Stakeholder Awareness and Integration Analysis • Juvenile Fire Setting and Safety Program

Introduction

One portion of this grant entailed surveying Maine social service and mental health providers as well as school health coordinators to assess their level of awareness regarding issues surrounding youth and fire safety. The surveys were designed to measure awareness, and whether this issue has been integrated in routine screening, assessment/evaluation and educational programming.

Based on results, the lack of awareness may be the largest obstacle for integration of prevention education or routine referral to intervention programs.

The specific goals for the survey project are outlined below with the outcome indicated in bold type.

1. Develop a target list of 400 individuals from the three target audiences (social services providers, mental health providers, and school health coordinators); **Surveys mailed to 1905 individuals. Responses from 439 individuals; most meaningful responses from 388 individuals.**

2. Develop and design the survey to determine: a) the level of awareness of juvenile fire setting among the targeted audience in contrast and comparison to other issues; b) Discern what issues they believe need to be discussed as part of their routine screening, evaluation, and assessment process; c) What issues they actually do integrate into that process; d) Why they integrated the issue into the process or why not. Respondents will also be asked if they'd participate in a workshop offering CEU's where juvenile fire setting will be the topic. **Survey instruments attached. Tally of responses and comments attached. Summary narrative of responses follows introduction.**

3. Develop data base to use for mailing the surveys, entering the data from the surveys and to send invitations to workshops; **See above response under number 1. Contact information and indication of willingness to attend training from 172 individuals.**

4. Mail the survey, do needed additional mailings to obtain the representative sample; **Completed January/February 2009.**

5. Enter data and conduct analysis. **Data recorded and tallied in spreadsheet, organized in original survey format and summary narrative February/March 2009.**

We will evaluate the survey as follows:
o Do respondents comprise a statistically representative sample of professionals from each of the given fields? **Yes. See next section titled Mailing Lists and Response.**

o Do we have representative responses from each of the counties and from service centers in each of those counties? **Yes. Based on how the surveys were mailed and the zip codes of respondents who chose to share their contact information for future training or educational materials, there is excellent indication the survey**

responses are geographically representative of the population centers in Maine. See next section titled Mailing List and Response.

o Do the survey results provide us with a solid picture as to the providers' awareness, choice, preference and integration of this issue into their routine professional activities? **Yes, there is significant evidence, based on response among all professional fields surveyed, that the major obstacle to dealing more effectively with youth and fire issues in Maine is the lack of awareness of both the problem and potential treatment options.**

Mailing Lists and Response

The survey was mailed to **1025 Licensed Clinical Social Workers** actively licensed with a mailing address in the state of Maine. This was 20% of the total active LCSW licenses in Maine, which kept the mailing manageable and cost-effective. To ensure responses would be geographically representative according to counties most populated (which are also the service centers throughout the state); the list was first sorted in descending order by county population. Then, every fifth entry was selected for mailing. At time of mailing, there was no way to sort out those professionals who worked with children (vs. only working with adults). Responses were received from **215 LCSWs**, which is **21%** of the mailing. The response from those LCSWs who work with children numbered 169, which is 16% of the total. The list came from State of Maine Office of Licensing and Registration (searchable online at http://www.maine.gov/pfr/professionallicensing/license_search.htm).

The survey was mailed to **574 Psychologists**, 100% of actively licensed psychologists with a mailing address in the state of Maine. Responses were received from **121 psychologists**, **21%** of 574 mailed; **116 work with children or 20%**. As with the LCSW list, at time of mailing, there was no way to sort out those professionals who worked with children (vs. only working with adults). The list came from State of Maine Office of Licensing and Registration (searchable online at http://www.maine.gov/pfr/professionallicensing/license_search.htm).

The list for survey mailing to **Director of Health Services / Director of Guidance Maine Schools** (all counties) numbered **87**. This professional title was the closest to "School Health Coordinator" as listed in grant narrative. Responses were received from **32** individuals representing **36.7%** of those mailed; this did include school curriculum health coordinators and health teachers. The list came from the State of Maine Department of Education (searchable and downloaded from https://www.medms.maine.gov/medms_public/LabelsHome.aspx).

The survey mailing went to all municipalities listed with the Maine Municipal Association (MMA) as having a "**Public Health Officer**" position; the count was **219**. The response from Public Health Officers totaled **71 or 32%**. This list was purchased from MMA.

Mailing total = 1905
Response Total = 439
Contact Information = 172 Respondents who provided contact information for further follow-up (educational materials) or training opportunities.

Survey Design

The survey instruments are attached to the summary narrative of survey results. Research and content for survey design came from the following sources:

Richard E. Taylor, Senior Research and Planning Analyst, Maine Fire Marshal's Office Department of Public Safety

Paul Schwartzman, mental health counselor and a nationally recognized expert on juvenile firesetting behavior, Rochester, NY

Juvenile Firesetter Intervention Handbook; Gaynor PhD, Jessica, USFA, FEMA 2002

Analysis of Maine Fire Incident Reports with Juvenile Involvement from 2004-early 2008; Simcock, Bonnie for Maine Fire Marshal's Office and Maine Juvenile Fire Safety Collaborative Program, 2009

Virginia Health Education

Pennsylvania Health Safety and Physical Education Standards

Madison Metropolitan School District Content Standards and Grade Level Performance Standards (http://www.madison.k12.wi.us/tnl/standards/health/health01.htm)

LAUSD Division of Instruction: Health Standards (http://www.lausd.k12.ca.us/lausd/offices/instruct/standards/standards06.html)

"School Health Safety: Where to Start;" Ellis, Richard, Journal of *Environmental Health*, Vol 67-2005

Survey Results

Mental Health Professionals

For analysis discussion purposes, the results of the Maine Licensed Social Clinical Workers and Psychologists will be discussed together under the general heading of "Mental Health Professionals." As stated in the opening section, the survey was mailed to all actively licensed psychologists (574) with addresses in the state of Maine, and a fifth (20%) of all actively licensed LCSWs (1025) with addresses in Maine, geographically sorted by counties most populated.

Since this survey was primarily targeted toward mental health professional who work with children, not much note will be given to the responses of those who indicated they do not work with *any* children (46). if those respondents who don't work with children filled out more than the top two questions on the survey, their responses were recorded and may be viewed in summation (as well as commentary) in the attached survey results.

Those who responded (and do work with children) number **169 Maine LCSWs** and **116 Maine Psychologists**. The vast majority of mental health professionals who responded to the survey (60% of psychologists and 72% of LCSWs) do provide direct counseling to clients. Over half of these professionals work with a clientele that is mostly composed of children; at least 50% of their work is with children. In fact, of the LCSWs who responded, 42% indicated that their counseling or evaluation services aid a client base almost entirely comprised of children, over 90%. These are professionals who spend a great deal of time working directly with children.

Almost **70%** of the mental health professionals indicated they **never** or **infrequently ask about curiosity/interest or behavior related to fire among their children clientele**. Less than 15% frequently or routinely screen for fire-related behavior or history. When asked about the issues most likely to prompt them to ask about fire-related thoughts or behavior, the vast majority (66-67%) chose an individual's psychological **history or prior diagnosis**. Other popular selections included **parent/teacher/other referral** (60% psychologists, 55% LCSWs), individual's answers to assessment tool used during **initial evaluation** (52% psychologists, 50% LCSWs). Psychologists placed slightly more emphasis on the existence of a **criminal record** (perhaps because they would more often be assigned this type of clientele) with 57% responding it may trigger a "fire" related question vs. 49% of LCSWs. Rounding out the selections were individuals family (28% psychologists, 44% LCSWs) and social circumstance (28% psychologists, 38% LCSWs). Of least importance was whether this question was a routine office procedure (12% psychologists, 21% LCSWs). Under "other" comments, both sets of professionals indicated a history of fire misuse would prompt a question, as would past trauma (physical, sexual or emotional) or history of other anti-social behaviors.

When asked whether these mental health professionals have seen a "trend" in treating children who have expressed interest or curiosity in fire (based on a scale of 0-4; 0 equals no trend, 4 equals extreme trend), 57% of psychologists selected 0; 41% of LCSWs selected 0. Twenty-one percent (21%) of psychologists and 19% LCSWs selected 1, 14% and 20% selected 2. Less than 13% selected a 3 or a 4. There is indication that about half of those questioned feel there is some mid-point trend to treating children with fire interest or behavior. However, some comments or answers on subsequent questions suggest there may have been confusion with the intent of this question. The question was originally asked with intent to "count" numbers of youth with fire interest or risky behavior who may be served by a practice. Instead, some respondents may have interpreted this as a scale of what priority their practice would place on the treatment of this particular issue IF it were presented by a youth. Therefore, some of the responses may have been hypothetical in nature.

When probed further about the situations, behaviors and/or diagnoses that may prompt concern or questions about fire misuse, each group had similar responses for their top four choices (although they differed in rank of popularity among the psychologists from the LCSWs).

<u>Psychologists</u>

Criminal behavior history (64%)
Lack of adequate supervision (53%)
Psychological diagnosis (53%)
Major family issues (51%)

<u>LCSW</u>

Lack of adequate supervision (63%)
Major family issues (56%)
Criminal behavior history (53%)
Psychological diagnosis (47%)

As for the specific diagnoses most likely to prompt fire-related questions, the top two responses by a wide margin were Conduct Disorder (psychologists 74%, LCSW 73%) and Impulse Control Disorder (psychologists 68%,

LCSWs 76%). Again, many of these responses may largely be hypothetical since so many indicated they never or infrequently ask about fire interest or fire risk behavior.

When asked whether they felt Maine has an issue with fires started by children, more than half selected the midpoint or below on a scale of 0-4 (0 equals no problem, 4 equals severe challenge). About 10-13% answered a "3" or "4." Of interest, 16% of psychologist s left this question blank; some commented they did not feel qualified to answer.

The awareness levels (scale of 0-4, 0 equals unaware to 4 very familiar) for the six statements relevant to fires started by Maine's youth varied a bit. For the first statement regarding quantity of fires involving youth, as well as the fourth (property/dollar loss), fifth (injury/death) and sixth (vast underreporting of fire incidents involving youth) statements, the vast majority of mental health professionals reported between a 0 and 1 indicating unaware to only slightly aware. Psychologists reported awareness between 2 and 3 for statements regarding gender/ risk prevalence and infant/toddler vulnerability. LCSWs also reported awareness between 2 and 3 for gender/ risk prevalence, but between a 3 and 4 for infant/toddler vulnerability.

Once a Maine mental health professional identifies a child as exhibiting curiosity about fire, to whom do they turn? The large majority (76-78%) identified their first contact as the parent or guardian of the child client. Of note, about 35% indicated they would first try to evaluate the child's risk for fire-setting behavior although of the fire behavior assessments listed in this survey, 85% or more of the psychologists and 80% or more of the LCSWs responded they were completely unaware of some of the more popular fire behavior risk screening tools.

The vast majority of both psychologists (83%) and LCSWs (77%) do have access to their client's records or medical histories indicating that this should not be an issue if a history of fire-related behavior or correlating diagnosis/situation is present.

When asked whether a referral for fire-related behaviors is recorded/tracked, answers varied among both psychologists and LCSWs. About half of each group indicated they've never made such a referral. About a quarter of LCSWs and psychologists responded they simply record the referral in a client's file. Among psychologists, 12% conduct some follow-up, while 20% of LCSWs report follow-up communication to determine outcome.

The question of personal liability appears to be of minor concern among Maine's mental health professionals with 19% responding they were concerned they may be involved in an investigation or testimony if they identified a child as at-risk for fire-related behavior. About 35-39% of respondents didn't answer this question directly and opted for the "I do not evaluate children for fire risk behavior." If questions surrounding this issue were asked more frequently, perhaps the level of concern would rise. About 40% of mental health professionals indicated a concern for personal liability does not interfere with their evaluation.

Once a client has successfully been referred to a prevention/intervention program, do their service providers check back in on behavior modification? Again, many respondents selected they do not evaluate for fire risk behavior (psychologists 30%, LCSWs 47%) or that they do not conduct any additional fire-risk surveys (psychologists 43%, LCSWs 30%).

The last question asked for specific input for training and educational materials of interest or need. While the answers varied (attached), general themes emerged. Most professionals would like any information pertaining to issues surrounding youth and fire since they are largely unaware. They would like the information in a format

available to share these with parents. They also want specific information about evidence-based /best practices, screening tools, and local referral options. In terms of information delivery, most want reading material, Internet accessibility and, if training workshops are held, continuing education credits available through their respective professional organizations.

Of the psychologists who responded, 40 provided their contact information; 76 LCSWs provided contact information.

Based on the mental health professional survey results and plentiful commentary (both response-specific and in general), it would appear that the major obstacle to the integration of routine screening and referral to intervention/prevention programs is a lack of awareness. This lack of awareness extends to both the behaviors/situations most predominantly correlated with fire-risk behavior and treatment options. This conclusion can be made based on the discussion of question-specific responses related to awareness, especially the Maine statistics on youth and fire, and screening tools. Other potential obstacles do not appear to be a problem; namely the access to or availability of a client's medical records or a concern for personal liability among mental health service providers.

School Health Coordinators (Director of School Health, Director of Guidance)

The survey was mailed to 87 educational professionals in all counties of Maine. This list was downloaded from the State of Maine Department of Education website. In all, 32, or about 37%, responded, representing a variety of positions within a school district such as district-wide curriculum coordinator or health teacher. Multiple respondents share duties within a school, such as teaching and counseling.

About half of respondents indicated they work with individual students for counseling services; another half said they also interact with groups or classes for special events. Eleven (11) respondents said they routinely teach health or safety curriculum. Within the group who teach, the age range varied from pre-kindergarten through 8th grade to only high school (grades 9, 10).

Respondents were asked who is typically responsible for the health/safety content area since many schools do not have a dedicated health teacher. Ten (10) responded it's the classroom teacher, 11 selected physical education teacher, 10 said health teacher (who may also teach other content area) and two selected life sciences teacher.

The survey asked about content delivery methods. Respondents selected lecture (16), handouts (16), video (14), guest speakers (11), text (10) and role play (9) as the predominant delivery mechanisms. The Internet was listed under "other" methods by two respondents.

When asked about typical content area for the health/safety curriculum to determine whether fire prevention and survival was included, respondents were more likely to choose health and development topic areas rather than accidental injury or safety-related topics. For example, nutrition and smoking were selected by 31, physical development, exercise and misuse of medicine, drugs or alcohol by 29 people, reproduction by 28, personal hygiene by 26, emotional development by 25 and physical/sexual abuse by 24. In contrast, vehicular and pedestrian safety, accidental poisoning, fire escape and fire prevention were selected by only 15 or 16 respondents.

The survey listed several curriculum examples (for various age levels or grades) that are specifically geared toward fire safety or prevention, or incorporate these issues along with other safety topics. Between the number of respondents who left these items blank or chose zero (scale of 0 equals unaware to 4 equals currently using), the assumption can be made that at least 80% of the education professionals surveyed, and in some cases up to 97%, are unfamiliar with ANY of the eight curriculum guides/programs listed. More than a quarter of the respondents left all of the scale choices blank, which may mean they were unaware, but it may also mean they didn't feel these particular programs were appropriate for the ages they teach. There was one comment about the relevancy of teaching fire safety/prevention to high school ages in particular. At least 53% and up to 69% selected zero, meaning they were unaware of the guides. Only one respondent selected a 4 for each of the guides, and only "Learn Not to Burn" had three people select a one, one person select a two, and two people select a four. "Play Safe, Be Safe" and the "Kid Safe Program" each had three people select a two or a three for their level of awareness.

When asked about content delivery frequency, the answers varied by grade level. Nearly half of the educational respondents indicated the delivery of health/safety information is ongoing throughout the year. About 40% indicated it's delivered within one semester (two selected quarter, another two selected "trimester"). Out of this time period, respondents were asked to rate how long they talk about fire safety issues; the majority selected they were unsure, that it was not applicable to their program or that they didn't cover (three were left blank). Six said they use a portion of one class, three said a few days, four said one week.

Respondents were asked to define their evaluation methods for health curriculum. The majority use student exams /quizzes (over 69%) or projects/assessments (over 41%) and class discussion (50%). Four respondents were unsure. When asked if there is follow-up based on [presumably poor] evaluation results, most answered there was no follow-up or they were unsure, but a handful said they use additional group lessons or student work.

On the scale from 0 to 4 (0 equals no problem to 4 equals severe problem), educational professionals were asked to rate whether they felt there is an issue in Maine with youth and fire misuse. Fifteen (15) selected the midpoint of 2, seven selected a 1 and six selected a 3. Three were unsure and one wrote "apparently."

When asked about the specific measures about youth and fire in Maine, awareness varied among the six statements. The first statement regarding quantity of fires involving youth, had the largest number of zeros as a selection: 16 (50%) selected a 0 (0 equals unaware to 4 being very familiar with statement), five selected a 1, seven selected a 2, four selected a 3, zero selected four, zero left it blank. The second statement about gender and age correlation for risk prevalence had a little more awareness among respondents – eight selected 0, five selected 1, 10 selected a 2, five selected a 3 and four selected a 4 (zero blanks). In regard to the vulnerability of infants and toddlers in a fire set by youth, people were more likely (than with the other statements) to select the midpoint or greater on the awareness scale: seven selected 0, one selected 1, six selected a 2, 10 selected a 3 and eight selected a 4. The fourth statement was about property or dollar loss: 12 selected a 0, eight selected a 1, 9 selected a 2, zero selected a 3 and only three selected a 4. The fifth statement about the numbers of injuries or deaths in fires started by youth in Maine and the sixth statement about the underreporting of fire incidents involving youth garnered very similar answers: 13 selected a 0, eight selected a 1, seven or eight selected a 2 and three or four selected a 3.

Based on the above response, the educational professionals surveyed are largely unaware or only slightly aware of the numbers of fires set by youth in Maine, the dollar loss, the amount of injuries or death and how many of

these incidents go unreported. While more indicated they are aware that boys between the ages of 8 and 14 are most at-risk for starting fires, it is interesting that some commentary indicated there's not a need for this type of curriculum at grade levels above elementary school.

Educational professionals were also asked to whom they would turn if they, a teacher or parent/guardian identified a child as at-risk for fire-related behavior. The majority (18 or 56%) said they would first turn to the parent. Presumably this is if the referral came from someone other than the parent in the first place. Nine (9) said they would try to evaluate the level of risk themselves although less than this number indicated ANY awareness for the screening tools listed in the survey. Seven said they would contact a mental health agency, six would contact the school guidance office, five would call the local fire department, three would call the local police, one would contact the county juvenile fire safety collaborative and one was unsure.

With the six fire risk behavior assessment tools listed, educational professionals were largely unaware (or left the items blank). Nearly 40% left each item blank, while the other (nearly) 60% indicated they had zero awareness of the risk surveys or evaluations. Only one respondent indicated a level 3 awareness (0 equals no awareness to 4 currently using) for each of the Colorado Juvenile Child or Family Risk Survey. One indicated a level 1, and another a level 2 for the Comprehensive Fire Risk Evaluation. Two people indicated level 3 awareness for the Maine "NASFM" Intake Form. It could be that the professionals are using similar behavior risk evaluation tools, but that they are titled a different name than those listed within this survey. However, it is probably a safe assumption that most have not seen these assessment tools, especially given the number of respondents who indicated on subsequent questions that they've never made such an evaluation.

A few of the school-based professionals indicated that access to a child's medical history is an obstacle (5 or 16%), but double that (11) said they do have access. Another 10 stated they don't counsel or evaluate children.

If a referral for fire-risk behavior were made, do the education professionals track the outcome of the referral? Most, 26, said they have never made such a referral. Only two stated the referral would be recorded in a student's file; another three stated there would be additional follow-up. One stated there would be no record, one was unsure. An additional question asked if any evaluation would be made as to whether behavior modification occurred. Twenty-one (21) indicated they do not evaluate children for fire-risk. Eight (8) said no additional survey would be done. Only one stated that an additional evaluation would be made after treatment. Two left the question blank.

It's unclear whether personal liability is of concern to school-based professionals in terms of identifying a child with fire-risk behavior. Most, 22, said they do not evaluate children for fire risk behavior. Only three stated they would be concerned, while six said a concern does not interfere with an evaluation. Two left this question blank.

In terms of training content, the education professionals would like materials for handouts, information on the screening/assessment tools, age appropriate resources for the classroom (integrated across curriculum), information on trends and severity of problem in Maine and referral options. There was a statement regarding the training format be a local, in-service day.

Of the 32 respondents from Maine schools, nine provided addresses for training and materials distribution.

The purpose of the survey to school professionals was to gauge awareness of the issues surrounding youth and fire in Maine both for prevention/education content purposes and for counseling individual students. The

answers to all questions indicate slight to some awareness of the issues surrounding youth and fires in Maine, but little to no awareness and integration of behavior assessment and/or curriculum content for prevention. To make judgment of why this content is not included is beyond the scope of this particular survey; although the state of Maine is just now beginning the conversation about standards for health and safety education. Injury prevention has historically not been included. One obstacle noted in commentary among school-based professionals is a preconception that fire safety and prevention is a topic reserved only for the very young. The statistics of who is most at risk for experimentation, retaliation or expression with fire prove otherwise.

The pool of respondents among educators/school health professionals was small, as was the initial list to survey. More investigation of this group could be warranted if there is a better way to pinpoint these professionals. It is also worth the time to broaden the curriculum content discussion among school administrators since schools are the best forum to repeatedly reach the largest number of children.

Public Health Officers

The survey was mailed to all 219 public health officers [PHOs] in Maine municipalities as listed with the Maine Municipal Association. From that group, 71 responded. Since this is a state-mandated but unfunded position, it is often a responsibility shared by another position. To understand how much time is allotted to this responsibility, the survey first asked what percentage of work time is spent on PHO duties. Sixty-four (64) stated they spend less than 10% of their work time on public health (eight said 0%, 56 said 1-10%), four said 11-25% of their time, while one each indicated 26-50%, more than 50% and 100%. From those who provided their contact information, it is the code enforcement officer, selectperson, town administrator or citizen volunteer (often from a medical-related profession) who performs this duty.

When asked if they provide any outreach to schools or community organizations on health or safety related issues, 56 (79%) stated NO while only 14 (2%) selected YES. When asked how often this outreach occurs, 25 selected “unsure,” 20 stated once a year, 12 said not every year. Only about four said they spend significant time on outreach. Under comments, some stated they were in the planning stages to provide more.

Public health officers were questioned about delivery of information. Forty-one percent (29, 41%) use handouts, followed by the popularity of lecture, guest speakers or one-to-one discussion (about 13 respondents or 18% for each). Video, text or role play was in limited use. The town newsletter (if available) or town report is also used to disseminate health and safety information to residents.

When surveyed about content of health/safety outreach (from the few who do any), public health officers were most likely to select nutrition, water safety, exercise and vehicular/pedestrian safety. There were a few entries under other categories as well. Of interest for this survey, only three indicated they cover fire escape/survival, while five cover fire prevention. Under other questions, comments were made that the local fire department is most likely to cover this topic in public outreach sessions. PHOs listed other categories they cover such as: building codes, smoke detectors, epidemic concerns, public health alerts and food handling safety.

If the PHOs did discuss fire safety, how long is the session on the topic? Twenty-six (26) selected “unsure,” while seven said a portion of one class, one said a day, two said a few days and one selected a week.

The majority of respondents, when asked their level of awareness for the eight fire and safety curriculum guides, either left the question blank or selected zero (scale of 0 equals unaware to 4 equals currently using). Between 63-68% of respondents left the selections blank and about another quarter (20-28%) selected they were zero aware. A handful of PHOs stated they did have varying levels of awareness of each curriculum ("Learn Not to Burn," "Kid Safe," and "Play Safe, Be Safe") among those that received four or five selections of a 4-level of awareness.

As to the question whether evaluations are performed after content delivery, 37 (52%) said they were unsure or not applicable. Nine (9) stated they use discussion, two use a survey. In the next question, another 31 (44%) were unsure (or question did not apply) about follow-up after evaluation results, 12 did not conduct follow-up, 2 used additional discussion and 23 (32%) left the question blank.

When asked their feelings on whether Maine has an issue with youth and firesetting, public health officials were mixed in their responses. Twenty-three (23) selected 1 (scale of 0 no problem to 4 severe problem), 17 (24%) selected a 2, 12 (17%) selected 0, 7 (10%) selected three and three (4%) selected a 4. Nine (9) or 13% left the question blank. Most public health officials would rate the problem between a 1 and a 2.

The presentation of specific measures involving youth and fire in Maine elicited similarly mixed responses among the six statements from the public health officers. For the first statement regarding quantity of fires involving youth, 36 (51%) selected a 0 (0 equals unaware to 4 being very familiar with statement), 11 selected a 1, eight selected a 2, seven selected a 3, three selected four, six left it blank. The second statement was regarding the gender and age correlation for risk prevalence; more PHOs were also seemingly aware of this statement – 20 selected 0, 14 selected 1, 14 selected a 2, 15 selected a 3 and three selected a 4 (five blanks). In regard to the vulnerability of infants and toddlers in a fire set by youth, this statement had the most people selecting a four for awareness: 14 selected 0, six selected 1, 11 selected a 2, 10 selected a 3 and 25 selected a 4 (five blanks). The fourth statement was about property or dollar loss: 33 selected a 0, 13 selected a 1, 8 selected a 2, 8 selected a 3 and only four selected a 4. The fifth statement about the numbers of injuries or deaths in fires started by youth in Maine had 32 responses of 0, 13 selections of 1, six choices for 2, nine selections of 3 and six 4s (five blanks). The sixth statement about the underreporting of fire incidents involving youth had the least awareness with 42 selections of 0, 11 of a 1, three 2s, six 3s and four 4s (five blanks). So, much like the other groups, the PHOS are largely unaware or only slightly aware of the numbers of fires set by youth in Maine, the dollar loss, the amount of injuries or death and how many of these incidents go unreported.

This group, of all groups surveyed, were more likely to turn to the local fire department should they be presented with a child who exhibited interest in or history of fire-related behavior. Thirty-six (36 or 51%) stated the fire department would be their first contact, 11 each selected county juvenile fire safety collaborative or their local police department. Ten PHOs (10) stated "other," listing "parent" as the most frequent contact. A total of eight would contact a mental health agency, while five responded they would contact the State Fire Marshal's Office. Another five were unsure who to contact.

While 54% of the PHOs (38) do not evaluate children for risky behavior, 21% (or 15) said they would be concerned about their personal liability if they made an evaluation. A similar percentage said they were not concerned with liability (13 responses or 18%).

As a group, the public health officers may be slightly more aware of the issues and some of referral options surrounding youth and fire, but they are limited in time and scope dedicated to the issue. Many perform zero

public outreach, relying solely on town print publications for public health alerts. Most , by virtue of the numbers who shared their address, would appreciate a more information even if they have limited ability to further educate the public. Their primary role is one of referral.

Out of 71 responses, more than half (35) of the public health officers provided their contact information for training and distribution of education materials.