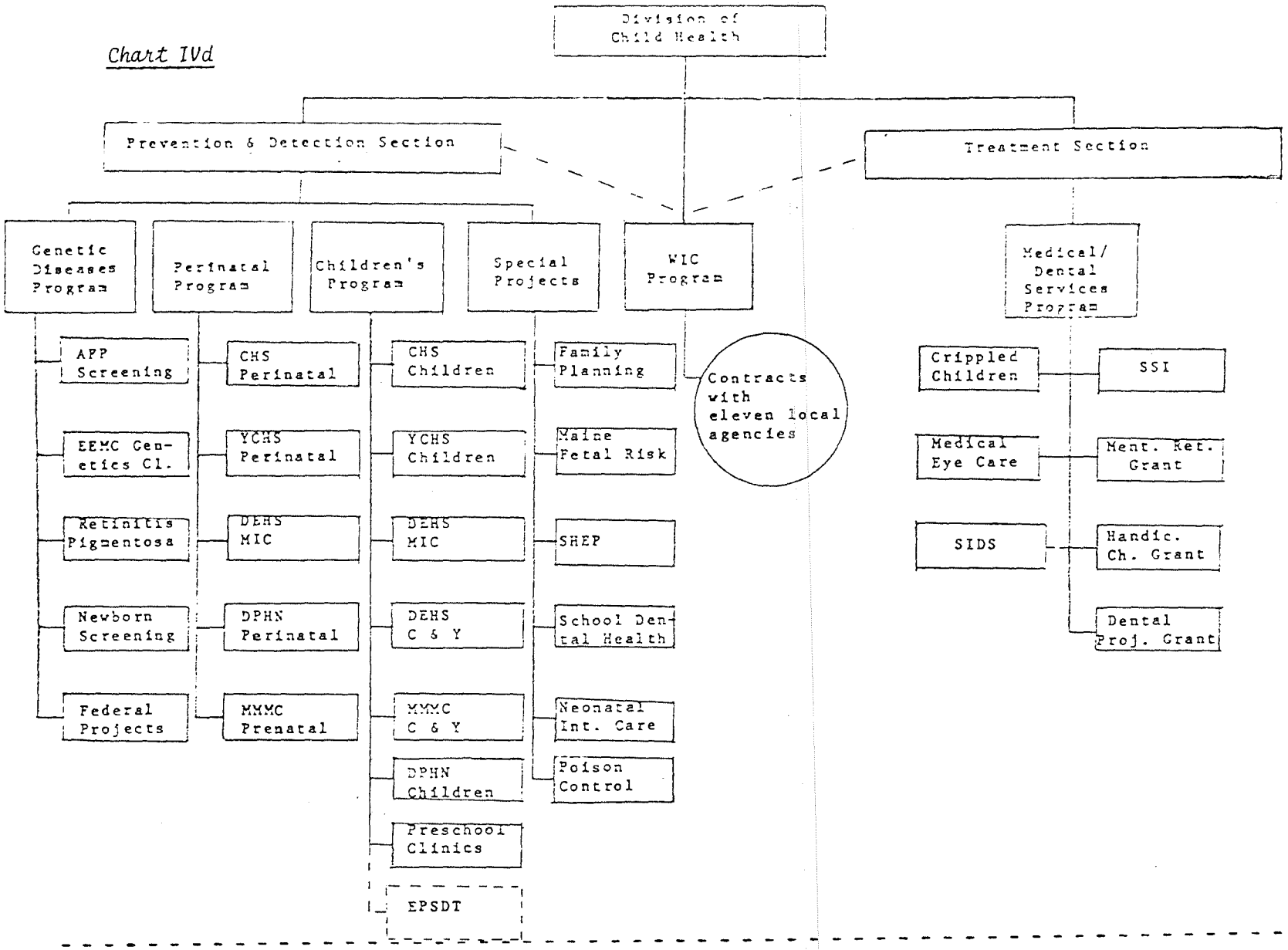
January 1980

*Chart IVc*




* Funded by the Department as an extension of its own services, through Medical Care Development, Inc.

*Chart IVd*




**Division Consultants**

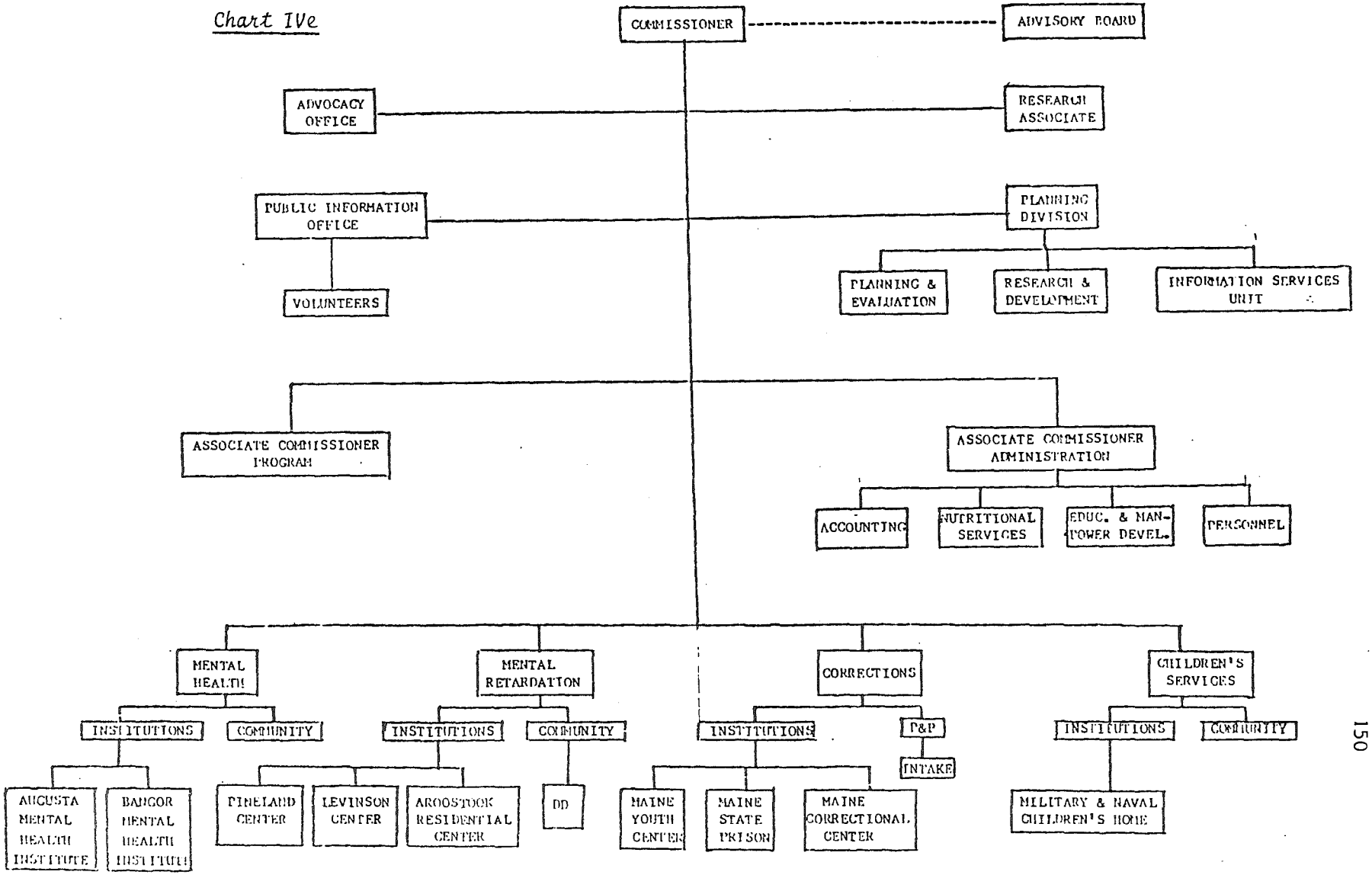
Medical
Nutrition
Speech and Hearing
Problem Oriented Practice
Program Evaluation
Public Health Nursing - Maternal & Child Health

**Division Advisory Committees**

Genetic Diseases Advisory Committee
Grant Management System Advisory Committee
Grant Review Committee
Pediatric Advisory Committee
Special Projects Advisory Committee
Technical Advisory Panel - Health Problem Selection

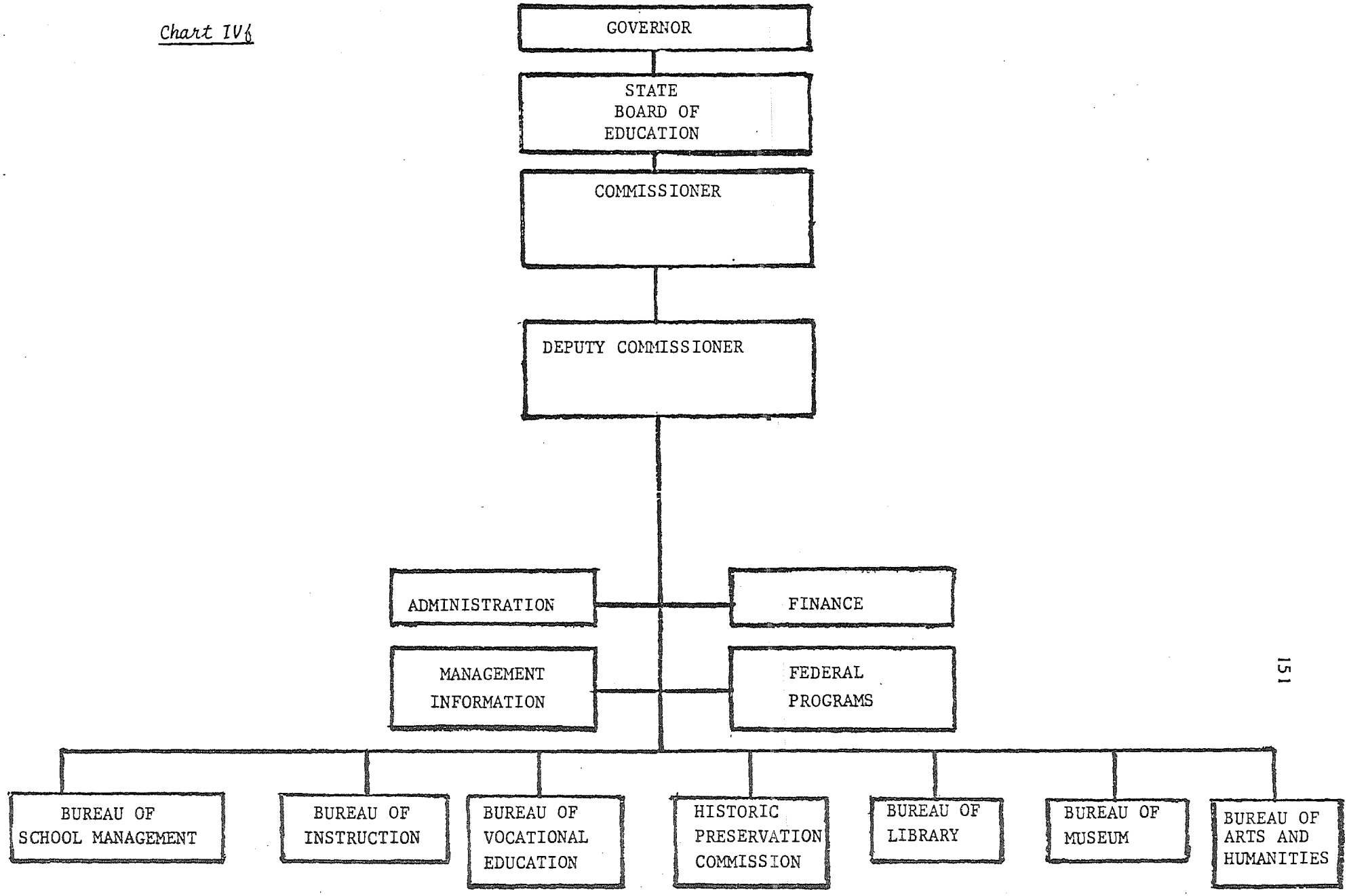
DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

*Chart IVe*



## Department of Educational and Cultural Services

Chart IVf



# APPENDIX


OFFICE OF
THE GOVERNOR

NO. 5FY 79/80
DATE October 2, 1979

AN ORDER ESTABLISHING THE GOVERNOR'S TASK FORCE ON MATERNAL AND CHILD HEALTH

WHEREAS, there is not a strong, coordinated system of maternal and child health services throughout the State of Maine; and

WHEREAS, through sound public policy which promotes prevention and early intervention of disease and other health problems, there is great potential for improving the health of Maine's citizens, and, as a result of prevention and intervention, for saving their tax dollars; and

WHEREAS, State Government should consider carefully coordinated approaches which have been developed by groups at the local level for improving the delivery of maternal and child health services; and

WHEREAS, there is a special and widespread concern about the problems of adolescent pregnancy in Maine:

NOW, THEREFORE, I, JOSEPH E. BRENNAN, Governor of the State of Maine, establish the Governor's Task Force on Maternal and Child Health to examine and make recommendations regarding approaches for improving the quality, availability and coordination of maternal and child health services in Maine.

MEMBERSHIP

There shall be twenty-five voting members on the full Task Force. Eighteen of these members shall be state legislators, private sector providers and other members of the public appointed by the Governor. Seven of these members shall be state employees invited to participate by the Commissioner of Human Services.

The Governor may invite other interested Maine citizens to serve as non-voting members on the subcommittees of the full Task Force.

The Commissioner may invite other appropriate state and federal officials to participate on the Task Force or any of its subcommittees as non-voting members.

RESPONSIBILITIES

The responsibilities of the Task Force shall be:

1. to complete a comprehensive review of the statutes, regulations, policies and financing involved in MCH programs and services;

2. to determine what additional information is required to identify more accurately the health problems and needs for health care of Maine's mothers and children;

3. to assess Maine's resources and capabilities for addressing maternal and child health problems;

4. to set priorities for the development and improved coordination of maternal and child health services;

5. to make recommendations to the Governor for improving MCH programs and services, including a plan for action by the 110th Maine State Legislature;

6. to take into account information gathered during public hearings in the development of the recommendations; and

7. to build public awareness of the problems and issues involved in the area of maternal and child health.

ADMINISTRATION

1. The Department of Human Services shall provide clerical and staff support services for the Task Force, making use of any federal funds which become available for this purpose.

2. The Department of Human Services shall reimburse members of the Task Force for actual and reasonable mileage, lodging and meal expense directly related to the activities of the Task Force.

3. The Final Report and recommendations shall be submitted by the Task Force on or before Labor Day, 1980.

4. This Executive Order shall terminate with the submission of the Final Report and recommendations.

Joseph E. Brennan
Governor

# GOVERNOR'S TASK FORCE
# ON MATERNAL AND CHILD HEALTH

## Task Force Chair

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