

**Maternal, Infant and Early Childhood  
Home Visiting Program Needs Assessment**

**Submitted by the State of Maine**

**Department of Health and Human Services**

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**Maternal, Infant and Early Childhood  
Maine Home Visiting Program Needs Assessment**

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*Sheryl Peavey, Project Director*  
[Sheryl.peavey@maine.gov](mailto:Sheryl.peavey@maine.gov)  
207-624-7992

# 1. Statewide Data Report

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The Maternal, Infant and Early Childhood Home Visiting Project has given Maine the opportunity to better understand its communities with a defined set of indicators, assess its service capacity and ultimately construct a continuum of home visiting services that is anchored to its evidence-based home visiting statewide program, Maine Families. For Phase 2 of this federal project, Maine combined its Title V epidemiology resources with its Maine Families evaluative resources to conduct a thorough and thoughtful needs assessment to identify under-served and high risk groups and begin to facilitate in-depth dialogue across previously competing or disconnected providers serving our families.

We chose to define “communities” at the county level. In Maine, counties are the smallest geographic level for which data typically are uniformly available and the population size is large enough to allow for stable and reliable estimates. Maine has 16 counties, ranging in population from under 17,000 to nearly 279,000; seven of the counties have populations under 41,000.

## **Process Used to Identify At-Risk Communities**

We began by identifying the indicators to be used for the home visiting needs assessment (HVNA). In addition to the measures specified in Table A of the Phase 2 Supplemental Information Request (SIR), we consulted with the executive director of the Maine Coalition To End Domestic Violence, the Maine Safe Families program coordinator, and the state’s lead Maternal and Child Health epidemiologist to identify an appropriate domestic violence indicator. Consensus was reached to use domestic assaults reported to the police. We chose to supplement that measure with survey data on intimate partner violence experienced before or during pregnancy. We also identified nine measures to be used in the “Other indicators of at risk prenatal, maternal, newborn, or child health” section of the state and at-risk communities data reports. Some of these measures (e.g., children eligible for free/reduced school lunch program) supplemented required measures specified in the SIR, while others (e.g., emergency department visits by children 0-4 years of age) provided a broader view of factors related to the health and well-being of young Mainers. The nine specific “other” indicators are:

1. Percent of births for which prenatal care did not begin in the first trimester
2. Percent of newborn hospital discharge records that include a drug withdrawal syndrome in newborn diagnostic code (ICD-9-CM 779.5)
3. Rate of births to women aged 15-19 years
4. Percent of 18-44 year olds who currently smoke

5. Percent of 18-44 year olds who report that their mental health was not good for 14 or more of the past 30 days
6. Rate of emergency department visits among 0-4 year olds
7. Percent of 18-44 year olds who currently do not have health insurance
8. Percent of children who are eligible for the free/reduced school lunch program
9. Rate of 0-17 year olds who are in the care or custody of the Maine Department of Health and Human Services (DHHS)

We reviewed the most recent Title V, statewide Head Start, and CAPTA needs assessments and extracted all data available for the selected indicators. The Title V needs assessment included statewide data on many, but not all, of the indicators selected for the HVNA, though sub-state data rarely were reported. More recent data had become available for many indicators since the Title V assessment was completed; we obtained updated data whenever possible. The statewide Head Start needs assessment was based on a survey of Head Start program staff and directors and did not include data on any of the measures in the HVNA. The CAPTA needs assessment was primarily qualitative and did not include data on any of the HVNA measures. All applicable data from these sources were included in the Maine State Data Report, which is based on the template provided in the SIR and is presented in Table A of this HVNA. (The updated data appear in the “Other” column; in most cases, the data sources used for the estimates in the “Other” column were the same as the primary data sources used in the Title V needs assessment.)

The most recent state- and county-level data available for each indicator are presented in Table B. Actual counts are presented, when available, in addition to the required rates and percents, in order to give an estimate of the absolute numbers of individuals or events represented by each indicator. The “Indicator” column also specifies the year(s) the data are from and superscripted numbers identify the data source; see Table C for specific source references.

In addition to the at-risk indicators shown in Table B, Table D presents demographic characteristics and additional birth measures in order to provide a broader view of each community, including measures of diversity and estimates of the numbers of individuals who could be served by home visiting programs. The “Characteristic” column also specifies the year(s) the data are from and superscripted numbers identify the data source; see Table C for specific source references.

**Table A. Maine State Data Report**

<b>Table A. Maine State Data Report</b>						
<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.2%	--	--	--	8.7%	Title V: 2004-2008 Other: 2007-2009
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	6.6%	--	--	--	6.4%	Title V: 2004-2008 Other: 2007-2009
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	6.0	--	--	--	6.1	Title V: 2003-2007 Other: 2004-2008
<u>Poverty</u> -# residents below 100% FPL/total # residents	12.8%	--	--	--	12.6%	Title V: 2005-2007 Other: 2008
<u>Crime</u> - # reported crimes/1,000 residents	--	--	--	--	25.8	Other: 2008
- # crime arrests ages 0-19/100,000 juveniles age 0-19	--	--	--	--	4,452.4	Other: 2008
<u>Domestic violence</u> -Rate: Domestic assaults reported to police, per 10,000	43.8	--	--	--	40.3	Title V: 2007 Other: 2008
-Percent: Intimate partner violence before/during pregnancy	~5%	--	--	--	5.5%	Title V: 2005-2007 Other: 2005-2008
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	4.1%	--	--	--	3.6%	Title V: 2007-2008 school year Other: 2008-2009 school year

Table A. Maine State Data Report

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	18.2%	--	--	22.1%	--	Title V: 2008, 18-44, females only, 4+ drinks SAMHSA: 2006-2008, 12+, males and females, 5+ drinks
-Prevalence rate: Marijuana use in past month	--	--	--	8.3%	--	SAMHSA: 2006-2008
-Prevalence rate: Nonmedical use of prescription drugs in past month	--	--	--	4.2%	--	SAMHSA: 2006-2008
- Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	--	--	--	3.0%	--	SAMSHA : 2006-2008
<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--	--	--	8.6%	Other: Jan-Jun 2010 (average monthly rate; not seasonally adjusted)
<u>Child maltreatment</u> -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) per 1,000	--	--	--	--	13.3	Other: 2009
-Rate of reported substantiated maltreatment: Neglect per 1,000	--	--	--	--	9.5	Other: 2009
-Rate of reported substantiated maltreatment: Physical abuse per 1,000	--	--	--	--	2.2	Other: 2009
-Rate of reported substantiated maltreatment: Psychological maltreatment per 1,000	--	--	--	--	5.8	Other: 2009
-Rate of reported substantiated maltreatment: Sexual abuse per 1,000	--	--	--	--	1.0	Other: 2009

Table A. Maine State Data Report

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>						
-Percent: Births for which prenatal care did not begin in 1 <sup>st</sup> trimester	12.2%	--	--	--	12.4%	Title V: 2004-2008 Other: 2007-2009
-Percent: Newborn hospital discharges with drug withdrawal syndrome	1.6%	--	--	--	1.6%	Title V: 2008 Other: 2008
-Rate: Births to 15-19 year old women, per 1,000	26.1	--	--	--	25.7	Title V: 2008 Other: 2007-2009
-Percent: Current smoker, 18-44 year olds	18.4%	--	--	--	23.1%	Title V: 2008, females only Other: 2008-2009, males and females
-Percent: Mental health not good for 14 or more of past 30 days, 18-44 year olds	--	--	--	--	11.5%	Other: 2008-2009
-Rate: Emergency department visits, 0-4 year olds, per 1,000	--	--	--	--	613.7	Other: 2008
-Percent: No current health insurance, 18-44 year olds	--	--	--	--	16.1%	Other: 2008-2009
-Percent: Children eligible for free or reduced school lunch program	39.0%	--	--	--	43.0%	Title V: 2008 Other: FY2010
-Rate: Children in Department of Health and Human Services care or custody, 0-17 year olds, per 1,000	6.5	--	--	--	5.8	Title V: 2007 Other: December 2009

**Table B. At-Risk Indicators, Maine, by County and Statewide**

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Indicator	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Premature births, <37 weeks gestation, average annual percent of live births and average annual count [2007-2009] <sup>1</sup>	8.2% 116	7.1% 51	8.9% 258	8.8% 26	7.3% 36	8.2% 102	7.0% 28	9.7% 29	8.2% 45	10.0% 159	9.4% 15	8.0% 31	10.2% 53	8.5% 34	7.7% 25	9.3% 187	8.7% 1,195
Low birth weight infants, <2500 grams, average annual percent of live births and average annual count [2007-2009] <sup>1</sup>	6.4% 90	5.6% 40	6.4% 187	7.0% 20	6.0% 30	6.2% 78	4.9% 20	7.5% 23	6.1% 33	6.7% 107	7.5% 12	5.8% 23	8.6% 45	7.8% 31	5.9% 19	6.3% 127	6.4% 885
Infant mortality, average annual rate per 1,000 live births and five year count [2004-2008] <sup>1, a</sup>	7.3 50	6.7 24	6.3 95	5.6 8	3.4 9	5.3 33	4.9 10	**	7.0 20	6.9 55	**	6.5 13	6.8 18	5.9 12	4.7 8	6.3 66	6.1 428

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Indicator	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Poverty, percent [2008] <sup>2</sup>	13.1%	15.2%	10.4%	17.5%	10.8%	11.8%	13.4%	10.9%	14.1%	15.9%	16.2%	9.8%	18.7%	12.6%	20.1%	9.4%	12.6%
Crime, rate per 1,000 population [2008] <sup>3</sup>	24.8	18.4	28.3	28.1	20.5	29.4	25.4	15.3	24.6	33.4	25.5	19.2	28.7	16.2	26.8	23.5	25.8
Crime arrests, 0-19 year olds, rate per 100,000 and count [2008] <sup>3,4</sup>	4,017. 3	7,158. 9	4,524. 7	4,741. 4	2,633. 9	4,837. 9	3,153. 1	4,636. 7	2,718. 9	4,774. 1	3,886. 3	4,450. 9	3,588. 3	2,184. 8	2,990. 9	5,198. 6	4,452. 4
Domestic assaults reported to police, rate per 10,000 and count [2008] <sup>3,5</sup>	58.1 620	26.0 186	37.7 1,037	46.9 140	20.5 109	56.0 676	27.0 110	34.8 121	45.0 255	34.0 505	16.4 28	24.2 88	44.3 228	29.0 112	29.0 94	49.6 1,002	40.3 5,311
Intimate partner violence before/during pregnancy, percent [2005-2008] <sup>6</sup>	7.0%	4.7%	5.3%	9.3%	3.3%	8.4%	5.0%	5.4%	5.9%	5.0%	5.4%	6.0%	4.2%	5.7%	9.9%	2.6%	5.5%

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<b>Indicator</b>	<b>Androscoggin</b>	<b>Aroostook</b>	<b>Cumberland</b>	<b>Franklin</b>	<b>Hancock</b>	<b>Kennebec</b>	<b>Knox</b>	<b>Lincoln</b>	<b>Oxford</b>	<b>Penobscot</b>	<b>Piscataquis</b>	<b>Sagadahoc</b>	<b>Somerset</b>	<b>Waldo</b>	<b>Washington</b>	<b>York</b>	<b>Maine</b>
High school drop-outs, percent and count [2008-2009 school year] <sup>7</sup>	5.5% 280	3.6% 125	2.4% 318	3.1% 46	4.2% 87	4.5% 226	3.2% 48	2.6% 29	3.2% 90	4.5% 317	5.3% 32	3.4% 62	4.8% 116	1.8% 25	4.3% 50	3.0% 232	3.6% 2,083
Binge alcohol use in past month, 12+ year olds, percent [2006-2008] <sup>8</sup>	20.9%	21.6%	24.1%	20.9%	21.6%	18.3%	20.5%	20.5%	20.9%	22.9%	22.9%	20.5%	18.3%	20.5%	21.6%	24.5%	22.1%
Marijuana use in past month, 12+ year olds, percent [2006-2008] <sup>8</sup>	8.0%	6.9%	8.8%	8.0%	6.9%	8.2%	7.5%	7.5%	8.0%	9.5%	9.5%	7.5%	8.2%	7.5%	6.9%	8.8%	8.3%
Nonmedical use of pain relievers in past year, 12+ year olds, percent [2006-2008] <sup>8</sup>	4.4%	4.2%	3.8%	4.4%	4.2%	4.2%	4.4%	4.4%	4.4%	4.1%	4.1%	4.4%	4.2%	4.4%	4.2%	4.6%	4.2%

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Indicator	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Use of illicit drugs, excluding marijuana, in past month, 12+ year olds, percent [2006-2008] <sup>8</sup>	2.8%	2.8%	3.0%	2.8%	2.8%	2.9%	2.7%	2.7%	2.8%	3.2%	3.2%	2.7%	2.9%	2.7%	2.8%	3.2%	3.0%
Unemployment rate, civilian labor force, average monthly rate (not seasonally adjusted) [Jan-Jun 2010] <sup>9</sup>	8.6%	10.5%	6.8%	10.4%	10.2%	7.9%	8.5%	8.3%	10.9%	8.6%	12.2%	7.3%	11.6%	10.0%	12.2%	8.3%	8.6%
Substantiated maltreatment: Overall, 0-17 year olds, rate per 1,000 and count [2009] <sup>1,10</sup>	16.6 402	14.9 213	7.8 464	13.1 78	15.2 160	13.2 333	9.7 78	6.2 42	15.8 186	18.1 554	21.8 74	4.3 36	24.9 277	6.8 56	12.9 86	11.6 517	13.3 3,703 <sup>b</sup>
Substantiated maltreatment: Neglect, 0-17 year olds, rate per 1,000 and count [2009] <sup>1,10</sup>	12.7 307	11.2 160	5.7 340	9.9 59	11.4 120	9.1 229	7.2 58	3.7 25	9.5 112	12.4 380	15.9 54	3.7 31	19.4 216	4.4 36	6.3 42	8.4 374	9.5 2,654 <sup>c</sup>

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Substantiated maltreatment: Physical abuse, 0-17 year olds, rate per 1,000 and count [2009] <sup>1,10</sup>	2.6 62	1.6 23	0.9 54	2.2 13	2.8 29	2.3 57	1.0 8	1.0 7	2.0 23	3.2 98	3.5 12	0.8 7	7.1 79	0.9 7	1.6 11	2.0 89	2.2 603 <sup>d</sup>
Substantiated maltreatment: Psychological maltreatment, rate per 1,000 and count [2009] <sup>1,10</sup>	5.7 137	4.6 66	3.1 186	6.2 37	5.2 55	5.4 135	4.4 35	1.0 7	6.5 77	9.2 283	11.5 39	1.2 10	12.1 134	2.4 20	10.2 68	5.5 243	5.8 1,609 <sup>e</sup>
Substantiated maltreatment: Sexual abuse, 0-17 year olds, rate per 1,000 and count [2009] <sup>1,10</sup>	0.7 18	0.6 8	0.5 32	1.0 6	1.7 18	0.8 20	1.2 10	1.0 7	0.7 8	1.4 42	**	**	1.3 15	1.2 10	**	0.6 25	1.0 270 <sup>f</sup>
Births for which women did not receive first trimester prenatal care, average annual percent [2007-2009] <sup>1</sup>	10.1%	11.3%	11.4%	10.8%	13.1%	13.6%	7.5%	11.0%	13.9%	15.9%	16.8%	9.5%	18.7%	11.6%	18.8%	11.2%	12.4%

**Table B. At-Risk Indicators, Maine, by County and Statewide**

Indicator	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Newborn hospital discharges with drug withdrawal syndrome, percent and count [2008] <sup>11</sup>	0.8% 11	0.9% 7	1.6% 46	**	3.1% 15	1.3% 16	2.9% 11	**	1.2% 6	2.8% 43	**	2.1% 7	2.4% 12	**	2.5% 8	1.0% 17	1.6% 215
Births to 15-19 year old women, average annual rate per 1,000 female population and average annual count [2007-2009] <sup>1,5</sup>	40.3 141	29.9 69	16.2 145	19.7 26	23.0 35	30.3 120	32.4 36	21.3 21	30.7 54	24.6 134	35.8 18	20.0 23	43.2 69	33.2 41	37.7 38	20.4 138	25.7 1,107
Current smoker, 18-44 year olds, percent [2008-2009] <sup>12</sup>	24.6%	29.2%	16.3%	20.3%	23.4%	17.9%	22.3%	27.1%	34.6%	24.3%	29.9%	18.1%	37.3%	25.6%	27.3%	21.5%	23.1%
Mental health not good for 14 or more of past 30 days, 18-44 year olds, percent [2008-2009] <sup>12</sup>	10.2%	14.6%	11.5%	10.8%	13.3%	9.5%	11.0%	14.1%	14.9%	9.8%	18.9%	11.7%	13.9%	12.5%	13.7%	9.0%	11.5%

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Indicator	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Emergency department visits, 0-4 year olds, visit rate per 1,000 population and count [2008] <sup>11,13,14,15</sup>	741.9 5,105	1,013.6 3,575	421.2 6,531	676.5 968	588.3 1,579	643.5 4,119	651.3 1,345	570.9 902	646.2 1,912	503.6 4,163	898.8 746	385.0 812	1,021.4 2,767	630.3 1,289	1,000.6 1,742	484.1 5,192	613.7 43,856
No current health insurance, 18-44 year olds, percent [2008-2009] <sup>12</sup>	18.6%	14.9%	12.0%	18.1%	19.9%	15.8%	27.1%	20.0%	21.5%	18.0%	12.4%	8.9%	23.6%	18.7%	22.7%	10.2%	16.1%
Children eligible for free or reduced lunch program, all ages, percent and count [FY2010] <sup>16</sup>	49.8% 8,117	52.4% 5,559	30.8% 12,466	52.6% 2,191	41.4% 2,775	42.9% 7,848	41.7% 1,972	43.8% 2,019	56.8% 5,653	46.9% 10,241	57.7% 1,579	35.5% 1,895	57.5% 4,686	56.4% 2,859	59.3% 2,769	34.8% 9,743	43.0% 82,372
Children in DHHS care or custody, 0-17 year olds, rate per 1,000 and count [December 2009] <sup>17</sup>	4.3 104	7.0 102	5.0 302	8.0 49	4.4 47	7.3 188	4.0 33	5.1 35	3.9 47	7.1 219	5.5 19	2.8 24	8.3 94	6.8 57	7.7 52	5.2 237	5.8 1,650

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Indicator	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
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\*\* Data are suppressed, per the Maine Center for Disease Control and Prevention Privacy Policy, because the count during the specified time period was less than 6. The associated rate or percent was included in z-score calculations, but is suppressed in this table.

- <sup>a</sup> 2008 death data are preliminary.
- <sup>b</sup> Includes 147 children for whom county was not identified.
- <sup>c</sup> Includes 110 children for whom county was not identified.
- <sup>d</sup> Includes 24 children for whom county was not identified.
- <sup>e</sup> Includes 77 children for whom county was not identified.
- <sup>f</sup> Includes 44 children for whom county was not identified.

## Table C. Sources for At-Risk Indicators and Community Characteristics Tables

- <sup>1</sup> Haggan K and Corkum B, Office of Data, Research, and Vital Statistics, Maine Center for Disease Control and Prevention. Personal communications, 8/10, 8/18, 9/2/10, and 9/10/10.
- <sup>2</sup> United States Census Bureau. Small area income and poverty estimates: Estimates for Maine counties, 2008. Available from <http://www.census.gov/cgi-bin/saipe/saipe.cgi> (accessed 7/27/10).
- <sup>3</sup> Cummings J, Department of Public Safety, Maine State Police, Uniform Crime Reporting Unit. Personal communication, 8/3/10.
- <sup>4</sup> United States Census Bureau. Annual Estimates of the Resident Population by Age, Sex, Race, and Hispanic Origin for Counties: April 1, 2000 to July 1, 2009. Available from: <http://www.census.gov/popest/counties/asrh/CC-EST2009-alldata.html> (accessed 8/30/10).
- <sup>5</sup> United States Census Bureau. Annual estimates of the resident population by selected age groups and sex for counties in Maine: April 1, 2000 to July 1, 2009. June 2010. Available from <http://www.census.gov/popest/counties/asrh/files/cc-est2009-agesex-23.csv> (accessed 7/26/10).
- <sup>6</sup> In-house analysis of Maine Pregnancy Risk Assessment Monitoring System dataset.
- <sup>7</sup> Maine Department of Education. High school graduation and dropout rates, 2008/09. Available from <http://www.maine.gov/education/gradrates/gradrate0809.xls> (accessed 8/6/10).
- <sup>8</sup> Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2010). Substate estimates from the 2006-2008 National Surveys on Drug Use and Health. Rockville, MD. Available from <http://oas.samhsa.gov/substate2k10/toc.cfm> (accessed 8/25/10).
- <sup>9</sup> Center for Workforce Research and Information, Maine Department of Labor. Civilian labor force estimates for Maine counties, 2010. Available from <http://www.maine.gov/labor/lmis/data/laus/Excel/CountyLaborForceEstimates.xls> (accessed 7/29/10).
- <sup>10</sup> Blanchard R, Office of Child and Family Services, Maine Department Health and Human Services. Personal communication, 9/10/10.

- 11 In-house analysis of Maine hospital discharge dataset.
- 12 In-house analysis of Maine Behavioral Risk Factor Surveillance System dataset.
- 13 United States Census Bureau. Annual estimate of the resident population by single-year of age and sex for the United States and states: April 1, 2000 to July 1, 2008. May 2009. Available from <http://www.census.gov/popest/states/asrh/files/SC-EST2008-AGESEX-RES.csv> (accessed 6/4/09).
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## 2. Definition of “Community”

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As noted in the statewide data report, we chose to define “communities” at the county level. In Maine, counties are the smallest geographic level for which data typically are uniformly available and the population size is large enough to allow for stable and reliable estimates. Maine has 16 counties, ranging in population from under 17,000 to nearly 279,000; seven of the counties have populations under 41,000.

## 3. Data Report of At Risk Communities and the State

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After gathering the data, the next step was to identify counties at risk on any indicator as well as those at greatest risk. The Phase 2 SIR stated that each community should be compared to the state. Maine’s population, however, is not distributed equally across its 16 counties. More than a third (36%) of the state’s population live in the southernmost two counties, and almost half (48%) live in the three largest counties (population-wise). Estimates for the state are thereby driven by these three counties and comparing a county to the state as a whole would be, in large part, a comparison of that county with the three largest counties. As such, we requested, and were granted, permission to use z-scores to identify the counties at greatest risk on each indicator. Z-scores measure how different a given county is from the average of all counties (regardless of the size of their population), which we feel is a better approach given the uneven distribution of Maine’s population. Z-scores also have the advantage of standardizing each indicator to the same scale.

The z-score calculation formula is:

$$z = \frac{\text{(county estimate – all-counties mean)}}{\text{standard deviation of the all-counties mean}}$$

Z-scores were calculated for each indicator for each county. In keeping with the Maine Center for Disease Control and Prevention Privacy Policy, counts less than 6 and associated rates or percents were suppressed in Table B; however, the suppressed rates or percents were used to calculate z-scores. Z-scores less than 0 indicate a lower level of risk (on that indicator) in that county than in all counties on average; z-scores greater than 0 indicate a higher level of risk in that county than in all counties on average. Communities at greatest risk for a given indicator were defined as those counties with a z-score of 1.0 or more.

The Phase 2 SIR required that multiple indicators be used to address certain risk areas, such as substance abuse and child maltreatment. In addition, as mentioned above, some of the “other” at-risk indicators we selected complemented required indicators. We did not want risk areas with multiple indicators to have more influence on the selection of the counties at greatest risk than areas with a single indicator, so we grouped the indicators into 16 “domains,” as follows:

1. Premature; low birth weight
2. Infant mortality
3. Below poverty level (all ages); free or reduced school lunch
4. Crime rate; juvenile arrest rate
5. Domestic assaults reported to police; intimate partner violence before or during pregnancy
6. High school drop-outs
7. Binge alcohol; marijuana; illicit drugs other than marijuana; nonmedical use of pain relievers; drug withdrawal syndrome in newborn
8. Unemployment
9. Overall child maltreatment; neglect; physical abuse; psychological abuse; sexual abuse (0-17 year olds)
10. Prenatal care begun after 1<sup>st</sup> trimester
11. Births to 15-19 year olds
12. Current smoker (18-44 year olds)
13. Mental health not good on 14+ of past 30 days (18-44 year olds)
14. Emergency department visits (0-4 year olds)
15. No current health insurance (18-44 year olds)
16. Children in DHHS care or custody (0-17 year olds)

A summary of the z-scores for each domain is presented in Table E. An X in a county’s column indicates that the z-score for the county was 1.0 or higher for that particular domain; if the domain consists of two or more indicators, an X means the county had a z-score of 1.0 or higher for at least one of the indicators in the domain.

The bottom row in Table E shows the total number of domains in which the county had one or more indicators with a z-score of 1.0 or higher. The totals ranged from 0 to 11. Every county except Sagadahoc had at least one domain with an indicator that had a z-score of 1.0 or higher; thus, every county except Sagadahoc could be said to be at greatest risk on at least one domain included in the HVNA. It is important to recognize here that even in those counties with zero or low total scores, there are individuals and families at risk for poor outcomes; the low totals only indicate that those counties are not at substantially higher risk than Maine counties on average.

There was a natural break in the distribution of the total scores, with 13 counties having totals between 0 and 4 and three counties having totals between 9 and 11. As such, counties at greatest risk were defined as those with a total score of 9 or more. The three counties that met this definition were Piscataquis, Somerset, and Washington. These three counties were at substantially increased risk on a broad range of factors affecting the health and well-being of the population served by home visiting programs. Z-score figures for these counties are shown in Table F; for indicators where data were suppressed due to counts less than 6, z-scores are listed simply as  $z < 1$  or  $z \geq 1$ .

Data reports for the three counties identified as being at greatest risk are presented in Table G. County-specific estimates are provided whenever possible; data for some indicators were only available at the public health district (in Maine, districts consist of one to four counties) or region (alternative groupings of counties used by SAMHSA) level. District- or region-level estimates are identified as such in the “Comments” column. Head Start data for these data reports come from the local community assessments completed by Head Start Programs. Each local assessment covered more than one county; however, county-specific data were provided, so we were able to extract data specific to our three identified counties.

A public hearing was held to provide stakeholders with the opportunity to comment on the Phase 2 needs assessment. We presented an overview of our rationale and approach, the methodology used to collect, analyze, and review at-risk indicators, our process to determine communities at greatest risk, and preliminary summary results. Several comments received were related to our definition of “community”, that is, whether our selection of county could be further refined to smaller geographies, especially in Maine’s urban areas. Our response was that for the present needs assessment, further refinement into smaller geographic units would result in units having “missing” data on key indicators needed for our risk summary algorithm. We also noted that there may be the potential for further geographic refinement during Phase 3. Another individual asked if data on “fathers” had been included in any of the risk indicators. We responded that several indicators (e.g., health insurance status, mental health, substance abuse, unemployment, poverty) included males.

**Table D. Community Characteristics, Maine, by County and Statewide**

<b>Table D. Community Characteristics, Maine, by County and Statewide</b>																	
<b>Characteristic</b>	<b>Androscoggin</b>	<b>Aroostook</b>	<b>Cumberland</b>	<b>Franklin</b>	<b>Hancock</b>	<b>Kennebec</b>	<b>Knox</b>	<b>Lincoln</b>	<b>Oxford</b>	<b>Penobscot</b>	<b>Piscataquis</b>	<b>Sagadahoc</b>	<b>Somerset</b>	<b>Waldo</b>	<b>Washington</b>	<b>York</b>	<b>Maine</b>
Total population [2009] <sup>5,18</sup>	106,539	71,488	278,559	29,735	53,447	121,090	40,801	34,576	56,244	149,419	16,795	36,391	50,947	38,287	32,107	201,876	1,318,301
Population, percent change [4/1/2000 to 7/1/2009] <sup>19</sup>	2.6%	-3.3%	4.9%	0.9%	3.2%	3.4%	3.0%	2.9%	2.7%	3.1%	-2.6%	3.3%	0.1%	5.5%	-5.4%	8.1%	3.4%
Children under 5 years old, percent and count [2009] <sup>5,18</sup>	6.3% 6,738	5.0% 3,564	5.5% 15,265	5.0% 1,485	5.0% 2,659	5.2% 6,357	5.0% 2,029	4.8% 1,644	5.3% 2,965	5.5% 8,209	5.0% 834	5.5% 1,988	5.3% 2,721	5.4% 2,055	5.4% 1,728	5.2% 10,521	5.4% 70,762
Women 15-44 years old, percent and count [2009] <sup>5,18</sup>	19.9% 21,178	17.0% 12,148	19.7% 54,961	20.5% 6,104	16.8% 8,980	18.4% 22,327	15.9% 6,506	15.5% 5,372	17.2% 9,701	20.5% 30,697	15.0% 2,516	18.0% 6,556	17.9% 9,099	17.7% 6,791	16.8% 5,384	18.6% 37,505	18.6% 245,825
Births, average annual count [2007-2009] <sup>1</sup>	1,403	722	2,902	292	498	1,255	399	304	550	1,592	164	389	521	399	323	2,013	13,726
Births to women <22 years, average annual count [2007-2009] <sup>1</sup>	293	152	330	67	87	244	74	57	124	303	40	55	131	80	79	297	2,413
Births to first time mothers, average annual count [2007-2009] <sup>1</sup>	582	304	1,396	127	232	593	175	131	242	707	66	171	223	172	130	895	6,148

**Table D. Community Characteristics, Maine, by County and Statewide**

Characteristic	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Total households, count [2006-2008] <sup>20</sup>	43,820	30,970	113,855	12,308	22,363	50,291	17,013	15,054	23,128	60,806	NA	14,749	21,031	15,563	14,348	81,028	544,101
Households with at least one person <18 years old, percent and count [2006-2008] <sup>20</sup>	32.0% 14,025	28.8% 8,911	30.2% 34,368	30.5% 3,749	26.8% 5,984	29.2% 14,703	27.5% 4,674	26.9% 4,044	29.8% 6,891	29.4% 17,861	NA	27.0% 3,977	31.0% 6,515	30.8% 4,791	27.6% 3,960	32.6% 26,403	30.0% 163,270
Children under 5 living in married-couple family households, percent [2006-2008] <sup>20</sup>	63.5%	65.3%	76.7%	63.4%	80.8%	69.1%	58.9%	78.9%	60.1%	71.4%	NA	77.9%	68.3%	67.9%	70.0%	81.4%	72.4%
Children <18 living with grandparent householder who is responsible for them (regardless of presence of parent), percent [2006-2008] <sup>20</sup>	2.5%	3.1%	1.3%	NA	3.1%	1.6%	0.6%	4.9%	2.4%	1.6%	NA	1.4%	2.5%	2.7%	5.4%	2.8%	2.2%
Race: White alone, percent [2008] <sup>19</sup>	95.7%	96.3%	94.5%	97.8%	97.3%	97.2%	98.0%	98.2%	97.9%	96.3%	97.9%	96.2%	97.6%	97.7%	93.5%	97.3%	96.4%
Race: Black or African American alone, percent [2008] <sup>19</sup>	1.9%	0.7%	2.1%	0.4%	0.4%	0.6%	0.4%	0.3%	0.4%	0.8%	0.3%	1.4%	0.4%	0.4%	0.5%	0.7%	1.0%

**Table D. Community Characteristics, Maine, by County and Statewide**

Characteristic	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Race: American Indian or Alaska Native alone, percent [2008] <sup>19</sup>	0.3%	1.5%	0.4%	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	1.0%	0.6%	0.4%	0.5%	0.4%	4.4%	0.3%	0.6%
Race: Asian alone, percent [2008] <sup>19</sup>	0.7%	0.6%	1.7%	0.5%	0.7%	0.7%	0.5%	0.4%	0.5%	0.9%	0.3%	0.7%	0.4%	0.3%	0.5%	0.8%	0.9%
Race: Native Hawaiian or Other Pacific Islander alone, percent [2008] <sup>19</sup>	<0.1%	<0.1%	0.1%	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	<0.1%	0.1%	0.1%	<0.1%	<0.1%	<0.1%	<0.1%
Race: Two or more races, percent [2008] <sup>19</sup>	1.3%	0.9%	1.2%	0.9%	1.2%	1.1%	0.9%	0.7%	0.9%	1.0%	0.9%	1.3%	1.1%	1.2%	1.2%	0.9%	1.1%
Ethnicity: Hispanic or Latino (regardless of race), percent [2008] <sup>19</sup>	1.6%	1.1%	1.8%	0.8%	1.0%	1.2%	1.0%	0.8%	0.8%	1.0%	0.8%	1.8%	0.7%	0.8%	1.5%	1.2%	1.3%
<45 year olds who are foreign-born, percent [2006-2008] <sup>20</sup>	4.1%	2.6%	5.2%	1.1%	1.7%	2.2%	0.9%	1.2%	1.0%	2.3%	NA	1.1%	1.8%	0.7%	3.1%	2.2%	2.8%

**Table D. Community Characteristics, Maine, by County and Statewide**

Characteristic	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York	Maine
Children <6 who live with their mother (with or without father) where mother is in the labor force, percent [2006-2008] <sup>20</sup>	67.2%	60.0%	64.4%	65.8%	71.1%	61.9%	65.1%	67.5%	70.7%	67.3%	NA	60.5%	64.5%	66.8%	60.0%	68.0%	65.6%
Children 5-17 years old who live in a home where only English is spoken, percent [2006-2008] <sup>20</sup>	91.1%	87.5%	91.3%	97.4%	97.1%	96.4%	98.0%	98.5%	94.5%	95.2%	NA	97.7%	95.1%	98.7%	93.0%	96.5%	94.3%
18-34 year olds (male and female) who are veterans, percent [2006-2008] <sup>20</sup>	6.5%	2.6%	2.9%	2.5%	3.7%	4.8%	5.3%	3.4%	4.9%	2.3%	NA	4.8%	6.2%	3.3%	3.8%	4.3%	3.9%
Persons per square mile [2000] <sup>19</sup>	220.8	11.1	317.7	17.4	32.6	134.9	108.2	73.7	26.3	42.7	4.3	138.6	13.0	49.7	13.2	188.4	41.3
Population living in rural area, percent [2000] <sup>21</sup>	42.7%	77.3%	34.3%	82.7%	95.2%	61.2%	61.6%	100%	82.8%	55.9%	100%	59.0%	74.5%	91.1%	92.0%	53.5%	59.8%

NA: Not available due to small population size.

**Table E. Summary of Z-Scores for At-Risk Indicator Domains**

Indicator Domain	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penobscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York
Premature / low birth weight								X		X	X		X	X		
Infant mortality	X															
Below poverty level (all ages) / free or reduced school lunch <sup>a</sup>				X					X		X		X		X	
Crime <sup>b</sup>		X				X				X						
Domestic violence <sup>c</sup>	X			X		X									X	X
High school drop-outs	X										X		X			
Substance abuse / drug withdrawal syndrome <sup>d</sup>			X		X		X			X	X					X
Unemployment											X		X		X	
Child maltreatment, 0-17 year olds <sup>e</sup>					X						X		X		X	
Prenatal care began after 1st trimester											X		X		X	
Births to 15-19 year olds	X												X		X	
Current smoker, 18-44 year olds									X				X			
Mental health not good on 14+ of past 30 days, 18-44 year olds											X					
Emergency department visits, 0-4 year olds		X									X		X		X	
No current health insurance, 18-44 year olds							X						X		X	
DHHS care or custody, 0-17 year olds				X									X		X	
<b>Total # of indicator domains on which county is at greatest risk</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>9</b>	<b>0</b>	<b>11</b>	<b>1</b>	<b>9</b>	<b>2</b>

<sup>a</sup> Poverty (all ages) and/or eligible for free/reduced school lunch program

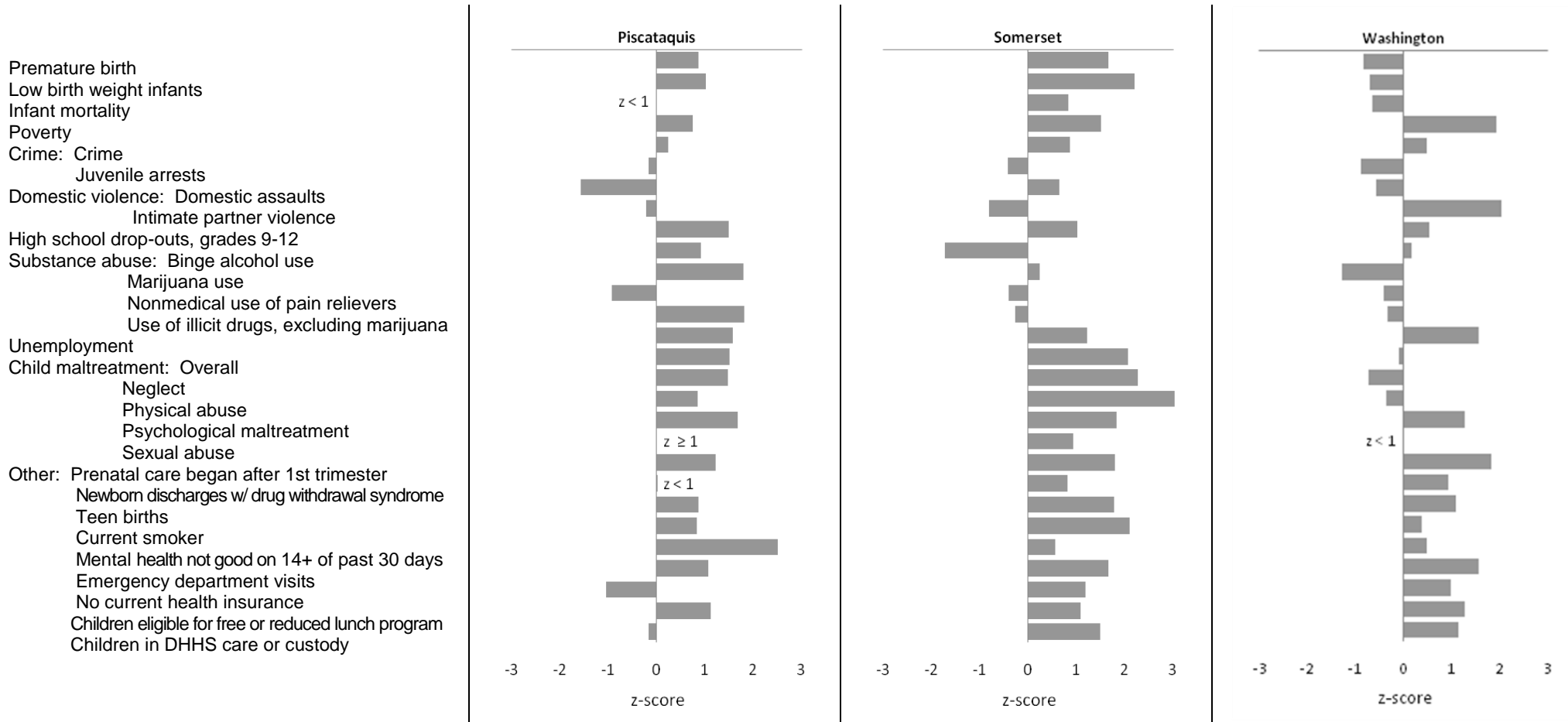
<sup>b</sup> Crime rate and/or juvenile arrest rate

<sup>c</sup> Domestic assaults reported to police and/or intimate partner violence before or during pregnancy

<sup>d</sup> Binge alcohol, marijuana, illicit drugs other than marijuana, nonmedical use of pain relievers, and/or drug withdrawal syndrome in newborn

<sup>e</sup> Overall child maltreatment, neglect, physical abuse, psychological abuse, and/or sexual abuse

**Table F. Z-score Figures for Counties at Greatest Risk**



**Table G. Data Reports for Counties Identified as Being at Greatest Risk**

<b>Table G. Piscataquis County Data Report</b>						
<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	10.4%	--	--	--	9.4%	Title V: 2004-2008 Other: 2007-2009
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	7.1%	--	--	--	7.5%	Title V: 2004-2008 Other: 2007-2009
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	6.3	--	--	--	**	Title V: 2003-2007, district-level data Other: 2004-2008, county-level data
<u>Poverty</u> -# residents below 100% FPL/total # residents	--	--	16.5%	--	16.2%	Head Start: 2007 Other: 2008
<u>Crime</u> - # reported crimes/1000 residents	--	--	--	--	25.5	Other: 2008

**Table G. Piscataquis County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
- # crime arrests ages 0-19/100,000 juveniles age 0-19	--	--	--	--	3,886.3	Other: 2008
<u>Domestic violence</u> -Rate: Domestic assaults reported to police, per 10,000	31.5	--	--	--	16.4	Title V: 2007, district-level data Other: 2008, county-level data
-Percent: Intimate partner violence before/during pregnancy	--	--	--	--	5.4%	Other: 2005-2008
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	4.3%	--	4.6%	--	5.3%	Title V: 2007-2008 school year Head Start: 2006-2007 Other: 2008-2009 school year
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	10.4%	--	--	22.9%	--	Title V: 2008, 18-44 year olds, females, 4+ drinks, district-level data SAMHSA: 2006-2008, , 12+ year olds, males and females, 5+ drinks, region-level data

**Table G. Piscataquis County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Prevalence rate: Marijuana use in past month	--	--	--	9.5%	--	SAMHSA: 2006-2008, region-level data
-Prevalence rate: Nonmedical use of prescription drugs in past month	--	--	--	4.1%	--	SAMHSA: 2006-2008, region-level data
- Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	--	--	--	3.2%	--	SAMHSA: 2006-2008, region-level data
<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--	--	--	12.2%	Other: Jan-Jun 2010 (average monthly rate; not seasonally adjusted)
<u>Child maltreatment</u> -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) per 1,000	--	--	--	--	21.8	Other: 2009
-Rate of reported substantiated maltreatment: Neglect per 1,000	--	--	--	--	15.9	Other: 2009
-Rate of reported substantiated maltreatment: Physical abuse per 1,000	--	--	--	--	3.5	Other: 2009

**Table G. Piscataquis County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Rate of reported substantiated maltreatment: Psychological maltreatment per 1,000	--	--	--	--	11.5	Other: 2009
-Rate of reported substantiated maltreatment: Sexual abuse per 1,000	---	---	---	--	**	Other: 2009
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>						
-Percent: Births for which prenatal care did not begin in 1 <sup>st</sup> trimester	17.4%	--	--	--	16.8%	Title V: 2004-2008 Other: 2007-2009
-Percent: Newborn hospital discharges with drug withdrawal syndrome	--	--	--	--	**	Other: 2008
-Rate: Births to 15-19 year old women, per 1,000	--	--	--	--	35.8	Title V: 2008 Other: 2007-2009
-Percent: Current smoker, 18-44 year olds	21.2%	--	--	--	29.9%	Title V: 2008, females only, district-level data Other: 2008-2009, males and females, county-level data

**Table G. Piscataquis County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Percent: Mental health not good for 14 or more of past 30 days, 18-44 year olds	--	--	--	--	18.9%	Other: 2008-2009
-Rate: Emergency department visits, 0-4 year olds, per 1,000	--	--	--	--	898.8	Other: 2008
-Percent: No current health insurance, 18-44 year olds	--	--	--	--	12.4%	Other: 2008-2009
-Percent: Children eligible for free or reduced school lunch program	53.7%	--	53.7%	--	57.7%	Title V: 2008 Head Start: 2008-2009 Other: FY2010
-Rate: Children in Department of Health and Human Services care or custody, 0-17 year olds, per 1,000	8.2	--	--	--	5.5	Title V: 2007 Other: December 2009

\* Source: Penquis Head Start Community Needs Assessment, Revised 1/21/2010; report covers Knox, Penobscot, and Piscataquis counties. Not all relevant data from the report could be inserted into this matrix because of incomplete data definitions or other data limitations.

\*\* Data are suppressed, per the Maine Center for Disease Control and Prevention Privacy Policy, when there are less than 6 events in the specified time period.

**Table G. Somerset County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.5%	--	--	--	10.2%	Title V: 2004-2008 Other: 2007-2009
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	8.0%	--	--	--	8.6%	Title V: 2004-2008 Other: 2007-2009
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	5.7	--	--	--	6.8	Title V: 2003-2007, district-level data Other: 2004-2008, county-level data
<u>Poverty</u> -# residents below 100% FPL/total # residents	16.7%	--	16.9%	--	18.7%	Title V: 2005-2007 Head Start: 2005 Other: 2008
<u>Crime</u> - # reported crimes/1000 residents	--	--	--	--	28.7	Other: 2008
- # crime arrests ages 0-19/100,000 juveniles age 0-19	--	--	--	--	3,588.6	Other: 2008

**Table G. Somerset County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Domestic violence</u> -Rate: Domestic assaults reported to police, per 10,000	60.9	--	49.2	--	44.3	Title V: 2007, district-level data Head Start: 2005, county-level data Other: 2008; county-level data
-Percent: Intimate partner violence before/during pregnancy	--	--	--	--	4.2%	Other: 2005-2008
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	5.0%	--	--	--	4.8%	Title V: 2007-2008 school year Other: 2008-2009 school year
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	18.6%	--	--	18.3%	--	Title V: 2008, 18-44 year olds, females, 4+ drinks, district-level data SAMHSA: 2006-2008, , 12+ year olds, males and females, 5+ drinks, region-level data

**Table G. Somerset County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Prevalence rate: Marijuana use in past month	--	--	--	8.2%	--	SAMHSA: 2006-2008, region-level data
-Prevalence rate: Nonmedical use of prescription drugs in past month	--	--	--	4.2%	--	SAMHSA: 2006-2008, region-level data
- Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	--	--	--	2.9%	--	SAMHSA: 2006-2008, region-level data
<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--	12.5%	--	11.6%	Head Start: February, 2009 Other: Jan-Jun 2010 (average monthly rate; not seasonally adjusted)
<u>Child maltreatment</u> -Rate of reported of substantiated maltreatment (substantiated/indicated/alt response victim) per 1,000	--	--	--	--	24.9	Other: 2009
-Rate of reported substantiated maltreatment: Neglect per 1,000	--	--	--	--	19.4	Other: 2009
-Rate of reported substantiated maltreatment: Physical abuse per 1,000	--	--	--	--	7.1	Other: 2009

**Table G. Somerset County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Rate of reported substantiated maltreatment: Psychological maltreatment per 1,000	--	--	--	--	12.1	Other: 2009
-Rate of reported substantiated maltreatment: Sexual abuse per 1,000	--	--	--	--	1.3	Other: 2009
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>						
-Percent: Births for which prenatal care did not begin in 1 <sup>st</sup> trimester	20.5%	--	--	--	18.7%	Title V: 2004-2008 Other: 2007-2009
-Percent: Newborn hospital discharges with drug withdrawal syndrome	--	--	--	--	2.4%	Other: 2008
-Rate: Births to 15-19 year old women, per 1,000	--	--	36.8	--	43.2	Head Start: 2002-2006 Other: 2007-2009
-Percent: Current smoker, 18-44 year olds	21.5%	--	--	--	37.3%	Title V: 2008, females only, district-level data Other: 2008-2009, males and females, county-level data

**Table G. Somerset County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Percent: Mental health not good for 14 or more of past 30 days, 18-44 year olds	--	--	--	--	13.9%	Other: 2008-2009
-Rate: Emergency department visits, 0-4 year olds, per 1,000	--	--	--	--	1,021.4	Other: 2008
-Percent: No current health insurance, 18-44 year olds	--	--	--	--	23.6%	Other: 2008-2009
-Percent: Children eligible for free or reduced school lunch program	53.8%	--	--	--	57.5%	Title V: 2008 Other: FY2010
-Rate: Children in Department of Health and Human Services care or custody, 0-17 year olds, per 1,000	9.7	--	--	--	8.3	Title V: 2007 Other: December 2009

\* Source: Kennebec Valley Community Action Program (Kennebec and Somerset Counties) Community Needs Assessment, 2009 and March 2008. Not all relevant data from the report could be inserted into this matrix because of incomplete data definitions or other data limitations.

**Table G. Washington County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Premature birth</u> -Percent: # live births before 37 weeks/total # live births	9.1%	--	--	--	7.7%	Title V: 2004-2008 Other: 2007-2009
<u>Low-birth-weight infants</u> -Percent: # resident live births less than 2500 grams/# resident live births	6.1%	--	--	--	5.9%	Title V: 2004-2008 Other: 2007-2009
<u>Infant mortality (includes death due to neglect)</u> -# infant deaths ages 0-1/1,000 live births	4.4%	--	--	--	4.7	Title V: 2003-2007, district-level data Other: 2004-2008, county-level data
<u>Poverty</u> -# residents below 100% FPL/total # residents	19.7%	--	--	--	20.1%	Title V: 2005-2007 Other: 2008
<u>Crime</u> - # reported crimes/1000 residents	--	--	--	--	26.8	Other: 2008
- # crime arrests ages 0-19/100,000 juveniles age 0-19	--	--	--	--	2,990.9	Other: 2008

**Table G. Washington County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
<u>Domestic violence</u> -Rate: Domestic assaults reported to police, per 10,000	21.2	--	--	--	29.0	Title V: 2007, district-level data Other: 2008, county-level data
-Percent: Intimate partner violence before/during pregnancy	--	--	--	--	9.9%	Other: 2005-2008
<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	3.7%	--	3.7%	--	4.3%	Title V and Head Start: 2007-2008 school year Other: 2008-2009 school year
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month	21.7%	--	--	21.6%	--	Title V: 2008, 18-44 year olds, females, 4+ drinks, district-level data SAMHSA: 2006-2008, 12+ year olds, males and females, 5+ drinks, region-level data
-Prevalence rate: Marijuana use in past month	--	--	--	6.9%	--	SAMHSA: 2006-2008, region-level data

**Table G. Washington County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Prevalence rate: Nonmedical use of prescription drugs in past month	--	--	--	4.2%	--	SAMHSA: 2006-2008, region-level data
- Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	--	--	--	2.8%	--	SAMHSA: 2006-2008, region-level data
<u>Unemployment</u> -Percent: # unemployed and seeking work/total workforce	--	--	11.5%	--	12.2%	Head Start: 2009 Other: Jan-Jun 2010 (average monthly rate; not seasonally adjusted)
<u>Child maltreatment</u> -Rate of reported of substantiated maltreatment per 1,000 (substantiated/indicated/alt response victim)	--	--	--	--	12.9	Other: 2009
-Rate of reported substantiated maltreatment: Neglect per 10,000	--	--	--	--	6.3	Other: 2009
-Rate of reported substantiated maltreatment: Physical abuse per 1,000	--	--	--	--	1.6	Other: 2009

**Table G. Washington County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Rate of reported substantiated maltreatment: Psychological maltreatment per 1,000	--	--	--	--	10.2	Other: 2009
-Rate of reported substantiated maltreatment: Sexual abuse per 1,000	--	--	--	--	**	Other: 2009
<u>Other indicators of at risk prenatal, maternal, newborn, or child health</u>						
-Percent: Births for which prenatal care did not begin in 1 <sup>st</sup> trimester	18.1%	--	--	--	18.8%	Title V: 2004-2008 Other: 2007-2009
-Percent: Newborn hospital discharges with drug withdrawal syndrome	--	--	--	--	2.5%	Title V: 2008 Other: 2008
-Rate: Births to 15-19 year old women, per 1,000	--	--	--	--	37.7	Title V: 2008 Other: 2007-2009
-Percent: Current smoker, 18-44 year olds	14.3%	--	--	--	27.3%	Title V: 2008, females only, district-level data Other: 2008-2009, males and females, county-level data

**Table G. Washington County Data Report**

<u>Indicator</u>	<u>Title V</u>	<u>CAPTA</u>	<u>Head Start</u>	<u>SAMHSA Sub-State Treatment Planning Data Reports</u>	<u>Other</u>	<u>Comments</u>
-Percent: Mental health not good for 14 or more of past 30 days, 18-44 year olds	--	--	--	--	13.7%	Other: 2008-2009
-Rate: Emergency department visits, 0-4 year olds, per 1,000	--	--	--	--	1,000.6	Other: 2008
-Percent: No current health insurance, 18-44 year olds	--	--	--	--	22.7%	Other: 2008-2009
-Percent: Children eligible for free or reduced school lunch program	56.7%	--	--	--	59.3%	Title V: 2008 Other: FY2010
-Rate: Children in Department of Health and Human Services care or custody, 0-17 year olds, per 1,000	5.8	--	--	--	7.7	Title V: 2007 Other: December 2009

\* Source: Child and Family Opportunities, Inc. Community Assessment, May 2010; report covers Hancock and Washington counties. Not all relevant data from the report could be inserted into this matrix because of incomplete data definitions or other data limitations.

\*\* Data are suppressed, per the Maine Center for Disease Control and Prevention Privacy Policy, when there are less than 6 events in the specified time period.

## 4. Quality and Capacity of Existing Programs

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Maine is fortunate to have early childhood home visitation services in place in each of its sixteen counties delivered under public and private, non-profit auspices. While Maine is a predominantly white state, it is home to diverse families living with multiple risk factors which influence the growth and development of the youngest children. Programs in some communities cater to these specific needs although most are targeted to first-time parents and those whose children have health or risk factors. Below are descriptions of each program available to families who are expecting a baby, or who have children birth through early childhood.

The programs attempt to work collaboratively within their community and state infrastructures to provide appropriate service to the target populations defined. Without exception, each of the seven programs researched for this Needs Assessment use a strengths-based approach to working with at risk populations. Each program also recognizes the importance of connecting with the early intervention and special education systems as natural partners in identifying and addressing concerns for young children. All seven programs also acknowledge the importance of mental health support and services particularly in relation to encouraging healthy caregiver and child attachments. This description includes four programs which are statewide or close to it in service delivery and three which target specific service areas and populations. The statewide home visiting services are: Maine Families; Home-based Early Head Start; Public Health Nursing; and Community Health Nursing. The latter two are funded differently (one is provided by public agencies and the other under contract) but have similar goals and services and are described together. The special purpose programs are: Maine Parent Federation's Parents as Teachers; Project Launch and Passages. There are other smaller programs such as Parent Program in Sagadahoc which provides home visits to parents of children with special needs and Healthy Kids in Lincoln County which provides services to families with second or third children who may be older than three months when referred (thus complementing admission criteria for other programs in the community) which do not have individual write-ups due to their limited size and scope.

### **Maine Families: Statewide**

Since 2000, Maine has provided universal home visiting to eligible families in every county of the state. Families who are expecting their first baby, are first time parents of a newborn, and all adolescent parents are eligible for this free service, though

exceptions to the age requirement can be made depending on the availability of home visitors. Recently rebranded as *Maine Families*, this program is comprised of professionals (Bachelor’s Degree required) delivering services from twelve sites and is administered by the Office of Child and Family Services, Early Childhood Division along with Maine Center for Disease Control, Maternal and Child Health.

The program employs highly-trained individuals who conduct visits in family homes at the frequency and intensity that works for each household. The home visitors follow the Parents as Teachers (PAT) curriculum, a nationally-recognized approach to empowering parents and caregivers with the knowledge necessary in raising healthy children. The professionalism and competency of the staff is given high priority for this program. Each home visitor must hold a Bachelor’s Degree in Early Childhood or a related field, and is trained in Infant Mental Health, Great Beginnings, and the well-regarded Touchpoints Approach, developed by Dr. T. Berry Brazelton. This foundation provides the home visitors with the skills needed to work with families in difficult situations, working toward positive outcomes for both caregiver and child.

The goals of Maine Families home visiting program include

- Nurturing families and their relationships
- Promoting positive and effective parenting
- Encouraging healthy living, considering all aspects of development
- Providing guidance in creating positive and creative learning environments
- Protecting children from violence, abuse and neglect
- Protecting children from preventable illness and injury
- Providing a connection to the community and needed resources
- Encouraging family self-sufficiency

<b>Maine Families: Home Visiting by County</b>	
<b>Area</b>	<b>Number of Families Served 2009-10</b>
Androscoggin	261
Aroostook	163
Cumberland	331
Franklin	129
Hancock	176
Kennebec	290
Knox	81
Lincoln	36
Oxford	152
Penobscot	205
Piscataquis	21
Sagadahoc	70
Somerset	139
Waldo	124
Washington	126
York	151
<b>State</b>	<b>2,455 families</b>

While the program can be molded to the needs of each county within the Standards of Practice, the goals are informed by national indicators such as those provided by Healthy People 2010 as well as current research related to child health and

development. As a result, serving prenatal families is a major goal in terms of striving to have the greatest impact on the targeted maternal and child outcomes; last year 49

percent of families enrolled prenatally. Maine Families staff develop both formal and informal working agreements with local hospitals, clinics, providers of WIC and Head Start services, and the Department of Health and Human Services to recruit and enroll families prenatally. When providers have a wait list for enrollment, they consider a number of factors to determine if priority should be given to serve families as promptly as possible. At the time of referral, priority may be given for the following concerns: postpartum depression, significant mental health diagnosis, substance abuse, cognitive challenges, domestic violence or any form of abuse, homelessness, or lacking necessary services.

The program uses a statewide database and evaluation system to track the work with families as well as pertinent demographic and family information that is reported according to State funding requirements. This database allows the users to get real-time information about services that directly informs the work, ultimately assuring high quality services are delivered and maintained. Above is a table displaying the number of families served in the past fiscal year. The caregivers of the families served were mostly among two age categories: 33 percent were 18 – 22, and 35 percent were 23 – 29 years old; 67 percent of the caregivers were married or partnering, and there was a wide range of levels of educational attainment and diversity in socio-economic categories as well.

### Home-Based Early Head Start: 10 out of 16 Counties

While the majority of Head Start and Early Head Start programming in Maine consists of center-based care and education, there are ten counties that offer home visiting services funded by the Federal Office of Head Start, State contributions, and American Recovery and Reinvestment Act (ARRA) funds as of September 2010.

<sup>1</sup>According to a statewide Head Start Report produced by the Maine Children’s Alliance (2009), enrollment priority is given to families living in poverty, though each site

<b>Head Start and Early Head Start: Home Visiting by County</b>	
<b>Area</b>	<b>Number of Slots Available 2009-10</b>
Androscoggin	50
Aroostook	72
Cumberland	48
Franklin	40
Hancock	0
Kennebec	30
Knox	0
Lincoln	29
Oxford	118
Penobscot	0
Piscataquis	0
Sagadahoc	15
Somerset	0
Waldo	40
Washington	0
York	42
<b>State</b>	<b>484 slots</b>

<sup>1</sup> Counties in which these services are not available are: Hancock, Knox, Penobscot, Piscataquis, Somerset, and Washington

carefully maintains wait lists for services using a formulaic selection process which considers demographic and other factors influencing a family's situation. Families who are not income-eligible may qualify for services if they are homeless, in geographic areas defined as "medically underserved," receive other public assistance such as TANF or SSI, involved in foster care, or have special needs.

In Early Head Start, services are delivered to families expecting a baby and those with children birth through age three through weekly, 90 minute sessions in the family's home. Head Start home visiting services follow the same model but provide support to families with children ages three through kindergarten. The curricula used varies by program, six of which report using The Creative Curriculum, the rest using a range of resources from individually designed curricula to Parents as Teachers (PAT) and Partners for a Healthy Baby models. Regardless of the chosen curricula, all Early Head Start home visiting programs must follow rigid Federal Performance Standards<sup>2</sup>.

Home visitors are trained in the Head Start philosophy and program expectations through pre-service and in-service opportunities with the goal of assuring staff have the knowledge and tools they need to work with vulnerable children and families. In 2008-09, the State Program Information Report (PIR) showed that 50 percent of home visitors held a Bachelor's Degree, while 50 percent ranged from having an Associate's Degree to having no credentials. The current national standard for Head Start is that 50 percent of staff have a Bachelor's Degree in Early Childhood, though almost all center directors reported preferring that all home visitors have a Bachelor's Degree and relevant experience if possible.

By completing the required Family Partnership Agreement, the goals of the family are clearly articulated and relate to the program intentions of

- Meeting the basic needs of every child
- Promoting positive and effective parenting and attachments
- Supporting all areas of growth and development
- Early identification of special needs and risk factors
- Ensuring children have access to ongoing preventative health care and services
- Ensuring families have access to mental health services
- Encouraging active parent involvement in all aspects of the program

Each site reports program data such as: enrollment information, curricula and assessment tools used, staff qualifications, and family information to a Regional Head Start Office, which in turn provides evaluation and technical support, and attempts to

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<sup>2</sup> Performance Standards can be found at the US DHHS website:

<http://eclkc.ohs.acf.hhs.gov/hslc/Program%20Design%20and%20Management/Head%20Start%20Requirements/Head%20Start%20Requirements>

control for quality in service delivery. The Maine Office of Child Care and Head Start are currently working on a state report, which is likely to be available for the next phase of the Needs Assessment<sup>3</sup>.

Since services to families living in poverty are the priority demographic, families could potentially become ineligible for services if they achieve set goals in areas of obtaining employment, relocation, and related economic success. This results in some turnover for the home visitors' caseloads, and the actual number of families served may not be reflected in the number of allocated slots by county (See table above).

### **Public Health Nursing and Community Health Nursing: Statewide**

Public Health Nursing and their grantees, Community Health Nursing, have served Maine since 1920. Funded by the Maternal and Child Health Services Title V Block Grant and the required State match to a portion of the General Fund, Public Health Nurses and Community Health Nurses are employed to cover the entire state. Currently there are 55 field nurses and health professionals that work with any woman, infant, or child with an identified health need. All nurses are required to be registered nurses, and have a solid foundation of knowledge in child development and current public health issues. The priorities of these nursing professionals include serving not only the special health needs of the target population, but also outcomes related to child maltreatment, infant mortality, low birth weight, and the overall health status of young children<sup>4</sup>.

Public Health Nursing and Community Health Nursing have defined their role as “assessing health status, defining health options, developing policies, and assuring access to services for individuals, families, and communities” (PHN Policy and Procedure Foundation Statement, as cited in the Annual Report, 2009). The curriculum used is considered to be a nursing model, where they look carefully at the needs of each individual client, whether they are a newborn or a breastfeeding mother. The documentation for each client is maintained in an electronic medical record, where the staff can assess the client’s initial problem and track the subsequent intervention, as well as a measurement of the client outcomes in terms of their knowledge, behavior, and status. The most common maternal and child health-related topics addressed in the last fiscal year include child health, parenting, and postpartum, though the targeted goals and outcomes can be a combination of these and considering the method of assessment, are unique to each individual.

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<sup>3</sup> The Maine Head Start Report for 2009 is available on the DHHS website at: <http://www.maine.gov/dhhs/ocfs/publications.shtml> under Additional Reports.

<sup>4</sup> Maine Public Health Nursing Program Fiscal Year 2009 Annual Report. For more information: <http://www.maine.gov/dhhs/bohdcfh/phn>

Public Health Nursing has a unique partnership with Maine’s Refugee and Immigrant Services (RIS) and works to meet with each new family who settles in Maine through this program. If a family with young children does not present with an identified health need, PHN assists the family in connecting to available community resources; this may include Head Start or Maine Families Home Visiting services.

<b>Public Health Nursing Services by County</b>	
<b>Area</b>	<b>Number of Unduplicated Households 2009-10</b>
<b>Androscoggin</b>	165
<b>Aroostook</b>	281
<b>Cumberland</b>	123
<b>Franklin</b>	30
<b>Hancock</b>	60
<b>Kennebec</b>	247
<b>Knox</b>	63
<b>Lincoln</b>	54
<b>Oxford</b>	82
<b>Penobscot</b>	343
<b>Piscataquis</b>	40
<b>Sagadahoc</b>	106
<b>Somerset</b>	107
<b>Waldo</b>	74
<b>Washington</b>	72
<b>York</b>	3
<b>State</b>	<b>1,850 households</b>

If a family with young children does not present with an identified health need, PHN assists the family in connecting to available community resources; this may include Head Start or Maine Families Home Visiting services.

While PHN and CHN typically track number of visits and number of hours providing Maternal and Child Health Services, for this needs assessment staff worked to estimate the number of unduplicated households served for PHN, and visits to individual clients for CHN. The families served are separated into two tables, one at left and one below.

Some goals of the Home Visiting Services provided by nurses include addressing:

- Child growth and development, and identifying or supporting special health needs
- Pregnancy, postpartum, and breastfeeding support
- Newborn and infant assessment
- Shaken Baby Syndrome
- Lead poisoning management and other toxic environmental concerns
- Communicable diseases and tuberculosis testing and treatment
- Refugee and migrant health

<b>Community Health Nursing Services by County</b>		
<b>Area</b>	<b>Unduplicated Individuals Receiving a Visit 2009-10</b>	<b>Estimated Number of Households<sup>5</sup></b>
<b>Androscoggin</b>	173	106
<b>Aroostook</b>	0	0
<b>Cumberland</b>	2,482	1,514
<b>Franklin</b>	0	0
<b>Hancock</b>	225	137
<b>Kennebec</b>	0	0
<b>Knox</b>	0	0
<b>Lincoln</b>	0	0
<b>Oxford</b>	0	0
<b>Penobscot</b>	336	205
<b>Piscataquis</b>	0	0
<b>Sagadahoc</b>	0	0
<b>Somerset</b>	0	0
<b>Waldo</b>	0	0
<b>Washington</b>	222	135
<b>York</b>	735	448
<b>State</b>	<b>4,173 clients</b>	<b>2, 838 households</b>

The following section provides details of programs that offer early childhood home visitation services, although on a smaller scale or serving a subpopulation identified as having potential of greater risk. The three programs reviewed are Maine Parent Federation, Project LAUNCH, and the Passages Program.

### **Maine Parent Federation Parents as Teachers: Kennebec and Somerset Counties**

Serving two of Maine’s sixteen counties since 1996, Maine Parent Federation (MPF) Parents as Teachers was one of the first to provide in-home services to families of young children. Originally funded by the Department of Education, MPF has established itself as a non-profit organization that relies on multiple funding sources including

<sup>5</sup> Calculated estimate by converting visits to individual clients to households served using the same ratio found for PHN (.61)

support from the State Department of Education IDEA funds to provide information and support to parents who have a variety of needs.

MPF as an organization has a staff well-versed in early intervention, special education, and family advocacy, a natural connection to the early childhood home visiting program offered to all parents in the two counties. The home visitors are trained in the Touchpoints Approach by Dr. T. Berry Brazelton, just as Maine Families staff are, and all are certified in the nationally-recognized Parents as Teachers (PAT) curriculum. The curriculum used is primarily PAT enhanced by on-staff expertise and knowledge of early intervention, delivered through home visits every-other-week. While this program is universally available to all expectant parents and families of children birth to kindergarten entry, they receive a large number of referrals from the Department of Health and Human Services, Child Protective Services, and Public Health Nursing. MPF is working to reach families living in rural areas, helping to connect them to necessary resources. The staff of MPF's Parents as Teachers program have recognized the increase in number of families served for whom mental illness and substance abuse are present and affecting parenting as well as child outcomes<sup>6</sup>.

The objectives for this program under the overarching goals of “providing information, support, and encouragement to help parents be their child’s first and most important teacher”<sup>7</sup> include

- Helping parents learn about child development
- Encouraging parents to use play as a means of teaching their child new skills in all domains
- Providing information on behavior issues and positive methods of child guidance
- Strengthening the parent and child relationship

In addition to home visits, Parents as Teachers staff offer playgroups and social gatherings for families and their children, workshops for parents and other professionals and community members, developmental screenings for children, and referrals to resources in the community. The services they provide are at no cost to families, and very low cost to community providers and partner agencies.

Since MPF is a relatively small program, the data collection methods are different from those previously described who serve multiple counties statewide. The data available from the last fiscal year, however, show that there were 175 families (155 from Kennebec County, 20 from Somerset County) served by the four full-time home visitors. The specific demographic information for these families was not available at the time of this needs assessment, though may be able to be obtained by the next phase.

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<sup>6</sup> Reported by PAT director in an interview on July 15, 2010.

<sup>7</sup> Accessed from the agency website <http://www.mpf.org/projects/pat.htm>, September 2010.

## **Project LAUNCH: Washington County**

October 2010 marks the second year anniversary for the Project LAUNCH grant in Maine. Formally titled *Linking Actions for Unmet Needs in Children's Health*, LAUNCH is a project of the Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the Administration for Children and Families (ACF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). The Washington County location is the first rural setting for the program, employing two full time equivalent home visitors through partnership with the Community Caring Collaborative (CCC). The CCC strives to expand the services available to families who have infants and young children through age eight who are considered at risk due to parental substance abuse, exposure to trauma, maternal depression, or developmental delay. This is accomplished through partnering with key community providers to deliver: mental health services, home visiting, prenatal and parenting support, peer support for parents, workshops and staff development opportunities, and the Bridging Program (a component of the work with Eastern Maine Medical Center).

LAUNCH staff must have a Bachelor's Degree and are extensively trained in order to provide appropriate service and support to this complex subpopulation of parents and adolescent parents. The curriculum used is called the Infant Family Support Program, though the staff are also trained in Infant Mental Health, the Touchpoints Approach (as are Maine Families and the Maine Parent Federation PAT home visitors), and many other related topics.

To date, the Washington County LAUNCH program has served 59 families who are in any of the target categories of: parent or adolescent parent with substance abuse issues, at risk of having substance abuse issues or maternal depression (can be prenatal or postpartum), infant born with drug addiction, child from birth to eight years old in a family with substance abuse, mental illness, or exposure to trauma. These families were provided with home visiting service delivered at a frequency and intensity that matched their need, and ancillary services through a closely-woven partnership of professionals working with the CCC.

A unique component of LAUNCH is the priority placed on developing and enhancing the connections between organizations and individuals working with this vulnerable population. All LAUNCH sites work closely within their communities to identify unmet needs that "guide their use of five prevention and promotion strategies drawn from current research."<sup>8</sup> The prevention and promotion strategies include home visiting,

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<sup>8</sup>Information provided by the LAUNCH Briefing Sheet, accessed at <http://projectlaunch.promoteprevent.org> August, 2010

integrated mental health treatment, mental health consultation, family strengthening and parent skills training, and developmental assessments.

The goals of the national LAUNCH Project are to

- Increase access to developmental screening, assessments, and services to young children
- Expand and improve culturally-relevant and evidence-based prevention and wellness practices
- Retain a workforce that understands child development and health
- Improve systems of care for young children at all levels
- Increase the number of children entering school ready to learn

According to the project's evaluator from the Maine Center for Public Health<sup>9</sup>, a priority going into the next fiscal year is to try to expand services to Hancock County.

Washington County LAUNCH also hopes to adapt the model for other parts of Maine.

### **Passages Program: Knox, Lincoln, Waldo, and Washington Counties**

Passages started in 1994 with a federal grant in Camden, Maine and expanded in recent years to a second, satellite location in Washington County at the Cobscook Community Learning Center, with the programs serving four counties in all: Knox, Lincoln, Waldo and Washington. It is a home-based high school degree program designed for pregnant and parenting adolescent boys and girls ages 14 - 20 years old. This program, supported by a combination of funds from the School Districts (Department of Education), grants, and philanthropic contributions, serves parents who wish to finish high school and continue parenting simultaneously.

Passages employs a total of three and a half (full time equivalent) teachers who are certified educators and experienced professionals who also have the ability to work with great compassion and knowledge of resources and systems in the community<sup>10</sup>. The program uses a curriculum developed to address three components in working with teen parents: academics, parenting, and life skills, delivered through weekly home visits with the students. There are 24 core skills that are covered, and then individual student objectives are created with consideration of the student's current performance and skill level in those 24 areas. In addition to one-on-one meetings with their teacher, students are required to complete six hours of community service each year, participate in five workshops offered at the school (transportation and childcare are provided), and must complete a final Passage project.

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<sup>9</sup> Reported by R. Spence, PhD. in an interview on August 2, 2010.

<sup>10</sup> Reported by director of Passages Program in an interview on July 29, 2010.

As a fairly new and relatively specialized home visiting program, Passages has served 53 families this past year, with the first two Washington County graduates completing the program in June 2010. The program works closely with the Community Caring Collaborative, Maine Families, Department of Health and Human Services, and the Restorative Justice Program in effort to meet the needs of students and their families.

The following table summarizes the continuum of home visiting services available in Maine, highlighting the major attributes of each program. It is followed by a table showing the number of families served per year.

Program	Service Area	No. of FTE Home Visitors	Credential/Qualification of Home Visitors	Eligibility Requirements	Funding Sources	Curriculum Model	Length of Service	Referral for Early Intervention Services	MH Provider On site or Referral
<b>Maine Families</b>	Statewide	64	BA in related field	First time parents prenatal-3mos, All teen parents, Foster, Adoptive, or Kinship parents	Various	PAT Touchpoints	Prenatal up to kindergarten	Yes	Yes, Referral
<b>Early Head Start</b>	Androscoggin, Aroostook, Cumberland, Franklin, Kennebec, Lincoln, Oxford, Sagadahoc, Somerset & York	34	Varies by county; BA preferred	Federal poverty guidelines; Prenatal & Parenting up to 3 yrs.	State & Federal Head Start Funds	Federal EHS Performance Standards	Prenatal up to child's 3 <sup>rd</sup> birthday	Yes	Yes, On site <sup>11</sup>
<b>Public Health Nursing</b>	Statewide	45	RN & experience	Women, infants, children with identified health needs	GF: MCHBG	Public Health Nursing (nursing model)	Duration of health need	Yes	Yes, Referral
<b>Community Health Nursing (PHN Grantees)</b>	Androscoggin, Cumberland, Hancock, Washington, York & City of Bangor	10	RN & experience	Women, infants, children with identified health needs	Part of match to MCHBG <sup>12</sup>	Public Health Nursing (nursing model)	Duration of health need	Yes	Yes, Referral
<b>Maine Parent Federation</b>	Kennebec & Somerset	4	Touchpoints trained & experience	All parents prenatal - 5 yrs.	Various	PAT Touchpoints	Prenatal up to kindergarten	Yes	Yes, Referral
<b>Project LAUNCH</b>	Washington	2	BA in related field	High-risk, drug addicted parents & Children 0 - 8 in high risk categories	SAMHS A	Touchpoints & Infant Family Support Program	Prenatal through 8yrs.	Yes	Yes, On site
<b>Passages</b>	Knox, Lincoln, Waldo, Washington	3.5	Teacher certificate & experience	Pregnant & parenting teens 14 -20yrs.	School districts & Grants	Academics, Parenting & Life skills	Until the student graduates	Yes	Yes, Referral

<sup>11</sup> Not all EHS sites offer on-site mental health services; this is unique to Cumberland County. All EHS sites do make referrals for mental health services.

<sup>12</sup> General Fund, which is part of the required match to the Maternal and Child Health Block Grant.

**Number of Families or Households Served in 2009<sup>13</sup>**

	<b>Maine Families</b>	<b>Head Start/ Early Head Start</b>	<b>Public Health Nursing</b>	<b>Community Health Nursing</b>	<b>Passages</b>	<b>Maine Parent Federation</b>	<b>LAUNCH</b>
<b>Androscoggin</b>	261	50	165	106			
<b>Aroostook</b>	163	72	281				
<b>Cumberland</b>	331	48	123	1514			
<b>Franklin</b>	129	40	30				
<b>Hancock</b>	176	0	60	137			
<b>Kennebec</b>	290	30	247			155	
<b>Knox</b>	81	0	63		16		
<b>Lincoln</b>	36	29	54		8		
<b>Oxford</b>	152	118	82				
<b>Penobscot</b>	205	0	343	205			
<b>Piscataquis</b>	21	0	40				
<b>Sagadahoc</b>	70	15	106				
<b>Somerset</b>	139	0	107			20	
<b>Waldo</b>	124	40	74		14		
<b>Washington</b>	126	0	72	135	15		59
<b>York</b>	151	42	3	448			
<b>State</b>	<b>2,455</b>	<b>484</b>	<b>1,850</b>	<b>2,838</b>	<b>53</b>	<b>175</b>	<b>59</b>

<sup>13</sup> Each program collects data differently:

- Maine Families, Maine Parent Federation, Passages, and LAUNCH report “families served.”
- Head Start and Early Head Start report “slots available.”
- Public Health Nursing reports “unduplicated households.”
- Community Health Nursing originally reported “visits to individual clients.” These figures have been adjusted by converting visits to individual clients to households served using same ratio found for Public Health Nursing (.61).

## Extent to Which Programs Meet the Needs of Eligible Families

Services to 0 - 5 Year Olds	
County	Percent Served
Androscoggin	8.6%
Aroostook	14.6%
Cumberland	13.0%
Franklin	14.2%
Hancock	14.3%
Kennebec	11.4%
Knox	7.7%
Lincoln	8.1%
Oxford	12.3%
Penobscot	9.4%
Piscataquis	7.4%
Sagadahoc	8.9%
Somerset	9.5%
Waldo	12.5%
Washington	24.2%
York	5.6%
<b>State Average</b>	<b>11.4%</b>

The current capacity of early childhood home visiting programs in Maine is displayed in the two tables above. In total, Maine has one home visitor for every 436 children under the age of five. Even with the recent expansion of Early Head Start as a result of ARRA funds, and the Community Health Nursing Grantees providing services where Public Health Nursing cannot afford to, the 162 home visitors available in the state are serving between six and twenty four percent of children birth to five years old (see table at left), depending on the county. Using this calculation, that is the percent of 0 to 5 year olds served, two counties have statistically lower service availability than the others: Piscataquis and York.

A second, more conservative way to assess the extent to which programs meet the needs of eligible families is to determine what proportion of families with new babies is served by home visitors. That analysis is shown in the table below. The range of families with newborns receiving home visiting services is a low of 22 percent in Sagadahoc to a high of over 90 percent in Washington, due in part to the special programs available such as Launch and Passages, both of which serve families in this high-risk county.

In this calculation the number of newborns per county is the denominator while the number of families receiving home visits is the numerator. Three counties in Maine can be considered high-need in that they have a statistically significant lower proportion of home visiting for the post-partum populations. These are Lincoln, Piscataquis and Sagadahoc.

Services to Newborns	
County	Percent Served
Androscoggin	27.9%
Aroostook	38.9%
Cumberland	63.1%
Franklin	44.5%
Hancock	69.7%
Kennebec	33.1%
Knox	31.6%
Lincoln	25.7%
Oxford	31.1%
Penobscot	38.9%
Piscataquis	23.2%
Sagadahoc	22.4%
Somerset	36.3%
Waldo	41.9%
Washington	90.4%
York	29.4%
<b>Statewide Average</b>	<b>41.9%</b>

## Service Capacity and Identified Gaps

To supplement the quantitative data to show where home visiting services are most lacking in Maine, the research team for this needs assessments conducted interviews with program managers at the state level and home visiting staff in each of the counties and also conducted focus groups with special populations. The team further examined data available from other needs assessments completed by CAPTA and the Title V MCH Block Grant programs, the Head Start Collaborative Office Assessment along with the triennial Community Needs Assessments completed by Head Start agencies, and Annual Reports provided by Public Health Nursing.

During interviews with key informants and professionals conducting home visiting with at risk families, there were a number of concerns that can be highlighted as relevant to the quality and capacity of services available. The following reflects both service needs and gaps in services.

- **Working with children and families living with low income and poverty.** This concern was identified by each program interviewed, applicable to every county though on differing levels. Providers in the early childhood field are likely to note this as an underlying cause to many other risk factors; therefore thoroughly addressing the issue of poverty can ease the effect of other risk factors.
- **Families who are homeless.** Given the nature of the home visiting profession it is very obvious to providers in this service industry to pay close attention to the living situation and condition of families' homes. Coupled with the extreme risks associated with homelessness, some programs particularly in the urban areas of the state are concerned that they are unable to adequately assist families who are both presently homeless or in danger of losing their homes.
- **New Mainers: Families who are refugees, immigrants, or asylum seekers.** The need for increased services in Androscoggin and Cumberland Counties is largely due to the number of African and Middle Eastern families who are settling in these two counties, designated by the Federal Refugee Resettlement Program through Catholic Charities Maine, Refugee and Immigrant Services<sup>14</sup>.

The prevalence of New Mainers in these two counties relocating in the past year is displayed in the table below. The providers who work in these areas with families for whom English is a second language discussed the need to consider the intensity and complexity of services given the common language barriers and unknown trauma that families have endured. Likewise, it is challenging to provide optimal support when the cultural norms are varied and unknown.

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<sup>14</sup> Further information on this program available on their website at: [http://www.ccmaine.org/info.php?info\\_id=73](http://www.ccmaine.org/info.php?info_id=73)  
Accessed July 2010.

Number of New Mainers in 2009		
Number of People	Descent	County of Residence
165	<b>Africa :</b> (Somalia, Rwanda, Congo, Sudan)	Androscoggin: 90% Cumberland: 10%
110	<b>Asia/Middle East:</b> (Iraq, Iran, Russia, Afghanistan)	Cumberland: 100%
25	<b>East Asia:</b> (Burma)	Cumberland: 100%
549*	<b>Africa:</b> Somalia (284), Sudan (98), Rwanda (31), Congo/Zaire (26), Ethiopia (12), Djibouti (8)  <b>Asia/Middle East:</b> Iraq (65)  <b>Other</b> (21)	Cumberland: 100%

\* This number represents known Secondary Migrants who chose to relocate to Maine by choice.

- Families living with substance abuse and mental illness.** It is well-known that children living in families with drug and alcohol addiction are at a greater risk for developmental delays and behavioral challenges. Across the state in both rural and urban areas, home visitors are challenged by working with families who have substance use issues. All program staff interviewed shared there is a need for increased training and careful supervision to support professionals working with this population. Families are often hesitant to disclose this very personal information to their home visitor possibly because they fear what will happen to their children if their habits are known. One program noticed that this past year more families served (66%) had either mental health issues or intellectual impairments, up from past enrolment of such families (around 25%). Extensive training and professional support are needed to adequately address this gap in service.
- Adolescent parents and their children.** Although the teen birthrate has not changed dramatically in the past couple of years, many agencies are concerned about the outcomes for babies born to adolescent parents. Providers spoke to the difficulty in connecting with teens around parenting and being responsible for their children. Two programs in the state convened a group of adolescent parents to talk about home visiting and what it is like to raise a baby as a teen; while the participants of these groups spoke highly of the support they have received from their respective home visiting programs, they shared that peers in similar

situations may not necessarily trust adults coming in to their homes. The work in this area is both to encourage young adults to take precautions toward pregnancy prevention and to strive to work with young parents in positive and non-judgmental ways. Another challenging component in working with adolescent parents comes as they age out of the “teen” demographic and prepare for adult expectation. In rural Maine, there is little in the way of support for individuals in their early twenties who seek further education and work, including those who are hoping to complete high school equivalency requirements<sup>15</sup>.

Across the state, there is a range of programs and services that target the young parent population; an analysis of births to teens and percent served by home visiting was completed for this needs assessment and is reflected in the table at left. The statewide average is under 32 percent.

The range in service capacity is vast: from three percent of all teen parents served by a home visitor in Somerset County, to over 87 percent in Waldo County. A test of statistical significance revealed that two counties, Somerset and York, have the highest need for services to this target population.

Services to Adolescent Parents	
Area	Percent Served
Androscoggin	23.9%
Aroostook	34.9%
Cumberland	21.2%
Franklin	85.1%
Hancock	31.0%
Kennebec	51.2%
Knox	63.5%
Lincoln	10.5%
Oxford	52.4%
Penobscot	21.1%
Piscataquis	25.0%
Sagadahoc	21.8%
Somerset	3.0%
Waldo	87.5%
Washington	72.2%
York	9.8%
<b>State Average</b>	<b>31.7%</b>

- Families who have children with special needs.** As stated, all home visiting programs place a priority on working closely with early intervention professionals such as Child Development Services in order to address developmental concerns. Many programs that provide early intervention services or special education have suffered from lost funding and changes in regulations. They have consolidated programs (closing many programs in rural locations forcing families to travel further for services), and are simply not staffed to serve the number of children to the degree they would like to see improvement in development. Home visitors routinely screen infants and young children for developmental delays and other health issues (such as for lead exposure and dental infections), but they rely on the State Child Find agencies for further assessment and treatment or therapy. Also given the recent changes in eligibility criteria to qualify for early

<sup>15</sup> Reported by the Executive Director of Cobscook Community Learning Center in an interview on August 25, 2010

intervention and special education, fewer children are receiving services as early as would be necessary to address parent and provider concerns. Providers also shared that they face challenges in securing mental health services to children who have experienced trauma or loss, with the exception of the two programs that have on-staff mental health providers (LAUNCH, and one Head Start agency).

- **Families who are isolated or without reliable transportation.** While home visiting services are not contingent on family transportation since the providers travel to the family, it is a service meant to connect families to necessary resources and empower them to take action and make decisions on their own. Public transportation services are not available in much of the state, so for families working with community providers and services and living in poverty, transportation becomes one of the biggest barriers to getting needs met. Home visiting programs (such as regional Community Action agencies) have recognized this issue and have yet to find a suitable and stable solution that would work for each region. Not surprisingly, the county with greatest risk and least service capacity is also the least populated and most rural in geographic location; this county is Piscataquis.

## 5. Capacity for Providing Substance Abuse Treatment and Counseling

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### Service Capacity

Substance abuse treatment and counseling is available throughout Maine from private providers as well as contractors supported by the Maine Department of Health and Human Services' Office of Substance Abuse. There are 218 substance abuse treatment providers offering a range of services from outpatient counseling to residential care. At least two programs in the state focus on services to pregnant women: Crossroads for Women and The Women's Project operated by PROP.

The range of substance abuse services and their classification is:

- Co-occurring
- Detoxification
- Detoxification Management
- DSAT
- Extended Care
- Extended Shelter
- Halfway House
- Intensive Outpatient
- Methadone Detoxification
- Methadone Maintenance
- Outpatient Services
- Problem Gambling Counseling
- Residential Rehabilitation
- Shelter

Treatment providers are spread throughout Maine’s eight districts. The number of treatment providers by district is as follows, with a low of 14 in the Midcoast district and a high of 45 in the Cumberland district which is the most populous, housing the city of Portland.

Location of Substance Abuse Provider Agencies	
District	
1. York	24
2. Cumberland	45
3. Western Maine	29
4. Midcoast	14
5. Central Maine	29
6. Penquis District	35
7. Downeast District	21
8. Aroostook	21
<b>Total</b>	<b>218</b>

The two programs with special services for pregnant women using substances are described below.

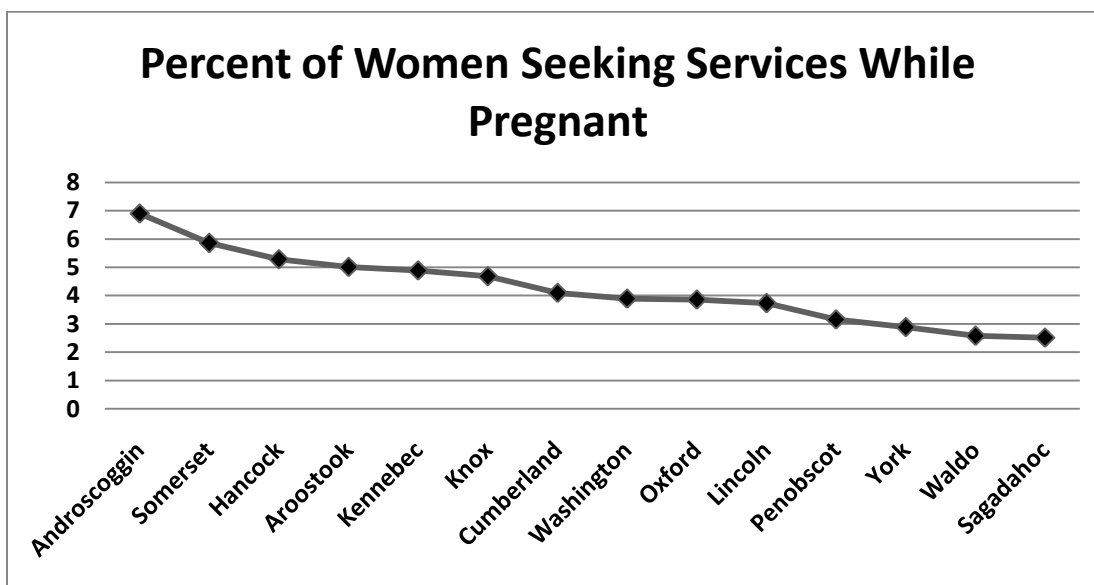
- Crossroads for Women:** Crossroads for Women appears to offers Maine’s most comprehensive treatment for substance abuse and mental health specialized for women. Crossroads operates a number of programs including: Outpatient Counseling; Intensive Outpatient Program (IOP). Medication Management; DEEP Services for Women; Residential Rehabilitation; Halfway House; Children And Mothers Program (CAMP); Services for Friends and Family Members; Transitional Housing; and the Kennebunk Counseling Center. CAMP is the only program in Maine that provides on-site living arrangements and child care services to minor children of mothers in residential treatment for drug or alcohol addiction. Children from six weeks to age ten may live with their mother while she participates in the Residential Rehabilitation treatment program in Windham, Maine.
- The Women’s Project:** The Women's Project is a statewide program for women affected by substance abuse operated by the People’s Regional Opportunity Program (PROP). The program is free and confidential. The primary purpose of The Women's Project is to support women as they consider recovery for themselves or manage their lives in the face of another's addiction. The Women's Project staff can help arrange for transportation and child care, offer support and advocacy, help set goals and strategies, educate about women's health issues, and make referrals to treatment programs

## Service Gaps

To assess substance abuse capacity and gaps for our particular target group, pregnant women and those of child bearing age, the research team examined the number of pregnant women in treatment and the number of licensed alcohol and drug counselors (LADCs) in Maine by county compared to the women of child bearing age by county. In addition, in the qualitative research reported above, families living with mental illness and substance abuse emerged as one of seven key areas of need in Maine.

### *Pregnant Women in Treatment*

The figure below displays the percent of women seeking services from a substance abuse treatment provider who are pregnant at the time of admission to those services as a proportion of all women of child-bearing age seeking services for substance abuse treatment. The source of the data is the Office of Substance Abuse's Treatment Data System which tracks all providers with a contract with substance abuse treatment contract with Maine DHHS. The range of pregnant women by county is 2.9 percent in Sagadahoc to 6.9 percent in Androscoggin. Two counties, Franklin and Piscataquis, are not reflected in the graph because their numbers are less than five each.



This data does not encompass all women seeking medication assisted treatment such as buprenorphine for opioid addictions if they are seeking treatment at private providers who do not record information in the Treatment Data System. There are 37 providers in Maine which offer buprenorphine. Fifteen of those do not appear on the Office of Substance Abuse’s provider list and therefore would not be counted in the numbers presented in this section. The research team will attempt to enhance these data during the expanded needs assessment.

The counties which are statistically higher than the others in terms of the proportion of women receiving substance abuse treatment while pregnant are: Androscoggin, Somerset and Hancock.

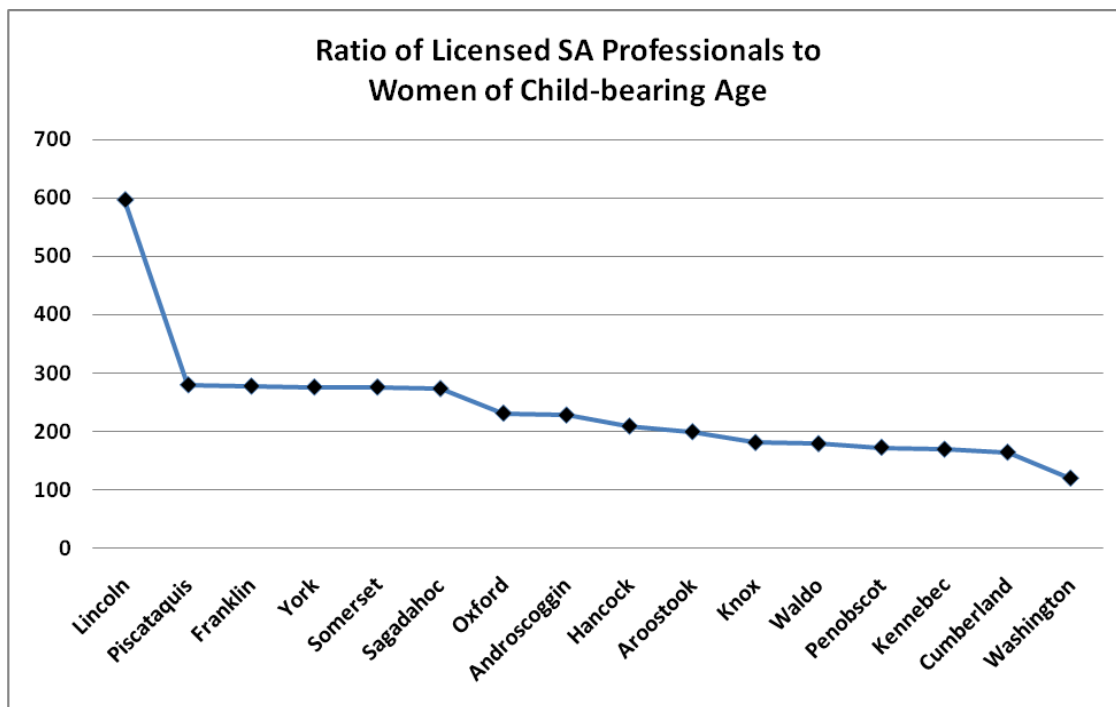
<b>Proportion of Pregnant Women Seeking Substance Abuse Treatment</b>		
<b>County</b>	<b>Number Pregnant at Admission</b>	<b>Percent</b>
<b>Androscoggin</b>	362	6.91*
<b>Somerset</b>	222	5.86*
<b>Hancock</b>	265	5.28*
<b>Aroostook</b>	399	5.01
<b>Kennebec</b>	593	4.89
<b>Knox</b>	192	4.69
<b>Cumberland</b>	1,659	4.10
<b>Washington</b>	257	3.89
<b>Oxford</b>	311	3.86
<b>Lincoln</b>	134	3.73
<b>Penobscot</b>	1,804	3.16
<b>York</b>	797	2.89
<b>Waldo</b>	233	2.58
<b>Sagadahoc</b>	199	2.51
<b>Franklin</b>	COUNTS TOO SMALL	
<b>Piscataquis</b>	COUNTS TOO SMALL	

### ***Licensed alcohol and drug counselors by county***

There are 1236 licensed alcohol and drug counselors (LADCs) with addresses in Maine. This equates to one counselor to every 199 women ages 15 to 44 on average. The figure below displays where they are licensed, by county, showing the number of women of child bearing age to each counselor. The only outlying county, meaning the county that is statistically lower than all the rest, is Lincoln.

There was no service duplication found.

The assessment thus far has identified the need for more services to avoid or prevent women from using substances while pregnant in Androscoggin, Somerset and Hancock counties and more licensed professionals needed in Lincoln County.



## 6. Narrative Summary of Needs Assessment Results

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Through this Needs Assessment process, Maine has taken a thoughtful and comprehensive look at its population and the services available to young children and their families. With careful consideration of federally-identified risk factors as well as additional factors related to maternal, newborn, and child health indicators<sup>16</sup>, along with an inventory of current home visiting services in Maine, the research team identified the communities (or counties) at greater risk.

Examining the data about our communities, we identified three counties that could be considered at higher risk for less than optimal child and family outcomes: Piscataquis, Somerset, and Washington counties. Those counties are generally rural and have been challenged by the declining economy in recent years. Once-flourishing mills that supported the local economy have disappeared and the residents in those communities are faced with driving long distances for employment or working low-wage jobs. The public health indicators we used to measure risk clearly separated these communities from the other thirteen counties and we are confident in our selection of these counties as being at higher risk based on this step in the needs assessment.

However, looking only at outcome indicators should not guide state policy. Indeed, we must also understand the capacity of our communities to serve Maine families. What we found in our analysis of service capacity was a misalignment between risk and lack of services; being at higher risk did not automatically correlate to a lower level of service capacity. As an example, Washington County has a greater proportion of services available to support the population of drug-affected infants and their families, primarily because of the influx of federal grant funds. Those federal funds will not sustain the services over time—a factor we must consider as we move into the next phase of our work.

Taking our data at face value, we must also acknowledge the challenges encountered in identifying and compiling data. We were able to find county-level data for most of the indicators used in the HVNA; however, several challenges were encountered:

- Some of the data presented in the Title V needs assessment were no longer the most recent available. Whenever possible, we obtained more recent data and used the most recent data when selecting counties at risk.

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<sup>16</sup> These included: early prenatal care, newborn hospital discharge with drug withdrawal syndrome, teen births, smoking, mental distress, emergency department visits, health insurance status, free or reduced lunch, and DHHS care or custody

- There were no quantitative data in the CAPTA needs assessment. The assessment stated that data from the Maine Kids Count report were used, but did not specify which of the numerous indicators in that report were utilized.
- The state-level Head Start needs assessment was based on a survey of Head Start program staff and directors and did not include data on the indicators used in the HVNA.
- Sub-state data were rarely reported in the Title V needs assessment. Some of the sub-state data that were reported were only at the public health district level, with each district including one to four counties.
- The substance abuse measures from the SAMHSA sub-state report were only available by region. Each region consisted of one to four counties.
- Some of the supplemental measures in Table D were not available for the smaller counties due to small population size. In particular, data from the American Community Survey will not be available for Piscataquis County (and for select measures for other counties) until 5-year estimates are released.
- Tribal-specific data were not available.
- Indicators based on hospital encounters (i.e., hospital discharges, emergency department visits) reflect the number of discharges or visits, not the number of unique individuals who were discharged or who visited the emergency department. For example, if a child is seen at one emergency department and then transferred to another emergency department, they will be counted twice in the emergency department measure. Such transfers may be more likely for Mainers living in more rural parts of the state.
- The child maltreatment indicator rates had to be calculated using maltreatment counts from 2009 and population estimates from 2007. More recent county-level population estimates for 0-17 year olds were not available. Due to Maine's slow population growth, we do not believe that the use of 2007 population data introduced any significant bias or error into our estimates.

Some additional comments about data collection systems are in order.

Services to families for each of the above programs have been discussed as thoroughly as possible through this first phase of the State Needs Assessment. It is clear, however that further work needs to be done in working with programs providing home visitation services on the importance of accurate and consistent data collection. At this time, the Maine Families program has a mandatory evaluation and assessment component, beginning with a web-based data tracking system; this is the only statewide system in

place with county by county information for comprehensive data collection and analysis. Likewise, the federally-funded Head Start and Early Head Start programs supply state-level data as collected through the federal Program Inventory Report, though each agency manages its data differently. This means that within one program there could be an inconsistent range of information from county to county depending on the leadership team and their management of systems. (For instance, some Early Head Start providers track services in a central location, while another has a paper-based record keeping.) Public Health Nurses are appropriately concerned with individual client information and outcomes, but it is difficult to assess how these outcomes to individuals are connected to the efforts of the professionals doing the work on a statewide, or even county level. Community Health Nursing, and Maine Parent Federation have acknowledged the challenges in data collection for a variety of reasons, and Passages and LAUNCH are fortunate to be relatively new and of smaller-scale where data has not become so complex or overwhelming. Among the programs, some collect information by visit, some by family, some by the number of individuals in a family who is seen, and some by household. These differences in data collection prevent exact measure of service provision across all seven programs, not to mention the difficulty in assessing the quality of care and the effects of changes over time.

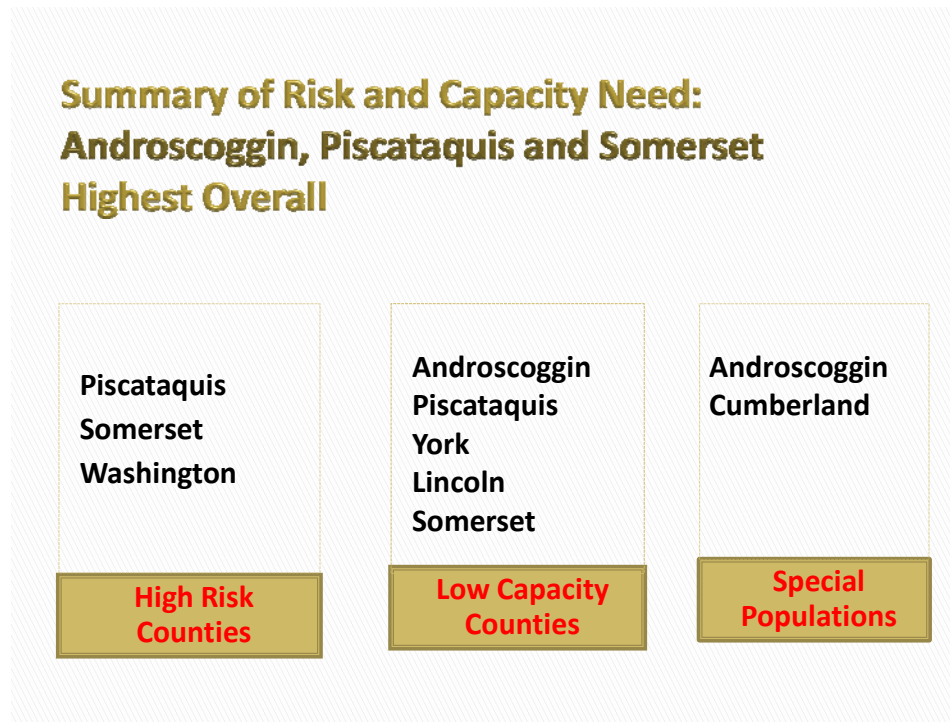
As long-standing programs, Head Start, Public Health Nursing and its grantees, as well as Maine Families have worked to assure eligible families are receiving timely services. They are also well aware of the importance of providing non-duplicative service. Through this Needs Assessment it was found that some families do indeed receive attention from multiple programs, however with the different eligibility requirements and in some cases, target populations (e.g., Early Head Start working exclusively with low-income families, Public Health with those with a medical need, and Maine Families with first time or adolescent parents) programs have systems in place to refer families to the appropriate provider. In Aroostook County, which is one of the more rural areas, Early Head Start and Maine Families have a formal agreement which organizes their enrollment process to assure families are connected with the model providing the best fit for their needs.

There are other examples of informal arrangements that connect the separate agencies, though further work must be done in this area. Providers who need to meet the quotas of their federal or state programs do not have the incentive to refer families to other agencies. A cursory review of the per-family costs of the various home visiting programs also reveals significant differences that can result in fewer families served. Our assessment shows the demand for services. As stewards of public and private funds, we must ensure that the state and our communities can more effectively and efficiently address these unmet needs.

For the next phase of this Needs Assessment and the development of the State Home Visiting Plan, home visiting providers could consider ways in which collaboration could

be enhanced to maximize funding as well as the content-area expertise across the state. This combined with attention to issues with data collection will improve the quality and consistency in the home visiting service.

Taking into account the communities with most risk indicators, the communities with the lowest home visiting capacity now, the communities with the lowest substance abuse treatment capacity, and the communities with the greatest special populations, defined primarily as foreign-born families seeking refuge in Maine, the following table displays the results of the needs assessment.



The three counties with the greatest need across the board are: Piscataquis, Somerset and Androscoggin. In the next phase of the needs assessment more detailed information will be gathered on the particular service needs of those counties to help with the State Home Visiting Plan and its implementation.

## Next Steps for Maine

This phase of the home visiting project helped to illustrate some gaps in data, particularly about special populations and unique geographical areas. Based on the input from the Public Hearing on the Maternal, Infant and Early Childhood Home Visiting Needs Assessment at the Maine Children's Growth Council meeting on September 13, 2010, the research team has refined its list of partners to interview, connected to new data sets to review and observed a generally increased awareness of Home Visiting as a critical component of early childhood systems.

We will continue our scheduled qualitative data gathering through key informant interviews and focus groups (including those already scheduled with Latino community organizations and formerly homeless adolescent parents).

We will further analyze and research the questions generated from this phase of the assessment, including garnering a greater understanding of the financing and sustainability of the services already in place.

We have already begun presentations to the partners who will help construct our vision of a healthy and functioning continuum of home visiting services. We are planning two stakeholder workshops throughout the Fall and Winter and intend to facilitate constructive dialogue locally through the use of Collaboration Coaches. We intend to take steps to have state agencies modeling the kind of collaboration we seek locally. Please see Appendix B for a DRAFT of the Maine Home Visiting Project workplan.

Finally, we will continue to use the Maine Children's Growth Council as the public forum for dialogue about Home Visiting in Maine to ensure the transparency and accountability that is necessary to achieve the sustainable Home Visiting systems change we want for Maine.

## 7. Appendix A: Letter of Concurrence from our State Partners in Title V, Head Start, Substance Abuse and Child Abuse Prevention

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September 15, 2010

Audrey M. Yowell, PhD, MSSS  
Health Resources and Services Administration  
Maternal Child Health Bureau  
5600 Fishers Lane  
18A-39  
Rockville, Maryland 20857



Dear Ms. Yowell,

On September 13, the Maine Children's Growth Council held a public hearing to present the initial findings of the Maine Maternal, Infant, and Early Childhood Home Visiting Needs Assessment required by the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (CDFA #92.505). The presentation included a description of the federal requirements of the needs assessment, the methodology employed by the project data team, a data picture of community characteristics, and both qualitative and quantitative descriptions of the state's home visiting and substance abuse service capacity.

We are in agreement that the initial findings of the Needs Assessment reflect an inclusive, thoughtful, systems-approach that coordinated our state's Title V, Head Start, CAPTA and Substance Abuse needs assessments and data sets. Based on the public comment from the hearing, we are excited to continue to work as partners with Project Director, Sheryl Peavey, to ensure that the subsequent supplemental information request will be as equally comprehensive and meaningful to collaborative early childhood systems change.

Sincerely,

A handwritten signature in black ink that reads "Jan Clarkin".

Jan Clarkin  
Executive Director  
Maine Children's Trust Fund

A handwritten signature in blue ink that reads "Valerie J. Ricker".

Valerie J. Ricker, MSN, MS  
Maine CDC  
Department of Health and Human Services

A handwritten signature in black ink that reads "Guy R. Cousins".

Guy R. Cousins, LCSW, LADC, CCS  
Director, Office of Substance Abuse  
Department of Health and Human Services

A handwritten signature in blue ink that reads "Patti Woolley".

Patti Woolley  
Director, Division of Early Childhood  
State Head Start Collaboration Office

## 8. Appendix B: DRAFT Workplan for Maine Home Visiting Project

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## Draft Six Month Workplan for MEIC HV Phase 2 → 3

Revised: 9/8/2010

Month	Activity	Objective
<b>Phase 2</b>	<p>SEPT</p> <ul style="list-style-type: none"> <li>• Public Hearing Presentation</li> <li>• Meeting with HRSA</li> <li>• Submit Phase 2 Needs Assessment</li> <li>• Continue Focus Groups and Key Informant Interviews</li> <li>• Obtain additional data based on Public Hearing (as needed)</li> <li>• Schedule additional FG and KI Interviews based on Public Hearing (as needed)</li> </ul>	<ul style="list-style-type: none"> <li>• Meet MCHB “System in the Room” philosophy</li> <li>• Meet MEIC HV NA Deadline (to secure MCH Block Grant)</li> <li>• Ensure inclusion of subpopulations and obtain more precise information about communities at risk</li> </ul>
<b>Phase 3</b>	<p>OCT</p> <ul style="list-style-type: none"> <li>• Continue Focus Groups and Key Informant Interviews</li> <li>• Schedule Core Service Dialogues* with Zero to Three (via EHS Technical Assistance Grant)</li> <li>• Develop Job Description for Collaboration Coaches</li> <li>• Data Team Analysis of Qualitative and Quantitative Data/Status Update</li> <li>• <i>Update Workplan Based on Federal Guidance (if issued)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Obtain more precise information about special populations / communities at risk</li> <li>• Facilitate discussion with EHS, HV (and others?) to discuss common ground and address barriers to data collection, operations, collaboration</li> <li>• Draft “enhanced” needs assessment for anticipated Phase 3 requirements</li> <li>• Prepare tools needed to get communities to stage of readiness for systems change (for HV continuum of services)</li> </ul>
	<p>NOV</p> <ul style="list-style-type: none"> <li>• Finalize Collab Coach Job Description and release to public **</li> <li>• Summarize findings from ZTT Core Svc Dialogues and develop preliminary list of funding needs for infrastructure</li> <li>• Develop State Home Visiting Plan outline</li> <li>• Update Maine Children’s Growth Council</li> <li>• <i>Update Workplan Based on Federal Guidance (if issued)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Secure coaches to support communities to reach stage of readiness for systems change (for HV continuum of services)</li> <li>• Prepare for anticipated Phase 3 submission requirements (both narrative and budget)</li> <li>• Ensure transparency in the MEIC HV Continuum of Service Development process</li> </ul>
	<p>DEC</p> <ul style="list-style-type: none"> <li>• Hire Collab Coach(es)</li> <li>• Develop communication strategy to share learnings from Collab Coach work</li> <li>• Work on draft State Plan</li> <li>• <i>Update Workplan Based on Federal Guidance (if issued)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Provide communities with coaches to help facilitate stage of readiness for systems change (for HV continuum of services)</li> <li>• Prepare for anticipated Phase 3 submission requirements (both narrative and budget)</li> </ul>
	<p>JAN</p> <ul style="list-style-type: none"> <li>• Provide update to Maine Children’s Growth Council</li> <li>• Meet with Collab Coaches regularly</li> <li>• Document shared learnings from collab coaches to inform timeline and potential infrastructure investments</li> <li>• <i>Update Workplan Based on Federal Guidance (if issued)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Ensure transparency in the MEIC HV Continuum of Service Development process</li> <li>• Prepare for anticipated Phase 3 submission requirements (both narrative and budget)</li> </ul>
	<p>FEB</p> <ul style="list-style-type: none"> <li>• <i>Update Workplan Based on Federal Guidance (if issued)</i></li> </ul>	