

Maine

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 03/14/2016 4.20.01 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State DUNS Number

Number 809045594

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Department of Health and Human Services

Organizational Unit Substance Abuse and Mental Health Services

Mailing Address 11 State House Station

City Augusta, ME

Zip Code 04333-0011

II. Contact Person for the Grantee of the Block Grant

First Name Sheldon

Last Name Wheeler

Agency Name Office of Substance Abuse and Mental Health Services

Mailing Address 41 Anthony Ave

City Augusta, ME

Zip Code 04333

Telephone 207-287-2595

Fax 207-287-4334

Email Address sheldon.wheeler@maine.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/1/2015 1:30:23 PM

Revision Date 3/14/2016 4:19:01 PM

V. Contact Person Responsible for Application Submission

First Name Cynthia

Last Name McPherson

Telephone 207-287-4234

Fax 207-287-9152

Email Address cynthia.mcpherson@maine.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:



STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

Paul R. LePage
GOVERNOR

September 21, 2015

Virginia Simmons, Grants Management Officer
Office of Financial Resources
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

This letter is to serve as authorization for Sam Adolphsen, Chief Operating Officer, Department of Health and Human Services, to sign for the SAMHSA Community Mental Health Services Block Grant Application and Assurances for the State of Maine.

Questions concerning this application should be directed to the contract administrator, Sheldon Wheeler, Director of Office of Substance Abuse and Mental Health Services at (207) 287-2595.

Sincerely,

Paul R. LePage
Governor

Cc: Mary C. Mayhew, Commissioner, Maine DHHS
Sam Adolphsen, Chief of Operating Officer, Maine DHHS
Sheldon Wheeler, Director, Office of Substance Abuse and Mental Health Services, Maine DHHS



PRINTED ON RECYCLED PAPER

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Sam Adolphsen

Signature of CEO or Designee¹: 

Title: Chief Operating Officer

Date Signed: 11/2/15

mm/dd/yyyy

DISCLOSURE OF LOBBYING ACTIVITIES		
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352 (See reverse for public burden disclosure.)		
1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: <u>Sam Adolphsen</u> Print Name: <u>Sam Adolphsen</u> Title: <u>Chief Operating Officer</u> Telephone No.: <u>207-287-1921</u> Date: <u>11/2/15</u>	
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)	

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

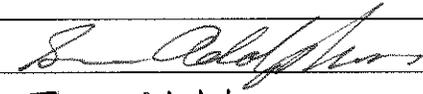
Signature: _____ Date: _____

Footnotes:

See signed LLL in attachments.

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known: _____ Congressional District, if known: _____		5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10.a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: <u></u> Print Name: <u>Sam Adolphsen</u> Title: <u>Chief Operating Officer</u> Telephone No.: <u>207-289-1921</u> Date: <u>10/1/15</u>	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Reporting Entity:

Page

of

Authorized for Local Reproduction
Standard Form – LLL-A

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

OFFICE CHILD AND FAMILY SERVICES
Application and Plan FY16/17

STEP 1: ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS.

Structure of the System of Care

Maine's mental health authority for children's mental health services is the Children's Behavioral Health Services (CBHS) unit within the Office of Child and Family Services (OCFS) program unit within the Department of Health and Human Services. Children's Behavioral Health Services staff provides leadership, in systemic planning and policy development, budget oversight, interdepartmental collaboration, legislative initiatives and systems advocacy on behalf of children with emotional and behavioral needs and their families. Mental health services for children are delivered at the local level through a district structure.

Focal Point of Responsibility for Children's Mental Health

The State mental health authority is the Department of Health and Human Services. The focal point for children's mental health the Children's Behavioral Health Services (CBHS) unit within the Office of Child and Family Services (OCFS) program unit within the Department of Health and Human Services... The statutory authority for the Children's Mental Health Program is cited in PL1998, Chapter 790.

Children's Behavioral Health Services within OCFS support and serves children, age birth through 5, who have developmental disabilities or severe developmental delays, and children and adolescents, age birth through 20, who have treatment needs related to severe emotional disturbance, intellectual disability, autism spectrum disorders, developmental disabilities, or emotional and behavioral needs, and the families of these children.

The OCFS statutory mission includes a strong family support focus. It is mandated to "strengthen the capacity of families, natural helping networks, self-help groups and other community resources to support and serve children in need of treatment" (M.R.S.A. Title 34-B. section 6204.1.A.) and to "(provide) in-home, community-based, family-oriented services." (34-B. section 6203.1.B.)

Target Populations

OCFS Children's Behavioral Health Services has three operational target populations:

- a. Children who have developmental disabilities or severe developmental delay, age birth through 5;
- b. Children and adolescents, age birth through age 20, who have emotional/ behavioral needs including children with serious emotional disturbance;
- c. Children, age birth through age 20, who have intellectual disability, autism spectrum disorders or pervasive developmental delay

In accord with P.L. 102-321, Maine defines serious emotional disturbance in terms of the Federal definition.

State/Local Administrative Structure

In April 2015, the Office of Child and Family Services implemented a realignment plan creating the following Children's Behavioral Health Service unit:

OCFS: Children's Behavioral Health Services unit is responsible for:

- Ensuring that any child between the ages of 0-21 and their family identified as needing a behavioral health intervention have access to and receive this service in the most effective, least restrictive setting as possible.
- That all youth transition successfully to adulthood
- That all possible employment options are sought for all youth
- Ensuring that children receive evidenced-based practices whenever possible
- Oversight and review of youth receiving residential treatment in state and out of state

- Reviewing suicides and serious suicide attempts
- Collaborating and consulting on child welfare cases for youth with behavioral health needs
- Implementing Partnering for Success CBT Plus initiative
- Work with the Office of Maine Care in developing and implementing policy related to children's services
- Overseeing the Block Grant for Community Mental Health Services funding and implementation
- Homelessness and Transitional Living Programing
- Directing and overseeing the Now Is The Time (NITT) Moving Forward Grant
- Providing program leads and content expertise for all contracts, i.e. respite, Autism Society, BHP training, deaf services, etc.
- Working closely with the Office of Quality Improvement and OCFS Quality team

Other Units within the Office of Child and Family Services:

OCFS: Clinical Policies and Practice:

The Medical Director is responsible for oversight of the clinical care delivered to children served by OCFS with specific focus on:

- Improving the access to and the quality of behavioral healthcare for youth with emotional/behavioral problems and developmental disabilities.
- Assisting in the development of effective prevention programs.
- Overseeing the general medical care of foster youth.
- Supervise the Behavioral Health Care Specialists (CS)
 - Determining which youth can be safely treated in a family/community setting and which can only safely be treated in a residential treatment program
 - Quality Improvement in residential treatment and -consultation for youth in residential treatment.
 - Consult with caseworkers/supervisors in their Districts on how to get the most effective care for foster youth.

OCFS: Child Protective Unit is responsible for:

- Prevention services which seek to promote the health, well-being, and safety of children and families by reducing the risk and effects of adverse childhood experiences (such as neglect, trauma, or exposure to violence). Administering best practice services that create a community of caring for intergenerational members focused on increasing protective factors such as; health, education and safety promotion, parenting education, social connections and family strengthening supports
- Operate a 24 hour statewide hotline to report child abuse and neglect. Emergency response system afterhours to assess serious immediate child abuse and neglect allegations.
- Assess the safety of children in the custody of their parents or caregivers. Develop plans to insure safety of children in their homes.
- Join with families and the community to promote long-term safety, well-being and permanent families for children.
- When children cannot be cared for safely in their homes petition the court for custody and provide licensed alternative living situations which provide safety and stability for children in custody.
- Provide rehabilitative services and reunification services to families when it has been determined children are in jeopardy (serious harm) and no longer safe in their care.
- Work with families in their home to reduce the risk of child abuse and neglect.
- Provide Adoption services for families who are interested in adoption of children in custody who are in need of permanent homes.
- Provide transitional services for youth in care who have reached the age of 18 and are in need of assistance to reach their educational and vocational goals.

OCFS: Early Intervention and Prevention Services:

OCFS early intervention and prevention services seek to promote the health, wellbeing and safety of children and families by reducing the risk and effect of adverse childhood experiences (such as neglect, trauma, or exposure to violence). Administering best practice services that create a community of caring for intergenerational members focused on

increasing protective factors such as health, education, safety promotion, social connections and family strengthening supports. This work is done through the following units:

- Early Care and Education Unit
- Child Welfare Intake Unit
- Policy and Training Unit
- Youth Transition Unit
- Prevention Services Unit

OCFS: Operations:

This unit is responsible for managing and directing the Offices operational activities.

Services include:

- Internal and external quality assurance and quality improvement programs;
- Administration of the Title IV-E program;
- Administration of the Foster Care Adoption program;
- Informational services systems including the Maine Automated Child Welfare Information System (MACWIS) and Enterprise Information System (EIS);
- Technology and reporting services;
- Financial services, including reporting, budget, and audit;
- Services related to the Interstate Compact for the Placement of Children (ICPC);
- Procurement and contracting services; and
- Primary liaison regarding federal regulations impacting OCFS financial and practice matters;

BEHAVIORAL HEALTH SERVICES OPERATIONS

The Director of the Office of Child and Family Services oversees all operations of Behavioral Health Services and is responsible for financial oversight of the OCFS budget, develops and implements policies relevant to the mental health system of care for children, represents the Department on issues affecting behavioral health services to include strategic planning and work with the Maine legislature, oversees contract development and provides leadership within the OCFS program.

Medical Director of the Office of Child and Family Services is a full time child psychiatrist who provides clinical expertise, consultation on clinical issues and promotes evidence- based and best practices in the field. The Medical Director consults with and supports field staff and provides clinical supervision to the Care Specialist unit. The Medical Director has responsibility for coordinating the management of children’s behavioral health treatment services that require prior authorization and utilization review. The Medical Director also provides technical assistance in the implementation and monitoring of fidelity of evidenced-based treatments. This position manages the follow staff:

- **Behavioral Health Policy Manager:** Responsibilities include developing and implementing Children’s Behavioral Health statewide policies in conjunction with the office of Maine Care Services (OMS) related to Section 65 Children’s Home and Community Treatment (HCT); Children’s Outpatient Services; and Children’s Residential Treatment. Researching and providing latest information to OCFS staff and community providers regarding evidenced-based, promising practices, and assessment tools for children with behavioral health care needs. Work on outcome data and performance-based standards for behavioral health services. Provide ongoing project collaboration with adult partners from the Office of Substance Abuse and Mental Health Services (SAMHS). Provide support to community providers as needed. Program Lead for HCT, Outpatient and Residential Services
- **Behavioral Health Care Specialists (district positions)** Provide Case Consultation on challenging behavioral health cases and assess whether or not the treatment is truly addressing the needs of the youth. Provide Behavioral Health Training to Child Welfare staff. Review youth in residential treatment and provide consultation regarding discharge planning as needed. Consult with Residential Programs in program design, making changes their programs and modalities of treatment. Record Reviews on Residential cases as needed. Assist Crisis

Programs and Psychiatric Hospitals with discharge planning for challenging youth. Follow up on Reportable Event reports involving suicide attempts, completed suicides, serious injuries; as well as; numerous restraints and/or other questionable behavior management techniques. Care Specialists who are nurses provide consultation to Child Welfare regarding psychotropic medication.

The **Behavioral Health Director** manages all activities statewide pertaining to the development and delivery of behavioral health and rehabilitative services for children and their families. The Behavioral Health Director is also responsible for the implementation of the delivery of mental health services to youth in the Department of Corrections two Youth Development Facilities and Juvenile Services Regional offices. This position manages the follow staff:

- **Behavioral Health Team Leader** : Responsibilities include supervision of the three Children’s Resource Coordinators; work in conjunction with the Office of Maine Care (OMS) in regards to Children’s Rehabilitation Services (RCS) Section 28, and Children’s Targeted Case Management Services (TCM), and Children’s Behavioral Health Homes on policy implementation/revisions; revise regional Community Provider Meetings; focus on APS data reports and performance measures for the two above services; be the Program Lead for Children’s Autism Services; focus on development of a Person Centered Planning Process for Children’s Behavioral Health Services. Provide Support to Community Providers as needed.
 - **Resource Coordinators (district positions)** work with community providers to develop or expand services needed in the region, act as local contact for collection of information on services and may act as liaison to other child serving entities of the state.
- **Behavioral Health Program Coordinators (district positions)** address specific child and family issues and work with community providers around individual children and youth (or specific groups) to ensure access to services, including services outside of the home.
- **Co-Location of Mental Health Staff in the Department of Corrections System:** Mental health services are provided to youth served in the Department of Corrections, Juvenile Services Division. Four **Behavioral Health Program Coordinators**, one currently vacant are co-located in Juvenile Services field offices. The BHPCs screen all caseloads of the Juvenile Community Correctional Officers (JCCOs) to identify youth in need of mental health services. In addition two (2) Clinical **Social Workers** are located at the Long Creek Youth Development Center in South Portland. There is one (1) BHPC located at the detention center at Mountain View Youth Development Center in Charleston. These personnel provide treatment in the facilities and assist in the coordination and development of services for youth returning to the community.
- **Project Manager/Program Specialist II** responsible for the Now is the Time-Healthy Transitions (NITT- HT) federal grant. This position supervises the
 - **Youth Coordinator /Program Specialist I** responsible for assisting with the “Now is the Time-Healthy Transitions”(NITT- HT) federal grant
- **Social Services Program Specialist II** is responsible for preparation of reports required by federal, legislative or departmental personnel, analysis of non-clinical data and information, and preparation of the children’s portion of the federal Block Grant for Community Mental Health Services application and the Healthy Transitions Initiative. This position supervises the
 - **Family Information Specialist (district position)** is responsible for communicating with parents who seek access to services for their child/youth, provide information to parents about community services, and maintain updated information about services provided statewide. Family Information Specialists are trained parent employees who are knowledgeable of the local service area and have a child with a disability.
- **Social Services Program Specialist I** is responsible for the management of the Community Services Block Grant and homeless services to youth statewide.

Additional support from within the Office of Child and Family Services Operations Unit:

Quality Assurance Team Leader is responsible for:

- **Social Services Program Specialists (district positions)** are responsible for participating in site visits to community agencies in order to review operations and services that are funded by the Department. These tasks include reviewing service trends, incident reports and performance outcome data, providing technical assistance and obtaining feedback from consumers.

Information Systems Manager is responsible for management and oversight of Information services and data related to OCFS business and programs. The Information Systems Manager supervises the following staff

- **Management Analyst II:** This position monitors, analyzes and produces requested data utilizing electronic data management systems and data bases affiliated with OCFS.
- **Management Analyst I:** This position supports and contributes to the work of the Management Analyst II and performs work associated with OCFS information and data collection and distribution.
- **Social Service Program Specialist:** This position's responsibilities include providing Information Services program support, reviewing and assessing statistical data and reporting materials, monitoring business procedures for data management system entry, and evaluating user needs and requests that generate the creation of tickets for individual data resolution or creation of new or revision of the functionality of the data management systems .

Children's Mental Health Services: The Division of Children's Behavioral Health Services (CBHS) contracts with private community-based agencies to provide the following Behavioral Health Services: case management; crisis services; individual planning fund administration, information and referral, clinical home and community-based behavioral health treatment; rehabilitate community support services; ; outpatient counseling and therapies; respite services, family support services, children's ACT services, medication management; homeless outreach, day activity, shelter and transitional living services, and short-term, intensive residential treatment services.

Intellectual Disability and Autism Services: The Division of Children's Behavioral Health Services (CBHS) contracts with private community-based agencies to provide the following Behavioral Health Services. The contracted agencies provide home and community-based services; identification and assessment; rehabilitative services; personal supports; case management; crisis services; medication management; short-term residential treatment ,individual planning funds, and respite for children with developmental delay, autism spectrum disorders and intellectual disabilities.

AVAILABLE SYSTEM OF TREATMENT, REHABILITATION AND SUPPORT SERVICES

The Department, in concert with all other child-serving state agencies, parents, community service providers and legislators who participated in the 1997 planning process culminating in A Plan for Children's Mental Health Services, identified a full array of services and supports essential to the children's system of care. Funding sources identified in the Plan include sources available to and employed by any of the four child-serving state agencies.

Six core mental health service components were identified and described below. Each core service is available in varying degrees of intensity, depending on the level of need. In addition to the core services, flexible resources (called individual planning funds) are available to provide for individual needs identified through the individualized planning process that cannot be addressed through categorical services or funding sources.

In Maine, the core service array is intended to provide a blueprint for developing service capacity in each geographic area of the state. The core service array with service components is summarized as follows:

- **Prevention/Consultation Services** include early intervention services for pre-school and very young children and includes identification of at-risk children, clinical consultation and information/education components. Services are designed to identify problems and intervene early. Information about health and emotional development can identify children "at risk" and trigger treatment services. Education activities inform the community about mental health problems; consultation services address individual cases and assist other agencies in handling mental health problems.

- **Crisis Intervention and Stabilization Services** are accessed through a single statewide, toll free 1-888-568-1112 crisis telephone line. Services include mobile crisis outreach services, crisis resolution, and short-term crisis stabilization units. Crisis services provide support and stabilization services to children and youth in their homes, schools or other community settings. Services are available 24 hours a day, 7 days a week. Crisis outreach includes an assessment of risk, identification of immediate needs, and development of a crisis stabilization plan, a crisis plan to follow in the event of re-occurrence, referral and follow up. Specific crisis interventions may involve a variety of in-home support services or short-term, out of home treatment in the community.
- **Individual Planning/Case Management Services** consist of screening and assessment, individual service planning, homeless youth, outreach and targeted case management. Case management services for children entail an individualized planning process. Assessment involves determination of an individual or family's strengths and needs, contributing factors, and existing assets and resources, as well as screening instruments that profile the child's functional abilities. These assessment instruments, the Child and Adolescent Needs and Strengths (CANS) Assessment Tool or the Children's Habilitation Assessment Tool, are administered at the time of service entry, and re-administered every ninety days and at completion of services.
- **Family and Child Supports** include respite care, parent and peer support services, information and referral services, and individual planning funds. These natural and extended supports are designed to strengthen the ability of families/caregivers to maintain children in their home and community. Family support and respite provide relief from constant caregiving, and support for each caregiver's problem-solving, communication skills, behavioral interventions, and advocacy
- **Community Outpatient and Treatment Services** consist of psychological/psychiatric evaluation; medication management; individual, group, and family counseling; and children's home and community-based treatment services that include several evidence-based practices. Clinical services represent a wide range of community-based treatment, including specialized interventions for substance abuse, trauma, etc. Problem-oriented counseling, skills training, and in-home behavioral treatment services to strengthen and stabilize the family living environment are designed to minimize the risk of out-of- home placement. School-linked mental health services provide a variety of educational/ psychological assessment and referral, individual and family counseling, special education, and other support services geared specifically to support the child or youth in the school environment.
- **Residential Services** include therapeutic (treatment) foster care and regular foster care for children in child welfare services care, and short-term intensive residential treatment for children with behavioral health treatment needs. Out-of-home residential services include specialized therapeutic homes with foster parents recruited and trained to care for children with serious emotional and behavioral challenges. Behavioral health services provide short-term, intensive temporary out of home treatment services (ITRTS).

INTEGRATION OF CHILDREN'S SERVICES

Office of Child and Family Services has developed strong and viable relationships with other child-serving state agencies, notably the Department of Corrections, Juvenile Services, the Department of Education, and the DHHS Office of Substance Abuse.

These relationships are nurtured and strengthened through active collaboration within the system of care. Collaboration and partnerships are developed at the regional level where services are delivered to children and their families; at the policy level where strategies are formulated and values are supported; and at the practice level where behavioral health services are shaped, evaluated, and promoted, based on outcomes beneficial to children and their families. OCFS promotes the interests of families through relationships with other state agencies and their divisions, and affiliates such as the Department of Education through the Maine Association of Special Education Directors.

OCFS is also connected with other state agencies and entities that are not directly involved with services for children and their families, but are important potential, future service providers for some youth as they begin to transition to adulthood. These agencies include the Office of Substance Abuse and Mental Health Services (SAMHS) which may be a provider for young adults with Serious Mental Illness (SMI) and the Office of Aging and Disability Services that could be a

destination for high need youth whose emotional, physical and behavioral needs require intensive and long term attention and support that would be available under the Home and Community-based Waiver offered through that office.

OCFS enjoys a close and productive working relationship with the DHHS Office of MaineCare Services (OMS), the Maine Center for Disease Control and Prevention (MCDC), and the Office of Quality Improvement (OQI). These units of the Department provide essential subject matter expertise to OCFS and they have been long standing partners in key areas within the behavioral health services program.

System of Integrated Services

Chapter 790, Public Law 1997 - A Coordinated System of Children's Mental Health Services

One year after the 118th Legislature commissioned a study of mental health services to Maine children and their families (LD 1744), which resulted in A Plan for Children's Mental Health Services, the legislature completed the reform process by passing LD 2295, Chapter 790, P.L. 1997, titled "**An Act to Improve the Delivery of Mental Health Services to Children.**"

The law amends Title 34-B M.R.S.A. by adding Chapter 15, Children's Mental Health Services. Chapter 790 focuses on the mental health needs of children who are served by all child-serving departments, introduces the principle that there should be a system in place that addresses these needs, and designates DHHS to be responsible for coordinating that system. The major sections of the law include:

- Creation of a Children's Mental Health Program,
- Defining the responsibilities of the four (4) child-serving departments,
- Establishment of a Children's Mental Health Oversight Committee,
- Planning for children with autism, developmental disabilities and intellectual disability

Section 15002: Children's Mental Health Program:

This program represents the structure that will coordinate the children's mental health care provided by all child serving departments. The program is now under the supervision of the Commissioner of DHHS. The Director of the Office of Child and Family Services has responsibility for the implementation, monitoring and oversight of the program.

This program will track the mental health care and services of all child serving departments, as well as the development of new resources and funds used to provide mental health services from each department's budget. The program does not diminish any entitlements already in place that are the responsibility of the various Departments by virtue of state or federal law, rule or regulation.

Fundamental values endorsed by the LD 1744 planning process are made explicit for all children and families. They include a child and family centered program and planning process, focusing on child and family strengths as the starting point for an individualized plan of services.

Principles of care delivery stress local service provision, prevention and early intervention services, and choice of care through a case management system. The program must implement uniform intake and assessment protocols and identify a central location for obtaining information and access to the program. The system of providing care must be a functionally integrated, network based system, with OCFS as the single point of accountability.

Section 15003: Responsibilities of the Departments:

Each Department has entered into memoranda of agreement that recognize, DHHS as responsible for the implementation and operation of the Children's Mental Health Program, and specifies the other Departments' respective responsibilities.

DHHS Office of Child and Family Services is responsible for developing policies and rules regarding access to care, eligibility standards, uniform intake and assessment tools, and access to information among departments. This includes responsibility to coordinate with the other Departments on developing community resources and support services and for monitoring care and services. The Departments must also determine existing service capacity, unmet needs, and the need for increased service capacity. The law instructs DHHS to adopt rules for mental health care for children under the Medicaid (MaineCare) program.

Chapter 790 requires that the Departments implement fiscal information systems that can track all appropriations, expenditures, and transfers of funds that are used for children's mental health services. This capacity exists within the Office of Child and Family Services through the integration of behavioral health services, early childhood services and child welfare services and fiscal data managed by the OCFS Program Fiscal Coordinator. Chapter 790 requires that federal block grant monies are to be used for children who are not eligible for Medicaid. General funds will be used to maximize the use of federal funds, including Title IV-E and other federal funds for the care of children living at home and in residential placements.

Management information systems must focus on care and support services delivered, needs and unmet needs for care, waiting lists, resource development, and costs of the program. Information is to be kept by treatment need, care provided, geographic area, and Department involvement. Information will cover children placed out of state who transfer to care in the State of Maine. Both internal and external evaluation processes of the program's effectiveness are required.

The law (Chapter 790) placed considerable emphasis on regular reporting to newly created oversight committee and to the legislature's Joint Standing Committee on Health and Human Services. All child-serving Departments continue to provide information to their legislative committees of jurisdiction, such as the Joint Standing Committee on Health and Human Services that oversees DHHS Office of Child and Family Services. Other committees of jurisdiction include the Joint Standing Committees on Education and Cultural Affairs and Criminal Justice and Public Safety.

Section B-2: Planning for Children with Autism, ID and DD

CBHS, in consultation and cooperation with the other child serving departments, was charged to develop a comprehensive system of services for children with autism, developmental disabilities, and intellectual disability. In designing the service system, the Department utilized the framework of the Children's Mental Health Program. OCFS has fully integrated children with intellectual disability and autism spectrum disorders into the system of services developed for children with mental health needs. Examples of this integration include targeted case management services and community-based mobile crisis services.

Interdepartmental Collaboration

Chapter 790, beginning with Memoranda of Agreement linking children's services and each of the three child-serving state agencies, has promoted a high level of interdepartmental collaboration since that time.

Department of Corrections- Juvenile Services/OCFS Children's Behavioral Health Services Interdepartmental Protocol Concerning Title 15 Referrals to the Department of Human Services

The purpose of this protocol is to establish a framework and process for meeting the needs of youth/children involved with the Department of Corrections (DOC) for whom remaining in their homes is contrary to their welfare or safety and may require Department of Health and Human Services custody. Because all departments recognize that there are consequences to removing children from their parents' custody, emphasis is placed on making all reasonable efforts to secure alternative options before consideration of state custody.

Office of Substance Abuse and Mental Health Services

The Office of Substance Abuse and Mental Health Services (SAMHS) maintains data on unduplicated adolescent admissions to substance abuse treatment facilities and services delivered in outpatient settings. In Maine, the SAMHS also works closely with the Department of Corrections, Juvenile Services and with the juvenile courts.

SAMHS provides support for outpatient and residential substance abuse treatment throughout the state and support for individual and family services statewide. Contracted substance abuse counseling and evaluation network services are also provided statewide. In addition, contracted substance abuse services are available in the two youth development centers, Long Creek located in South Portland and Mountain View located in Charleston.

Department of Education/OCFS

OCFS Children's Behavioral Health Services regularly participates with staff from the state Department of Education on a wide variety of policy level issues as well as specific operational initiatives. Included among these activities is the

Interdepartmental Resource Review Committee which identifies priority needs for all children, and reviews new or enhanced program models.

Child Development Services (DOE)/ Behavioral Health Services

OCFS Children's Behavioral Health Services continues close collaboration with Child Development Services within the Department of Education. A major objective will be to identify common connections with families that receive services from both CDS and OCFS. These connections can be identified through OCFS contracted case management agencies. Other objectives include training initiatives that provide a consistent and comprehensive overview of the CDS and OCFS missions and operations for pre-school/early intervention services and to identify the assessment tools used by CDS and OCFS.

School-Based Health Centers

Twenty-four (24) Maine schools have established a School-Based Health Center (SBHC).

A School-Based Health Center is a health center located on or near school grounds and staffed by qualified health professionals. Each center operates under the guidance of a local advisory board, broadly representing the community, including parents and students. The Health Center Advisory Board decides what services to offer at each center.

Services are provided by physicians, physician's assistants, nurse practitioners, mental health providers, and dental hygienists, in cooperation with school nurses. A medical director oversees clinical services. Health Center staff work closely with school staff and students' primary care providers.

Day Treatment/Local Education

Day treatment services are available to participating schools through MaineCare Children's Behavioral Health Day Treatment Services, Section 65.06-13. DHHS MaineCare has initiated several major policy changes related to school-based behavioral health day treatment, programs for children with cognitive impairments, and various related special education services such as speech and language services, physical therapy, and occupational therapy. The Department of Education is working very closely with MaineCare staff to provide training and certification for Behavioral Health Professionals who will provide direct services to students in day treatment programs.

Intellectual Disability Services Transition

The Office of Child and Family Services (OCFS) and The Office of Aging and Disability Services (OADS) continue to work collaboratively on transition to adulthood. Both departments agree that youth should have flexibility in choosing which system to receive service from between the ages of 18 and 21 years. Information sharing between children and adult systems for planning purposes begins at age 16. An electronic tracking system has been created and training has occurred which allows Community Case Manager, as well as department staff to work within an electronic data tracking system to ensure a smooth transition to services when needed and/or other resources if the youth is found ineligible. Referrals to OADS take place at age 17. Eligibility decisions are shared at age 17 ½. Services cannot be provided until at least age 18, depending on wait lists. A workgroup has been developed to begin work on a FAQ document. A website is available for the public, case managers and service providers to be informed on eligibility at:

http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/CM_Manual/Eligibility.html . As well as the CBHS page on transition: <http://www.maine.gov/dhhs/ocfs/cbhs/transition-adulthood>

MOU between OCFS and SAMHS Regarding Transition Age Individuals

An important product of the *Moving Forward* Initiative has been the concurrent development of an updated **Memorandum of Understanding** between the Office of Child and Family Services and the Office of Substance Abuse and Mental Health Services. This MOU, effective May 14, 2009 formally addresses the roles, responsibilities, and commitments of Maine's Mental Health Authorities to enhance and sustain a high quality mental health system of care for transition age individuals. Both offices recognize the need to enhance and coordinate policies, procedures, services, and supports for individuals from ages 16-25.

The Moving Forward "Now is the Time Healthy Transitions" (NITT HT) Initiative

The successful transition of young people to adulthood has been identified as a priority area within the Department of Health and Human Services. To address this priority, in 2015 the Maine Department of Health and Human, Services

Office of Child and Family Services applied for and was awarded this grant. *The Moving Forward (NITT-HT) Initiative* is being implemented as a result of a five (5) year federal Substance Abuse and Mental Health Services Administration (SAMSHA) grant titled, “Now is the Time”—Healthy Transitions (*NITT-HT*). This grant will allow the continuation of services provided under the previous five year grant to additional geographically locations within the state. The NITT-HT Initiative also included the inclusion of Portland Identification and Early Referral (PIER) program in Cumberland and Androscoggin Counties.

Through training, early identification and treatment, targeted case management, youth peer support, community outreach, and on-going program evaluation, the Department expects this *Initiative* to: improve access to and efficacy of state-of-the art services for young people who are experiencing serious emotional and behavioral challenges; assist young people in the development of essential life skills, improve education, employment, and well-being outcomes; help youth increase their connections to the community; and keep communities safer by increasing public awareness and reducing stigma to treatment.

The specific goal of NITT-HT *The Moving Forward Initiative* is to develop and implement a youth-guided seamless System of Care for youth and young adults ages 16 to 25 with a serious emotional disturbance (SED) or serious mental illness (SMI) diagnosis who have experienced trauma in their lives. This is to be accomplished by partnering with youth, families, community and advocacy organizations; implementing the evidence-informed Transition to Independence Process (TIP) model of transition services, Portland Identification and Early Referral Services (PIER) program and the Intentional Peer Support model of alternative support through Youth Peer Specialists; utilizing trauma-informed tools; and maintaining a Learning Collaborative to help agencies integrate and sustain the practice.

SYSTEMS ACCESS PROGRAM AND UTILIZATION REVIEW

Inpatient Services and Hospital Capacity: As of July 2015 the number of beds for children and adolescents at Maine inpatient psychiatric hospitals totaled 96 and were allocated as follows:

Provider	Location	Service Type + amount	Total
Spring Harbor	Westbrook	Child=14, Adolescent=14 MR/DD/Autism Unit = 11	39
St. Mary’s	Lewiston	Child/ Adolescent = 18	18
Northern Maine Medical Center	Fort Kent	Serves age range from 4-17	7
Acadia (Bangor)	Bangor	Child=16, Adolescent=16	32
Maine Inpatient Psychiatric Beds			96

Maine has two privately operated psychiatric facilities, one in Bangor with a child and adolescent unit of 32 beds, and one in Portland with two child and adolescent units of 14 each, and a unit for individuals with MR/DD/ASD. There are two general hospitals with child psychiatric units: a 7 bed unit in northern Maine (Fort Kent), and an 18 bed unit in central Maine (Lewiston).

Systems Access Program and Utilization Review

Much of the reduction in out of state placements during this period can be attributed to internal and external collaboration among the state’s child-serving state agencies.

The Department established a Children’s Services Utilization Review Program to assess the quality and effectiveness of hospital care and residential treatment rendered to children and adolescents from the State of Maine. The focus of the program, supported through OCFS Children’s Behavioral Health Services Behavioral Health Care Specialist staff and other personnel, is to ensure that the clinical care that is approved for children and adolescents with behavioral health needs is consistent with best practices and standards and meets generally-accepted levels of medical necessity.

Residential Treatment Services: Intensive Temporary Residential Treatment Services (ITRTS) Policy

ITRTS is defined as an intensive level of care that provides treatment for children and adolescents in a structured setting that includes 24- hour supervision. This program provides the necessary services, which cannot be instituted in a home due to the unsafe behaviors of the child, but do not require hospital level of care.

Formal prior authorization and continued stay processes for residential treatment are required for all children. This single integrated system is to ensure that all children across the state receive the most effective treatment services, in the least restrictive environment, for the right duration of time. The prior authorization process includes submission of an application and clinical documentation that is then reviewed by the state's administrative service organization, APS Healthcare. Once a child is admitted into a residential treatment program, any requests for continued stay are submitted by the residential provider. APS Healthcare utilizes the same eligibility of care criteria used during the prior authorization to determine if the child continues to need this level of care.

ITRTS residential data reflects all children who have received residential treatment. In FY14, a total of 803 children received residential treatment services. CBHS continues to monitor these numbers and implement Continuous Quality Improvement measures in an effort to ensure that children in Maine receive the most effective treatment services in the least restrictive environment possible.

Children in Out of State Placement LD 790 specifically directs the Department to report periodically on progress made in meeting schedules for transitioning children receiving treatment out of state back to care in the State of Maine. OCFS authorizes and tracks out of state admissions of all children with behavioral health needs whose care is paid for by MaineCare funds.

The census of children who were served out of state in July 2013 was 24 and the census of children receiving treatment out of state in July 2014 was 35 resulting in a net change of +9 children during the 12 month period.

Office of Substance Abuse and Mental Health Services (SAMHS): Co-Occurring/Dual Diagnosis Services

Services to children and adolescents with co-occurring mental health/substance abuse needs are provided by the Department of Health and Human Services through SAMHS.

The following agencies have specific programs for youth that are funded through SAMHS to provide substance abuse treatment. **Residential** – Day One; Phoenix Academy of Maine. **Intensive Outpatient** - Day One; Open Door Recovery. **Outpatient Program** – Day One; Community Concepts (school based services). While these programs have specific programs for adolescents, most substance abuse providers in the State of Maine do work clinically with adolescents as well as adults.

Medical/Dental Services for Children

Publicly funded dental services for Maine children under the age of 21 are available through the MaineCare program. Access to these services is limited to children eligible for MaineCare and by the numbers and locations of dentists who are enrolled as approved vendors. OCFS district offices maintain an informal list of dental providers who are willing to take children with MaineCare insurance. OCFS has provided for interpreter services to overcome language barriers between dental professionals and the child and family.

Medical services for children are provided through MaineCare. Public health services are provided through the Department of Health and Human Services (DHHS), Center for Disease Control. OCFS does not provide medical services beyond those that are characterized as behavioral health services. Maine expanded medical coverage for many children beginning in 1998 through the Cub Care program, which is now part of the State Children's Health Insurance Plan (SCHIP).

State Children's Health Insurance Program

MaineCare, with Title XIX funding, provides coverage to children from birth to 12 months of age in families with income through 191 % of the federal poverty level (FPL), children ages 1 through 5 in families with income through 140 % FPL, and children ages 6 through 18 in families with income through 132 % FPL. With Title XXI funding, (under MaineCare expansion), MaineCare provides coverage to uninsured children ages 1 through 5 in families with income from 140%

through 157 % of the FPL and provides coverage to uninsured children ages 6 through 18 in families with income from 132% through 157% of the FPL; and under a separate child health program (formerly “CubCare”) provides coverage to children from birth to 12 months of age in families with income from 191 % through 208 % of the FPL, and to children ages 1 through 18 in families with income from 158 % through 208 % of FPL. For insured children between the ages of 1 through 5 in families with income from 140% through 157% of the FPL and for insured children ages 6 through 18 in families with income from 132% through 157% of the FPL, Maine Care provides coverage with Title XIX funding.

Covered MaineCare services, both Title XIX (Medicaid) and Title XXI (CHIP) funded, includes but is not limited to: hospital, physician, therapies (OT, PT, and Speech), medication, lab and x-ray, durable medical equipment, vision and hearing, ambulance, transportation, behavioral health, family planning and case management. The total average number of enrollees so far in **2013** is, cumulatively **15,729**; CHIP-Medicaid Expansion: **10,160**; CHIP-Cub Care: **5,569**.

Rehabilitation and Employment Services

OCFS/CBHS works collaboratively with adult service systems regarding appropriate services and supports, including employment, during the transition planning phase – beginning usually two years or more before a young person enters adult services. Activities include an agreement with the Office of Ageing and Disabilities Services (OADS) to begin early collaborative planning for young people at age 16, so that the adult service system can begin resource planning for future needs

Another resource is the Division of Vocational Rehabilitation, Department of Labor. Schools refer young people to VR Counselors who specialize in transition planning regarding employment. These VR Counselors provide technical assistance/consultation to schools, as well as talk with students and family members and thus provide an emphasis on employment for youth with serious mental illness, cognitive disabilities, as well as youth with other disabilities.

Department of Education

The Maine Department of Education publishes a child count, of the total number of students in Maine. The child count data is a snapshot of students ages 3-21 receiving special education and related services on December 1st. The child count is completed by school administrative units and the nine regional Child Development Services sites. It reflects all students with Individual Educational Plans regardless of placement.

The special education child count lists 14 areas of Disability/Exceptionality. Six specific areas among the total 14 categories represent a range of disabilities that suggest a level of severity or type that are likely to be included in the children’s system of behavioral health care.

Child Development Services (CDS)

The Child Development Services System (CDS) is established for the purpose of locating, and maintaining a coordinated service delivery system for children, from birth to under age 6; early intervention services for eligible children, from birth to under age 3; and free, appropriate and public education services for eligible children from age 3 to under age 6, who have a disability consistent with the federal Individuals with Disabilities Education Act (IDEA).

Maine’s CDS system at the end of FY15 showed a census of about 5,582 children. In the IDEA Part C program for children ages 0-2, the total count of active children was 1407. Children remain in Childfind status after they have been referred to CDS, until they have been evaluated and determined eligible for services. Childfind accounted for 431 of Part C children. The rest, 976 children, had qualified and had an Individual Family Service Plan (IFSP).

Part B –619 the program for children ages 3-5, accounted for 4,175 of the children in the system; 945 had been referred and were being evaluated to determine if they qualified for services. The 3230 children in this age group had been found to be qualified and had a plan of service in place. The total served under both parts was 4206 children. The services that each child receives are determined by either an Individual Family Service Plan (IFSP) or an Individual Education Plan (IEP) which has been developed by the child’s early childhood services team.

Services Provided by Local School Systems

The Maine Department of Education provides education and related services to Maine's students with disabilities through school subsidy, contractual and federal funding through IDEA, and the Individuals with Disabilities Education Act. These services include the following:

Certified Educational Personnel which include: Administrator of Special Education, School Education Consultant, School Psychological Service Provider, Vocational Education Evaluator, Speech and Hearing Clinician, School Nurse, Teacher of Students with Disabilities, Teacher – Severe Impairments, Teacher-Hearing Impairments, Teacher – Visual Impairments and Adapted Physical Education.

Licensed Contractors which include persons licensed by appropriate state agencies to provide supportive services to students with disabilities, to include: Audiologists, Interpreter/ Translator, Licensed Clinical Professional Counselors, Occupational Therapists and Physical Therapist Assistants, Psychologists, Social Workers, Speech-Language Pathologists, Speech-Language Pathology Aides and Assistants, and Attorneys.

Auxiliary Staff which include those Educational Technicians I, II, and III approved by the Office of Certification and assigned full or part time to provide special education services.

Geographic Areas within Children's Integrated System of Care

The Department of Health and Human Services, Office of Child and Family Services (OCFS), is organized and administered through eight district offices.

The Department of Corrections, Division of Juvenile Services is organized according to three regions , in addition to Mountain View Youth Development Center (detention service only) in Charleston and Long Creek Youth Development Center in South Portland. Regionally-based Juvenile Community Corrections Officers (JCCO's) serve as the correctional case managers for juveniles who are under the supervision of the Division, regardless of their status within the legal system. OCFS Children's Behavioral Health Services personnel are assigned to and co-located within these offices and facilities. The behavioral health and juvenile corrections systems are fully integrated and have established exceptional working relationships as evidenced in the materials included earlier in this section of the application.

The Department of Education conducts administrative and program operations from its central office in Augusta. The Department serves a diversified public school constituency at the local level. DOE's Special Education unit relates primarily to Special Education Directors within the public schools. Maine currently has 230 school administrative units comprised of 492 municipalities. These school administrative units are served by 137 Superintendents of schools in 134 administrative offices.

The Child Development Services system is an Intermediate Educational Unit that provides both Early Intervention (birth through two years) and Free Appropriate Public Education (for ages three through five years) under the supervision of the Maine Department of Education. CDS consists of nine regional sites and a state office. The state CDS office maintains a central data management system, system-wide policies and procedures, and provides centralized fiscal services for regional CDS sites.

MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

Target Population Defined by Chapter 790

Maine's legislation for children's mental health, Chapter 790, defines a "child", for purposes of children's mental health services, as follows:

"Child" means a person from birth through 20 years of age who needs care for one of the following reasons:

- A. A disability, as defined by the Diagnostic and Statistical Manual of Mental Health Disorders published by the American Psychiatric Association;
- B. A disorder of infancy or early childhood, as defined in the Disorders of Infancy and Early Childhood Disorders published by the National Center for Clinical Infant Programs;
- C. Being assessed as at risk of mental impairment, emotional or behavioral disorder or developmental delay due to established environmental or biological risks using screening instruments developed and adopted by the departments

through rulemaking after consultation, review and approval from the Children's Mental Health Oversight Committee;
or

- D. A functional impairment as determined by screening instruments used to determine the appropriate type and level of services for children with functional impairments. The functional impairment must be assessed in 2 or more of the following areas:
- 1) Developmentally inappropriate self-care;
 - (2) An inability to build or maintain satisfactory relationships with peers and adults;
 - (3) Self-direction, including behavioral control;
 - (4) A capacity to live in a family or family equivalent; or
 - (5) An inability to learn that is not due to intellect, sensory or health factors.

The LD 790 definition includes the population known as children with severe emotional disturbance, (SED) as well as children and youth whose behavioral and emotional needs are less severe than the SED population.

Maine continues to define children with Serious Emotional Disturbance (SED) in accordance with the accepted federal definition for this segment of the target population covered under the Children's Block Grant for Community Mental Health Services State Plan.

Maine Estimates of SED Population

URS Table 14A reports the FY2014 State SED population figure for the 0-17 years of age at 9,299.

Sources of Data and Information in this Application

The FY16/17 Block Grant Application and Plan relies on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plans. OCFS Children's Behavioral Health Services utilize the following sources of data and information:

- **Year End Contract Reports** Office of Child and Family Services (OCFS) contracts with providers to deliver all community-based behavioral health services. Providers report performance data, numbers served and a variety of quality improvement indicators on a quarterly basis. State Fiscal Year (SFY) 4th quarter (year-end) reports are a major source of data used by the Department, and are referenced in this application. Contract reports show unduplicated counts of children served for the particular service component under contract. However, when different types of services are added together, the total number is a duplicated client count.
- **Maine Integrated Health Management Solution (MIHMS)**
This is the current MaineCare claims management system that replaced the MECMS system. MIHMS is also a MaineCare claims payment system and has the capacity to generate reports on program costs and unduplicated counts of individuals served.
- **Enterprise Information System (EIS)** The Maine Department of Health and Human Service began using the Enterprise Information System in 2002 .It is a comprehensive and integrated information system that supports planning, management, and quality improvement for all aspects of the department's operations across all its categorical services, including adult mental health, children's services, and adult intellectual disabilities. This integrated information system facilitates the planning, development, and maintenance of a responsive, quality, and cost-effective service system to meet the needs of its service recipients, as well as the government agencies and programs serving them. OCFS currently utilizes EIS for Individual Planning Funds, CANS assessment tool, Reportable Events, Grievance, CBH documentation, Mobile Crisis Out of Home Request Form and Transition Process between OCFS Children's Behavioral Health Services and the Office of Aging and Disability Services. Additional projects under development are Contract Reviews and complaints in the system.
- **Advantage ME** is the current State financial information system. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. In addition to the standard accounting functions of accounts payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY14 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health and Human

Services for children, through the Office of Child and Family Services, and for adults, through the Office of Substance Abuse and Mental Health Services.

Children Receiving Publicly Funded Services

OCFS Children’s Behavioral Health Services accounts for the number of children served using Departmental funds by three primary sources: (1) Year-end contract reports submitted to the Office of Quality Improvement by provider agencies that include both general-funded and MaineCare-funded children; (2) Information from internal accounting systems capturing services provided on a per diem basis for children served in residential treatment programs - known as Intensive Temporary Out of Home Treatment Services; (3) MaineCare only funded programs such as Children’s Home and Community-Based Treatment (HCT), Assertive Community Treatment (ACT) and Rehabilitative Community Services (RCS) and supports for children who have emotional/ behavioral needs. Contract services are listed below for FY14, using information reported to OCFS/CBHS field personnel, Office of Contract Management contract administrators, and/or the Office of Quality Improvement for MaineCare services. The Intensive Temporary Out of Home Treatment Services count is derived from residential placements for youth in the care of OCFS, paid through the OCFS budgeted room and board account and reported by OCFS /CBHS Behavioral Health Care Specialists.

Behavioral Health Services

Children Served, by Program Type Under Community Provider Contract FY14

Type of Service	# Served	Type of Service	# Served
Case Management	7,609	Outpatient Services	20,511
Crisis Services Resolution	2,286	Medication Management	5,440
Crisis Stabilization/Residential	665	Parent Self Help/Support	955
Residential PNMI+ Treatment Foster Care	803	Sibling/Peer Support	375
Homeless Services	953	Rehabilitative Community Treatment	3,099
Respite Services	278	Home and Community-based Treatment	3,427
Individual Planning Funds	160	MultiSystemic Therapy (MST)*	627
Functional Family Therapy (FFT)*	159		

TOTAL SERVICES PROVIDED to CHILDREN (FY14) 47,347

Estimation of Unduplicated Count of Children Served

Individual service categories reported above provide an unduplicated count of all children who received that service during FY14. However, when a series of individual service categories are added together, the total represents the number of services delivered to children, and not an unduplicated count of all children served because children are likely to receive multiple services. OCFS Children’s Behavioral Health Services has employed a planning assumption that children and families in Maine receive an average of two different types of service over a year. Based on that assumption, then it is estimated that the unduplicated count of children of served through agreement with OCFS was in 23,673 FY14.

In addition to the National Outcome Measure (NOM), URS Basic Table 2A measure access to services for children and youth who receive MaineCare behavioral health services. In FY14 the unduplicated count of children and youth who received MaineCare behavioral health services was 23,102.

TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS

Outreach to Homeless Youth

The table below illustrates the current services available for youth who are homeless in Maine. The table shows geographic areas where homeless services are now available for youth. The services above were awarded through a competitive bid process. The State of Maine is currently in the process of developing a Request for Proposal for selection of services for State Fiscal Year 2017

<u>PROGRAMS SERVING HOMELESS YOUTH FY16</u>						
Agency	Service Area Focus	Service Type				FY16
		Outreach	Day Drop In Center	Shelter	Transitional Living	Total Funding
Day One	Cumberland county	100,000				100,000
Preble Street Resource Center	Cumberland county	175,000	175,000	118,459		468,459
Opportunity Alliance	York and Cumberland counties	197,047				197,047
Home Counselors Inc.	Lincoln county	46,202				46,202
New Beginnings	Androscoggin county	80,000	75,000	100,550	606,144	861,694
Shaw House	Bangor area	38,907	186,973	106,858	228,053	560,791
FY16 Total funding by service		637,156	436,973	325,867	834,197	2,234,193

STATEWIDE TOTALS, HOMELESS YOUTH SERVICES (includes state general funds and federal grant funds)	2,234,193
--	------------------

Services in Rural Areas

The State of Maine is essentially a rural state when considered in light of its land area, 30,862 square miles, and the total population of 1,328,301 according to the most current estimate of the United States Census (2010), and the distribution pattern of the population within the geographic area, including Maine’s island communities. Given these conditions, for purposes of planning the term “rural” means any area of Maine not identified by the United States Census Bureau to be a Core Based Statistical Areas (CBSAs).

Maine has three primary CBSAs within its border. Maine’s CBSA populations are centered in the Cities of Portland, Bangor and Lewiston-Auburn. The Portland CBSA totals 350,825, the Bangor CBSA totals 129,263, and the Lewiston Auburn CBSA totals 104,505 for a grand total of population of 743,708, or 55.9 % of the total Maine population. This data is based on the most current US Census data for 2010.

The areas of Maine located outside the three CBSA’s are clearly rural. The population living outside Maine’s primary CBSA’s totals 584,593 or 52.73% of the population. A closer examination of the towns that comprise CBSA’s shows a substantial number of towns and villages that are essentially rural in nature. When everyday standards of “rural” or “urban” are applied to the census data for CBSA and Non-CBSA, most Maine people would agree that the SMA total over-represents Maine’s non-rural population.

Overcoming Rural Barriers

The rural nature of Maine has always posed challenges for children and families seeking services. That condition is not likely to change, given the population distribution, the typical distance factors between where people live and where services have traditionally been located, and the lack of public transportation services, except in a handful of cities.

Health Technology/ Tele-Health Given today’s technological possibilities in the area of communication, Maine is beginning to move forward to provide professional behavioral health consultation services using telecommunications as a medium. A first step was the addition of formal rules that recognize tele-medicine as a legitimate medium to provide consultation through broadcast sites that connect the behavioral health professional with another professional (or with a client in a direct service encounter) which is capable of reaching people in remote and or rural areas.

With the involvement of the Medical Director, OCFS has collaborated with and received support from the Office of MaineCare Services in developing a MaineCare policy that now includes tele-psychiatry as a reimbursable Medicaid service. This policy has expanded access to and allows for financial support of psychiatric services for children and their families who are in rural or remote sites, and who would otherwise not benefit from these services.

In FY11, the Department continued work to create and pilot a centralized system for making tele-medicine psychiatric consultation available to primary care physicians statewide, in order to determine its feasibility. The planning for this initiative was directed through a working group co-convened by the Governor’s Office of Health Care Policy and the Maine Health Access Foundation (MeHaf). Maine Medical Center (Portland) applied for and received a grant from Maine Health Access Foundation to pilot the Massachusetts Child Psychiatry Access Project in the mid coast region of Maine.

Telehealth services continue in the State of Maine. Services are to be delivered in accordance to Chapter 1 MaineCare Benefits Manual, Chapter 1 section 1.06-2. <http://www.maine.gov/dhhs/oms/rules/index.shtml> In June 2014 the Maine Board of Licensure in Medicine issued updated guidelines for telemedicine-distance medicine http://docfinder.docboard.org/me/administrative/dw_policy.htm

Increasing Services Statewide

One way to relieve transportation and service access problems is to increase the provider base and bring services closer to families. CBHS provides funding for a wide array of behavioral health services, habilitation services, and family supports in every region of the State of Maine through contracts with private agencies. The table below illustrates the availability of core behavioral health services and supports within the eight districts within DHHS. This data covers all contracted agencies that provided children’s services in Fiscal Year 2015

NUMBER of PROVIDERS LOCATED IN REGIONAL GROUPINGS (FY15)

SERVICE PROVIDED	Number of Providers				Statewide # of Provider Locations by Service
	Statewide Unduplicated # Providers by Service	Region 1	Region 2	Region 3	
Targeted Case Management	69	41	48	31	120
Outpatient Services	71	37	35	33	105
Medication Management	21	8	10	8	26
Rehabilitative and Community Support Services (RCS)	53	25	33	26	84
Children’s Home and Community-Based Treatment (HCT)	38	24	28	23	75
Crisis Services	10	2	6	2	10
Respite Care Services	1	1	1	1	3
Peer/Family Support	6	5	4	5	14
Homeless Outreach	6	3	2	1	6
Assertive Community Treatment	1	1	0	0	1
Number of Provider Locations		147	167	130	444
Unduplicated count of Providers statewide	118				

MANAGEMENT SYSTEMS

The FY16 budget (Allocation Plan) for Children’s Behavioral Health Services shown in the Table below represents state general funds and seed to match MaineCare, and other federal funds (MH Block Grant, and SAMHSA and the ”Now is the Time”-Healthy Transitions Initiative) that are available and allocated for contracts with community service providers to support the behavioral health system of community services.

Department of Health and Human Services; Office of Child and Family Services					
FY16 Behavioral Health Services Funding - Community Services					
Services	General Fund 013607	MaineCare Seed 073117	MH Block Grant 015 Federal	Other 013 Federal	Total
Crisis Resolution	1,855,186	3,174,690			5,029,876
Case Management		7,497,750			7,497,750
CANS /YOQ	64,256				64,256
Behavioral Health Professional Training and Certification				271,153	271,153
Rehabilitative Community Services and Supports (RCS)		20,310,297			20,310,297
Deaf Support (TCM)	98,000				98,000
Family/ Youth support – self help	102,448		775,000		877,448
Home and Community-based Treatment Services (HCT)		11,064,456			11,064,456
Outpatient Services	34,500	8,961,750			8,996,250
Medication Management		1,746,808			1,746,808
Homeless Youth services	594,000				594,000
Mediation	5,000				5,000
Individual Planning Funds	100,000				100,000
Respite	1,500,000				1,500,000
Residential Treatment		9,727,850			9,727,850
Room and Board	3,793,700				3,793,700
NITT -Healthy Transition Initiative				999,302	999,302
Mental Health Advisory Board			7,500		7,500
Grand Total	8,147,090	62,483,601	782,500	1,270,455	72,683,646

The FY16/17 allocation plan for the portion of the Block Grants for Community Mental Health Services dedicated to children services is shown in the Table below. Maine utilizes these funds to address the needs of children who have serious emotional disturbance and their families.

CBHS BLOCK GRANT FOR COMMUNITY MENTAL HEALTH SERVICES ALLOCATION SFY 2016		
VENDOR	SERVICE	AMOUNT
To be selected competitive bid ,State of Maine RFP #201505089	Family Support Statewide Network	\$ 250,000.00
To be selected competitive bid ,State of Maine RFP #201505089	Youth Support Statewide Network	\$ 225,000.00
To be selected competitive bid ,State of Maine RFP #201505089	Transformational Grant (up to 6 awards to be made)	\$ 300,000.00
OTHER		
Maine Medical Center	PIER PROGRAM	\$ 37,536.00
Quality Improvement Council	State Mental Health Advisory Board - operations	\$ 7,500.00
		\$ 820,036.00

Intended Use of CMHS Block Grant Fund

In accordance with the scope and requirements of PL 102-321 CMHS Block Grant funds are requested for community behavioral health services, with special emphasis on alternatives to inpatient hospitalization. Funding requested for support to community-based programs is compatible with the direction established by A Plan for Children’s Mental Health Services, as directed and accepted by the 118th Maine Legislature.

Distribution of federal funds under the CMHS Block Grant is implemented through decisions made by the Department in consultation with the Statewide QIC Children’s Committee. The Office of Child and Family Services issues contracts with specifications for all services, including conformance with all PHS Act requirements and applicable service conditions of the CMHS Block Grant. DHHS Contract Management contract administrators monitor contracts through quarterly and year-end fiscal and narrative reports from service providers.

The Block Grant for Community Mental Health Services distribution among specific contracts are made at the central office level, using rationale that identify programs that serve children that are not covered by MaineCare and those which provide services to children who are not eligible for MaineCare funding. More recently, a third consideration is to use of the Block Grant for Community Mental Health Services funds for initiatives that are transformational in nature and directly benefit children with serious emotional and behavioral issues, and their families.

Limitations for Expenditure of Block Grant Funds

Maine law M.R.S.A. Title 34-B offers guidance on the distribution of these federal funds. Section 15003.5.C. states that “(all child serving) departments shall shift children’s block grant funding toward the development of a community-based

mental health system that includes developing additional community-based services and providing care and services for children who are not eligible for services under the Medicaid program. The departments shall maximize the use of federal funding, the Medicaid program, and health coverage for children under the (State Children’s Health Insurance Program).”

Background to Strategies for Investment of Block Grant Funds

The Department fully endorses future Block Grant strategies for investment that are consistent with the resource development priorities contained in the Plan for Children’s Mental Health Services, which is a stakeholder driven plan for developing a community-based children’s mental health system, and by Maine legislation, Chapter 790, both of which were shaped with substantial parent and family input. In this context, the Department supports the following strategies for investment of block grant funds:

1. Use block grant funds within the parameters established under Chapter 790. Funding should be directed for services to children and families who are not eligible for MaineCare services or for services that are not Medicaid reimbursable, such as respite care and family support.
2. Within the parameters of Chapter 790, use block grant funds to supplement services provided with state general funds, where the demand for service surpasses the current capacity to meet established needs. This strategy would identify current service areas that are of established high priority, and for which children and families are not being served, or are underserved, as shown by waiting lists for service or other documented sources of information.
3. Secure input from the QIC Children’s Committee with regard to service areas that are seen as a priority and should be considered for purposes of block grant investment. In prior years the committee recommended family support, peer support and child transition services to adult services as priority areas. In addition to the family support initiatives noted above, these funds were also dedicated for implementing regional family support planning and to supplement respite care services in southern and central Maine.
4. Recently the offices of Substance Abuse and Mental Health Services and Child and Families Services issued RFP ##201505089 titled Peer Supports and Services . Final proposals were due August 18, 2015. It is expected that service agreement will be in place by January 1, 2016.

Section I. State Information

Section II. Planning Steps

Step I: Assess the strengths and needs of the service system to address the specific populations.

Overview and Organizational Structure of the Public Behavioral Health System in Maine

Maine's Department of Health and Human Services' office of Substance Abuse and Mental Health Services (SAMHS) provides statewide leadership in defining, measuring and improving the Quality of services and supports to adults with serious mental illness. In September 2012, the Office of Substance Abuse and the Office of Adult Mental Health Services were merged to form *one* state agency; Substance Abuse and Mental Health Services (SAMHS). The rationale for this change was to bring the various behavioral health agencies in the state together to further integrate and provide a more holistic milieu of services and support to the people of Maine. The new organization consists of the office of the Director's office and three Associate Directors. The five (5) Pillars under SAMHSA include 1) Prevention and 2) Intervention; 3) Treatment and 4)Recovery; and 5) Data, Quality Management, and Resource Development.

The State of Maine operates the public behavioral health system under the guidance of the consent decree that was established in 1988. The consent decree requires the State of Maine to meet established goals or measures listed out in detail as part of the document that makes up the consent decree. The State reports on those measures to the court master on a quarterly basis. As a partial result of the consent decree, SAMHS, itself, has minimal provision of direct client services, rather, SAMHS contracts out MH direct services to independent MH agencies across the state. As such, SAMHS role is to provide leadership in the realm of Prevention, Intervention, Treatment and Recovery from addiction and/or mental illness, to individuals, their families, and the community. SAMHS, in collaboration with all state agencies and community partners, develops, monitors, and improves the lives of those affected by addiction and mental illness across the lifespan.

Operating from a recovery-orientated framework, direct services provided by contracted agencies, include peer-to-peer services, intensive case management, outreach through community workers, and outpatient counseling. All community mental health providers contracted with SAMHS are "co-occurring capable," and DHHS is striving to have all providers integrate mental health and substance abuse services into their practices. DHHS's MaineCare Services (state Medicaid program) created and launched the first state of its Health Homes initiative for members in chronic condition in January 2013. Building off the Maine multi-payer Patient Centered Medical Home model, starting April 1, 2014, the Department launched Behavioral Health Home services to manage the physical and behavioral health needs of eligible adults and children. Both organizations receive a per member, per month (PMPM) payment for Health Home services provided to enrolled members. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community mental health providers.

In addition, SAMHS supports a Housing First model that has been successfully incorporated into mental health and substance abuse authorities in several other states.

SAMHS contracts with community-based agencies for the provision of residential supports and services, medication management, Medication Assisted Treatment (MAT), crisis services, Assertive Community Treatment (ACT), daily living supports, peer supports and other services essential to recovery. All services and supports are designed to increase the ability of each consumer to live and thrive in his or her chosen community.

In addition to the two state-operated psychiatric facilities, Maine has six private hospitals with dedicated psychiatric units, and two private psychiatric hospitals that partner with SAMHS to provide inpatient treatment as close to an consumer's home community as possible. Through the state funded Bridging Rental Assistance Program (BRAP), SAMHS provides rental supports for consumers being discharged from these hospitals as well as residential treatment options. These Olmstead friendly housing vouchers provide consumers with choice, independence, and control over where they live and what services they choose to receive, while simultaneously providing the hospital system and residential treatment facilities with the ability to facilitate discharges in a timely manner.

Those in the Mental Health Treatment and Recovery communities know that two of the most effective tools to support individuals recover from mental illness or addictions are a home and a job. In addition, systems of care recognize that access to safe, decent, and affordable housing is a medical necessity for many persons with disabilities. In Maine, SAMHS supports the provision of housing and jobs by:

1) Promoting independent housing vouchers which represent a foundation of recovery and hope.

- To the greatest extent practicable, SAMHS allocates tenant-based housing vouchers which empower consumers and enhance individual choice, independence, and allow the consumer to control their housing and the amount and type of services they choose receive.
- Independent housing vouchers deliver real therapeutic value; promote consumer empowerment; support both civil and disability rights; and are demonstrated to be radically cost effective when compared to high cost, high intensity, institutionalized care.
- Vouchers can be used in either the community or group settings—at the consumer's discretion. Independent housing vouchers are a logical extension of the concept, Money Follows the Person, in which the consumer directs their own care, and in this case, their housing as well.

2) Prioritizing employment services as essential to recovery and community integration.

- The services provided are highly individualized and, to every extent possible, tailored to meet the consumer’s needs.
- State funds are supplied to supplement federally funded vocational programs in order to enhance SAMHS capacity to serve consumers currently on waiting lists.
- SAMHS coordinates funding and programming opportunities with sister agencies such as the Department of Labor, and Office of Aging and Disability Services.

SAMHS strongly supports the Recovery process and has designed our office to specifically include Recovery as one of our pillars. Recovery Supports available and accessible include Recovery Coaching Training and Recovery Coaching, Recovery Peer Support Centers, statewide warm line, recovery telephone support, a peer crisis respite program, supported employment, clubhouses, long-term vocational support, peer support in emergency departments in some hospitals, peer support at Riverview Psychiatric Center, the Stability Through Engagement Program (STEP) housing program and an Intentional Peer Support Training and Certification Program. Many of these supports are designed to be low-barrier and easily accessible for individuals.

Local and regional entities that provide services funded by the Mental Health Block Grant include:

SAMHS Community Mental Health Services Block Grant Allocation SFY 2016		
Vendor Name	Service	Amount
Aroostook Mental Health Services, Inc.	Community Integration	22788.00
Aroostook Mental Health Services, Inc.	Transportation	26978.00
Aroostook Mental Health Services, Inc.	Crisis Stabilization - Mobile Response	5281.23
	VENDOR TOTAL	55047.23
Catholic Charities Maine	Community Integration	27850.00
	VENDOR TOTAL	27850.00
Community Health & Counseling Services	Community Integration	26323.00
Community Health & Counseling Services	Crisis Stabilization - Mobile Response	34740.75
	VENDOR TOTAL	61063.75
Kennebec Valley Mental Health Center and Kennebec Behavioral Health	Medication Services	54745.65
	VENDOR TOTAL	54745.65

Maine Medical Center	Portland Identification and Early Referral Program	50558.82
	VENDOR TOTAL	50558.82
Shalom House, Inc.	Community Integration	27850.00
	VENDOR TOTAL	27850.00
Maine Association of Substance Abuse Programs	Resource Development	32548.50
	VENDOR TOTAL	32548.50
Maine Behavioral Healthcare	Community Integration	103234.00
Maine Behavioral Healthcare	Medication Services	16578.00
Maine Behavioral Healthcare	Crisis Stabilization - Mobile Response	6802.00
	VENDOR TOTAL	126614.00
Sweetser	Community Integration	115024.72
Sweetser	Medication Services	23019.16
	VENDOR TOTAL	138043.88
Syntiro	Fiscal Agent for QIC	7500.00
	VENDOR TOTAL	7500.00
Tri-County Mental Health Services	Community Integration	63834.47
	VENDOR TOTAL	63834.47
OTHER (TBD)	Peer Support RFP - MHBG Place Holder	225000.00
OTHER	Crisis RFP Placeholder	45019.47
OTHER (SAMHS)	Resource Development	32548.50
	GRAND TOTAL	948224.00

SAMHS has made a commitment to set aside a minimum of 25% of its allocation towards supporting Peer related services in the SFY 2016-2017 MHBG application. SAMHS envisions a continuum of Peer related services and supports funded by a variety of measures which could include: State General Funds, SAMHSA Block Grant Funds, as well as Medicaid funding. Currently, agencies receiving Block Grant funding through SAMHS are focusing on serving the uninsured and those services not covered by other insurance. Maine is unique in that 50% of its state Block Grant funds are dedicated to prevention activities which are administered through

the state Office of Children’s and Family Services—a description of these services is included later on in this section of the document.

SAMHS provides Intensive Case Management (ICM) services to individuals with mental illness who are incarcerated. The goal is to provide individuals, who are integrating back into community, immediate intervention and connections to established services with coordinated discharge planning.

A significant partner of DHHS is the Maine Health Access Foundation (MEHAF). MEHAF is a national leader in Integrated Behavioral Health Care with their priorities focused on: Advanced Health System Reform, promoting patient centered care, improving access to quality care and achieving better health in the community. Maine’s Mental Health agencies are partnering with MEHAF to improve the integrated behavioral and physical health to their communities and individuals they serve. For example, Tri-County Mental Health Agency has its behavioral health professionals working in primary care offices across its service region. Behavioral Health professionals are on-hand to assist immediately when a doctor realizes a patient might benefit from counseling about lifestyle changes. They can offer depression counseling or connect patients with other needed mental health services.

Maine’s DHHS Office of Continuous Quality Improvement (OCQI) is involved in the AHRQ/DHHS Multiple Chronic Conditions (MCC) project, an epidemiologic study of utilization, cost, quality of care, and outcomes for long-term, MaineCare members with multiple medical co-morbidities and behavioral health disorders. OCQI provides snapshot data from this project to the community on an ongoing basis.

To address the unmet need of Older adults with SMI , SAMHS supports Gero - Psych Services and Specialized Nursing Level Care involving three facilities : Mount St. Joseph’s- Waterville- 18 Nursing Care Beds, 16 Residential Care beds; Hawthorne House- Freeport- 18 Beds and Gorham House- Gorham- 17 Beds. Utilization Review Nurses collaborate with APS Healthcare on resident admissions and discharges. SAMHS also has a Pre-admission Screening and Resident Review (PASRR) and Complex Case Mix Group under Treatment. The Pre-admission Screening and Resident review program seeks to ensure that individuals who are otherwise eligible for care in a nursing facility (NF) and who also have a mental illness, intellectual disability, or other related conditions, receive the additional care necessary to meet their individual needs. PASRR is a required process before any admission to a nursing facility. Screening is required regardless of the source of payment and whether or not mental illness, intellectual disability or other related condition is known or suspected.

The Complex Case Mix Group under Treatment administers “ complex cases” which are cases that require integrated case management to facilitate access to effective treatment, keep costs reasonable, address unmet needs, and promote informed decision making by the individual and the agencies involved. Individuals referred either do not meet categorical eligibility requirements, or their unmet needs are so complex that they cut across multiple office

services. Individuals with complex needs may have impairments in physical, intellectual, cognitive, and emotional functioning and/or serious medical diagnoses, compounded by major social, psychological, legal, environmental or financial issues. Integrated services coordination involves collaboration with individuals, state agencies, provider agencies, families and physicians. The goal is to provide a comprehensive approach, wherein all the person's needs are coordinated via a multidisciplinary team.

To address the SMI/SED in rural or homeless populations, SAMHS administers the PATH program (Projects for Assistance in Transition from Homelessness). The PATH statewide program has been re-designed to more effectively target the rural SMI literally homeless populations in the state. Conducting outreach to the extremely rural homeless populations and ensuring access to services among the same population is a complex issue, and has been reorganized within SAMHS under Resource Development to align it with SAMHS housing resources, the state funded Bridges for Rental Assistant Program (BRAP) and HUD Shelter Plus Care Programs. The PATH program measures the following resources on individuals enrolled in the program: housing, medical, behavioral health or mental health resources or a veterans Administrative Service resource as well employment/education. Maine's PATH program mandates utilization of Homeless Management Information System (HMIS), an electronic data system which tracks and documents homelessness across the United States and in Maine. Maine's PATH program mandates utilization of this system for all persons who receive both outreach/engagement services as well as PATH Enrolled services. Maine is committed to ending homelessness, especially among individuals with SMI, with \$ 1,041,182.00 committed as a state match to the \$300,000 PATH Block Grant Funds.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system.

Through the Consent Decree, SAMHS’s mental health service infrastructure has been designed to identify and respond to unmet service needs before they can develop into “critical service gaps.” The new Office of Data, Quality Management, and Resource Development (DQMRD) and the Office of Continuous Quality Improvement (OCQI) work together on data collection systems to provide a continuous source of information upon which sound policy and program decisions are based and implemented. Each of these components of the SAMHS service infrastructure comprises an important part of the whole of what has developed into an increasingly sophisticated data collection system.

SAMHS consults with and is advised by family and consumer organizations including the Statewide Quality Improvement Council (QIC), the Consumer Council System of Maine, the Advocacy Initiative Network (AIN), NAMI-Maine, and other groups. Our relationship with each of these groups is highly valued. We are currently working within SAMHS and Maine CDC to reach out to the Maine Tribal communities to develop a relationship, and an invitation to join the QIC has been extended. We have also incorporated into the SAMHS home page of our website the opportunity for anyone to review and comment on Maine’s Block Grant application.

Input from multiple and diverse sources provide a critical benchmark against which the validity of our data is assessed and refined in a Quality Improvement cycle. As has been previously noted, Maine is geographically expansive and demographically diverse. Service delivery challenges in the more populated, urban areas of south and south-central Maine often differ from those in the other, more rural regions of the state. In order to capture these variances, unmet need data is compiled by county then tabulated statewide. Recent data indicate the following statewide unmet need areas for 4th quarter state FY 2014:

Reported Unmet Resource Needs	2014 Q1	2014 Q2	2014 Q3	2014 Q4
7a. Mental Health Services	1,129	1,153	1,079	1,229
7b. Mental Health Crisis Planning	245	266	258	274
7c Peer, Recovery, and Support	344	365	369	375
7d Substance Abuse Services	93	113	98	106
7e. Housing	1,052	1,053	918	1,017
7f. Health Care	1,227	1,254	1,112	1,158
7g. Legal	169	154	167	158
7h. Financial Security	730	766	701	830
7i. Education	314	312	273	306
7j. Vocational / Employment	454	489	469	506
7k Living Skills	317	343	319	378
7l. Transportation	771	749	669	767
7m. Personal Growth/Community	387	427	398	409

Other Resources	173	184	150	171
Total Statewide Unmet Needs	7,551	7,793	7,158	7,848
Distinct Clients with Unmet Needs	2,778	2,773	2,483	2,696
Distinct Clients enrolled in Case Management Services	10,247	10,361	9,132	9,847

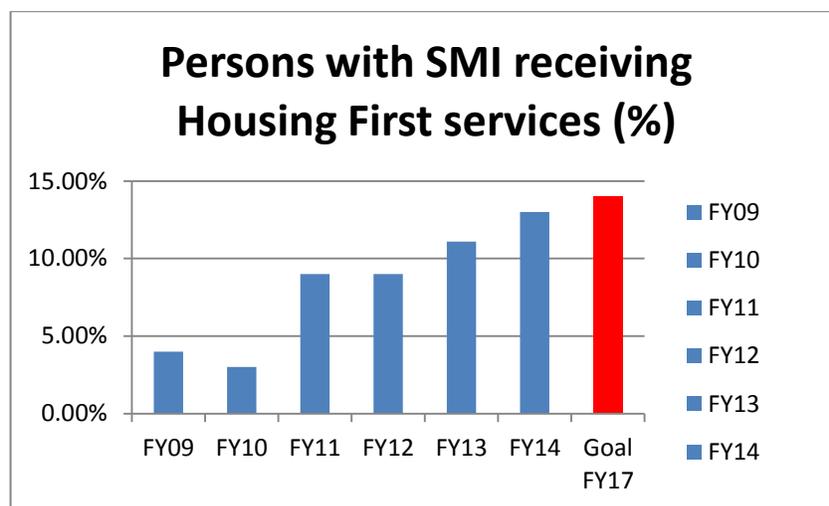
The following table, from the Kaiser Family Foundation website, demonstrates Maine’s long standing commitment to serving the uninsured. At this time, Maine has not undergone any Medicaid Expansion initiatives.

Health Insurance Coverage of the Total Population, 2013

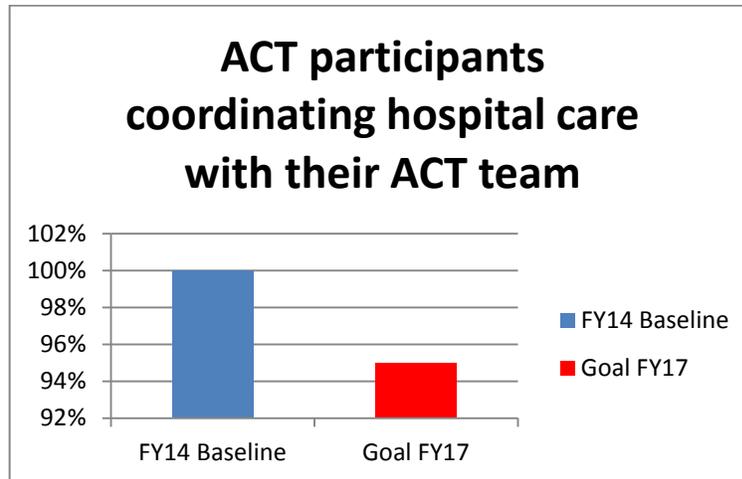
Location	Employer	Other Private	Medicaid	Medicare	Other Public	Uninsured	Total
United States	48.2%	6.0%	15.6%	14.7%	2.0%	13.4%	100.0%
Maine	46.3%	5.0%	19.7%	17.3%	1.9%	9.6%	100.0%

SAMHS continues to evaluate traditional outcome measures reported in the MH Block Grant, as well as building on our newly adopted measures in the 2014/2015 MH Block Grant: Promotion and support of evidence based practices (Assertive Community Treatment) and Promotion and support of promising practices (Behavioral Health Home Model). The following are outcome measures that depict outcome measures from FY2009 to FY2014 and targeted outcomes for FY2017.

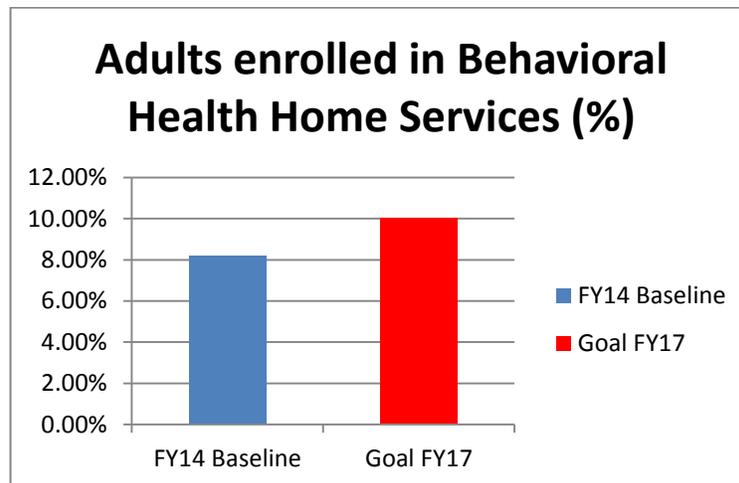
- **Adult: Promotion and support of evidence based practices** --Increased the percentage of persons with SMI receiving Housing First services from 12.5% to 14% by the end of FY17



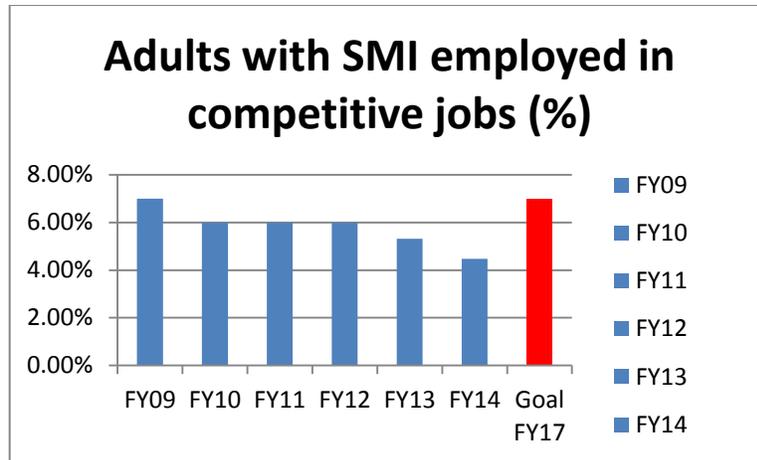
- Adult: **Promotion and support of evidence based practices** - 95% of ACT participants coordinating hospital care with their ACT Team by the FY17 (Baseline data showed 100% participated)



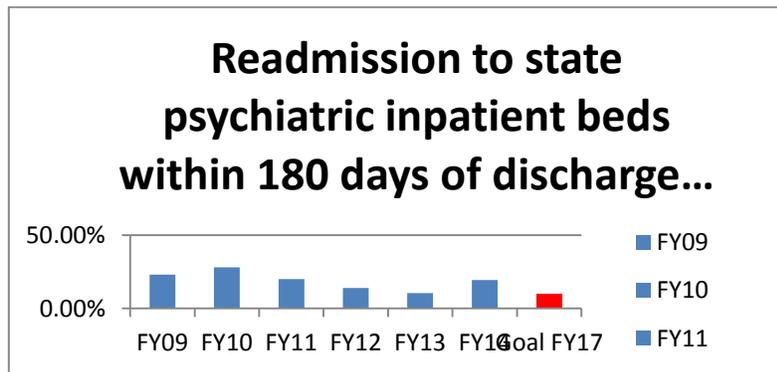
- Adult: **Promotion and support of promising practices** --Increased percentage of adults enrolled in Behavioral Health Home Services from 8.2% to 10% by the end of FY 16



- Adult: **Promotion and support of evidence based practices** --Increased percentage of adults with SMI employed in competitive jobs from 4.47 % to 7% by the end of FY17



- **Adult: Prevention and Wellness** -- Reduced percentage of readmission to state psychiatric inpatient beds within 180 days from 14% to 10% by the end of FY17



- **Adult: Increase Access and Capacity**--Decreased the number of person with SMI on the waitlist to CI services by 25% by the end of FY17

SAMHS and its partners are actively engaged in various transformational initiatives to address unmet service needs, particularly around the issues of collecting, analyzing, and reporting on client identifiable data. This ongoing effort may require a systems change approach. It will involve all parties mentioned above, in addition to an analysis of Federal and State confidentiality policies, rules, and statutes. Subsequently, a substantial investment of time and dollars may need to be spent on future implementation of information technology solutions.

SAMHSA conducted an onsite review of Maine’s behavioral health system in the summer of 2012. This visit resulted in a request for technical assistance from SAMHS which consists of:

- assistance regarding Strategic Planning for integration of SAMH services;
- assistance understanding, reviewing, and possibly developing data systems that will help gather, collect and utilize better data; and
- assistance reviewing and educating on regulations related to data integration between substance abuse and mental health.

STEP 2 IDENTIFY UNMET NEEDS AND CRITICAL GAPS

Summary Statement on Strengths and Needs

It has been the practice of OCFS/Children's Behavioral Health Services to identify system needs each year and to include the most pressing and significant of those needs in the priorities section of the Block Grant for Community Mental Health Services application/ plan. Progress and outcomes for these areas and topics are accounted for in the subsequent plan.

Sources of Data and Information in this Application

The FY16/17 Block Grant Application and Plan relies on statistical data and information that are critical to indicate performance and outcomes that indicate progress in an action plans. OCFS Behavioral Health Services for Children utilize the following sources of data and information:

- **Year End Contract Reports** Office of Child and Family Services (OCFS) contracts with providers to deliver all community-based behavioral health services. Providers report performance data, numbers served and a variety of quality improvement indicators on a quarterly basis. State Fiscal Year (SFY) 4th quarter (year-end) reports are a major source of data used by the Department, and are referenced in this application. Contract reports show unduplicated counts of children served for the particular service component under contract. However, when different types of services are added together, the total number is a duplicated client count.
- **Maine Integrated Health Management Solution (MIHMS)**
This is the current MaineCare claims management system that replaced the MECMS system. MIHMS is also a MaineCare claims payment system and has the capacity to generate reports on program costs and unduplicated counts of individuals served.
- **Enterprise Information System (EIS)** The Maine Department of Health and Human Service began using the Enterprise Information System in 2002. It is a comprehensive and integrated information system that supports planning, management, and quality improvement for all aspects of the department's operations across all its categorical services, including adult mental health, children's services, and adult intellectual disabilities. This integrated information system facilitates the planning, development, and maintenance of a responsive, quality, and cost-effective service system to meet the needs of its service recipients, as well as the government agencies and programs serving them. OCFS currently utilizes EIS for Individual Planning Funds, CANS assessment tool, Reportable Events, Grievance, CBH documentation, Mobile Crisis Out of Home Request Form and Transition Process between OCFS Children's Behavioral Health Services and the Office of Aging and Disability Services. Additional projects under development are Contract Reviews and complaints in the system.
- **Advantage ME** is the current State financial information system. It is an Enterprise Resource Planning (ERP) system specifically designed to support the functions performed by the State of Maine. In addition to the standard accounting functions of accounts payable, accounts receivable, and general ledger, Advantage ME also performs the specialized functions of encumbrance control, fund accounting, grants and project management. Advantage ME incorporates a variety of business functions, such as budgeting, general accounting, cost accounting, accounts payable, procurement, treasury, and accounts receivable, resulting in a single, integrated system that addresses the key financial management processes that the State of Maine needs. Advantage ME generated FY15 data used to calculate and document the State's total current expenditures for all mental health services provided by the Department of Health and Human Services for children, through the Office of Child and Family Services, and for adults, through the Office of Substance Abuse and Mental Health Services. These expenditures are the source for reporting the State's general fund contributions to the maintenance of effort data that is required by CMHS and reported Block Grant for Community Mental Health Services application and plan.

Service Gaps and Unmet Needs

Currently APS Healthcare, our states ASO, Administrative Services Organization provides Behavioral Health Utilization Management and generates data to track children who have requested, are waiting for and who are utilizing case management services, community behavioral health treatment services and rehabilitative community services, and Intensive Temporary Residential Services. OCFS receives data on a weekly basis. Service utilization, wait list data, outcomes, service gaps and trends are examined by OCFS staff and OCFS and APS Healthcare meet regularly to review, discuss and make changes as needed.

Identifying needed services come from district level resource development activities and from ongoing discussions among Maine's child-serving state agencies. Some examples of the identification of needs and services that were developed in recent years resulted from discussions with the service provider community and through interdepartmental collaboration were: crisis services for children with mental retardation and autism, transitional processes from hospitals to home and local schools, and development of specialized inpatient capacity for children with Intellectual Disabilities or Autism.

As a new fiscal year begins, Children's Behavioral Health Services staff discusses possible systems needs and service gaps that are not already addressed as action targets under the current Block Grant for Community Mental Health Services priorities. These needs tend to be continuing in nature due to funding constraints or institutional barriers, which would require legislative action to ameliorate. Examples are:

- Systems issue in the transition of children with mental retardation or autism who are at risk of being found ineligible for adult mental retardation services. The risk factor may affect children whose intellectual quotient score is at or slightly above 70. Different transitional issues face youth who seek services from the Office of Substance Abuse and Mental Health Services (SAMHS).
- Children with Asperger's disorder who are lost in the transition to adult services, due to the lack of specific inclusion of this disability in Maine legislation.
- Services for children who are medically fragile and who have behavioral health needs.

In July, 2014 CMS issued a memo stating that states will provide treatment for Autism for children within state plans. With this CMS guidance, OCFS made the decision to not pursue a children's waiver. Instead, OCFS is working with the Office of Maine Care to write a preventative state plan amendment that will add Protective oversight and supervision which is now an allowable service within rehabilitative services for children in the community and residential treatment. Respite services are provided by a private agency and is paid for by state general dollars.

Children's Behavioral Health Services has focused on extensive service development to address wait time issues in the area of case management, behavioral health treatment services, and rehabilitative community services, and supports, wait times for these services will continue to be monitored in FY16/17.

Two years ago Children's Behavioral Health Services developed a two-year strategic plan which has guided services based on the identified the following goals: 1) To provide youth and young adults with a seamless transition from child serving systems to adulthood, with opportunities for meaningful participation in their communities; 2) Improvement of the overall quality and effectiveness of community-based children's behavioral health services through the work of the CQI Program, which reviews data and other sources of information in order to recommend changes to policy, practice, and system design. 3) Identify children with behavioral health needs and provide effective services at the earliest point possible, using evidence-based

practices and clinically-appropriate interventions, to mitigate the effects of behavioral health disorders and improve overall health outcomes and 4) Achieve a trauma informed integrated child and youth serving system.

Building upon the work our previous plan below is an overview of the objectives related to Children's Behavioral Health services from the current Office of Child and Family Services STRATEGIC PLAN; for January 2015- June 2016

STRATEGIC GOAL #1: IMPROVE STABILITY, HEALTH AND WELL-BEING, AND QUALITY PERMANENT CONNECTIONS OF INDIVIDUALS AND FAMILIES.

OBJECTIVE #2: Increase access to evidence based children's behavioral health services.

Desired Outcomes:

- Increase by 10% the number of children who receive evidence based practice.

Critical Action Steps:

- Research evidence based programming and best fit models for Maine and continuation of CBT+ pilot/ grant.
- Develop policy recommendations in partnership with OMS for Sections 97, 65 and 28 and organize stakeholder input.
- Explore use of a Single Assessing Agency.
- Develop evaluation tools to measure outcomes and efficacy.
- Develop and implement a clinical review process and protocol for residential treatment

STRATEGIC GOAL #2: IMPROVE SAFETY OF YOUTH, FAMILIES, AND COMMUNITIES.

OBJECTIVE #2: Increase effectiveness of residential treatment to allow youth to return home.

Desired Outcomes:

- Proportion of youth discharged from residential treatment that go directly to a home setting increases from 40% to 60%.

Critical Action Steps:

- Review and analyze the current "findings" protocol, laws and practice within Maine. Make recommendations on best practice and amendments to the rules. Including the high use for 'indications' and 'emotional maltreatment'.
- Promulgate new "findings" rules and prepare for legislative bills accordingly.
- Implement a real-time quality assurance practice such as Rapid Safety Feedback.
- Engagement with the districts on the Child and Family Services federal plan reviews with measurable improvements in voice recordings, family share practice, relative searches, and health assessments.

OBJECTIVE #4: OCFS will conduct oversight and monitoring on internal and external services utilizing desk reviews, site reviews, and contract compliance.

Desired Outcomes:

- 100% of all appropriate information will be referred to PIU.
- RFP's and contracts will have clear performance measures.
- Provider visits and reviews in partnership with other DHHS offices.

Critical Action Steps:

- Create a finance team within OCFS.

- Create a QA work plan for the next 18 months including review protocols and rapid response protocols.
- Provide clarity around the roles of finance and the role of quality assurance/ management activities to internal staff.
- Integrate performance measures into Maine Care policy and contracted services in partnership with DCM and OCQI.
- Dissolve zero-dollar contracts and move all compliance measures into Maine Care policy.
- Develop budget projections, variance reports and fiscal goals for OCFS spending including Maine Care funding.

STRATEGIC GOAL #3: IMPROVE ALL CHILDREN’S ABILITY TO TRANSITION SUCCESSFULLY TO ADULTHOOD.

OBJECTIVE #2: Improve all children’s ability to transition successfully to adulthood through identification, planning, and employment services.

Desired Outcomes:

- 100% of all youth currently identified with a developmental disability will have a transition plan initiated at age 16 to be completed and entered into EIS by age 18.
- 100% of all youth with severe and persistent mental illness will have a transition plan initiated at age 16 to be completed and entered into EIS by age 18.
- 100% of youth aging out of foster care will have a transition plan completed by age 18.

Critical Action Steps:

- Integration of CBHS policies with transition opportunities including the role of employment services and career exploration.
- Coordination with OADS and SAMHS on the operations of the district teams and overall monitoring of the youth in transition.
- Development of monthly reports and easy tracking mechanisms to follow the youth.
- Implementation of the online system through EIS in partnership with OADS.
- Creating state agency workgroups with DOE, DOL and DOC to insure collaboration and coordination of transition issues.
- Research and deployment of a person-centered planning process.
- Development of a case management manual.

STRATEGIC GOAL #4: ENSURE EFFICIENT USE OF RESOURCES THROUGH ADEQUATE OVERSIGHT TO ACHIEVE QUALITY OUTCOMES.

OBJECTIVE #2: Select and implement a clinical outcome measure with demonstrated reliability and validity in outpatient treatment and HCT.

Desired Outcomes:

- 100% of Outpatient and HCT Provider Agencies will use the Youth Outcome Questionnaire (YOQ) consistently.
- Expectation of usage and reliability change index will be established.

Critical Action Steps:

- Consideration of a Value Based Purchasing Strategy, in conjunction with Section 28.
- Selection and review of possible tools and instruments.
- Policy revisions to the CBHS services within OCFS.
- Stakeholder review and input on changes.
- Training and deployment plan for direct care works and BH agencies.

- Establishment of an evaluation of the fidelity of the service and tool.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Planning Steps

Quality and Data Collection Readiness

Questions for CLD readiness answered:

1. Maine's mental health data collection system is currently fragmented across various data sources, including, Medicaid, EIS, HMIS, APS software systems, and our own Data and Research division in SAMHS. Data collected is at the individual level and can be reported at the client level and other aggregated levels.
2. The State has a separate data collection system for TDS data (FEiWITS) which is separate from the fragmented MH data collection "systems".
3. The State is currently able to report data out by number of clients served.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Adults with Severe and Persistent Mental Illness
Priority Type: MHS
Population(s): SMI (Homeless)

Goal of the priority area:

Increase the percent of homeless persons with SPMI receiving Supported Housing Services

Objective:

By the end of year 2 of this grant, the percentage of homeless persons with SPMI receiving Supported Housing Services will be increased by .05 %.

Strategies to attain the objective:

Targeted services to rural and homeless populations; continue to develop strategies to accurately document the numbers of homeless individuals with SMI who need services in Maine; continue to develop more reliable data that can be used as a baseline for comparison years; maintain or increase current level of funding for Maine's Substance Abuse and Mental Health Services support of programs that service mentally ill individuals.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase the number of homeless persons with SPMI receiving Housing First Services
Baseline Measurement: In FY14, 1, 561 persons with SPMI received Housing First Services
First-year target/outcome measurement: By FY16, 1,639 persons with SPMI will receive Housing First services (.05%)
Second-year target/outcome measurement: By FY 17, 1,721 persons with SPMI will receive Housing First services (.05%)

Data Source:

Legacy Housing Database

Description of Data:

Persons enrolled in Supported Housing Vouchers, BRAP, and Shelter Plus Care

Data issues/caveats that affect outcome measures::

Potential growth in the number of person with SMI superseding the number of additional housing resources.

Priority #: 2
Priority Area: Adults with Severe and Persistent Mental Illness
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Reduce readmission to state psychiatric inpatient beds within 180 days of discharge

Objective:

By the end of this 2 year grant period , 10% of individuals with SPMI will be readmitted into state hospitals in patient beds within 180 days of discharge.

Strategies to attain the objective:

Development of a Comprehensive Community Based Adult Mental Health System. State psychiatric hospital with continue to promote recovery planning for patients including strengthening connections with community providers and enhance discharge planning activities such as coordinating housing placements; foster active involvement of consumers in the planning and delivery of treatment and recovery based services; ongoing utilization review of admissions and discharges and treatment planning including readmission data from all hospitals with psychiatric beds.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Reduce number of individuals with SPMI readmitted to state psychiatric hospital inpatient beds within 180 days of discharge
Baseline Measurement: FY14, 64 individuals with SPMI were readmitted into state psychiatric hospital inpatient beds within 180 days of discharge (19.5%)
First-year target/outcome measurement: By FY16, 50 individuals with SPMI will be readmitted into state psychiatric hospital inpatient beds within 180 days of discharge (15%)
Second-year target/outcome measurement: By FY17, 33 individuals with SPMI will be readmitted into state psychiatric hospital inpatient beds within 180 days of discharge (10%)

Data Source:

DIG Legacy Survey
Currently using MaineCare data.

Description of Data:

This is an existing measurement within our system

Data issues/caveats that affect outcome measures::

Resources available to promote timely discharge include both state and federal funds

Priority #: 3
Priority Area: Adults with Severe and Persistent Mental Illness
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Increase access to Community Integration by reducing waitlists

Objective:

By the end of this 2 year grant , reduce the percentage of individuals with SPMI on the CI waitlist to 25%.

Strategies to attain the objective:

Promote best practices; maintain and improve a performance based, accountable, and transparent system; foster active involvement of consumers in the planning and delivery of treatment and recovery services; prepare service utilization data related to financial expenditures in order to inform DHHS- Administration, relevant legislative committees- Appropriation and Financial Affairs and Human Services.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase CI Access for Adults with SPMI by reducing waitlists
Baseline Measurement: FY 14, 805 Adults with with SPMI are currently on the waitlist for CI services
First-year target/outcome measurement: By FY 16, 685 Adults with SPMI will be on the waitlist for CI services (15%)
Second-year target/outcome measurement: By FY 17 , 605 Adults with SPMI will be on the CI waitlist (25%)

Data Source:

SAMHS MH Data/APS Health Care

Description of Data:

This is an existing measurement within our system to monitor the waitlist for Community Integration

Data issues/caveats that affect outcome measures::

Availability of state and federally funded resources

Priority #: 4
Priority Area: Adults with Severe and Persistent Mental Illness
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Increase number of individuals with SPMI who are employed in competitive jobs

Objective:

By the end of the 2 year grant , the percentage of individuals with SPMI in competitie jobs will increase by 7%.

Strategies to attain the objective:

Continue to fund and increase the number of employment specialist positions state wide, as well as the continued support of training in employment practices for community support workers; develop consistent collection strategy that captures employment data cross all recipients. Support and promote best practice regarding the ACT Fidelity Standards which support competitive employment.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase number of Adults with SPMI will be employed in competitive jobs.
Baseline Measurement: FY14, 547 Adults with SPMI were employed in competitive jobs (4.7%)
First-year target/outcome measurement: By FY16, 33 Adults with SPMI will be employed in competitive jobs (6.0%)
Second-year target/outcome measurement: By FY17, 38 Adults with SPMI will be employed in competitive jobs. (7.0%)

Data Source:

Enterprise Information System (EIS)/Adult Well Being Survey/Contract Performance Measures

Description of Data:

Performance measures from employment related contracts as well as data obtained electronically through our and our partner's data systems.

Data issues/caveats that affect outcome measures::

Data systems have improved, however, Maine's economy has not yet kept pace with the nation, which impacts employment statistics for SMI populations to an even greater extent than the general population.

Priority #: 5
Priority Area: : Adults with Severe and Persistent Mental Illness
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Promotion and Support of Promising Practices (Behavioral Health Homes)

Objective:

By the end of this 2 year grant, the percentage of Adults with SPMI will be enrolled in Behavioral Health Homes will increase to 10%

Strategies to attain the objective:

Development of a comprehensive based mental health system: state will continue to promote and support evidenced based practices. Education and awareness of the Behavioral Health Home model will be essential to improving coordinated care among the consumer and provider community alike.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of Adults with SPMI enrolled in Behavioral Health Homes

Baseline Measurement: FY14, 1,561 Adults with SPMI are enrolled in Behavioral Health Homes

First-year target/outcome measurement: By FY 16, 140 Adults with SPMI will be enrolled in Behavioral Health Homes (9.0%)

Second-year target/outcome measurement: By FY17, 156 Adults with SPMI will be enrolled in Behavioral Health Home (10%)

Data Source:

MaineCare data sets and APS Health Care

Description of Data:

Persons enrolled in State A or B of MaineCare's Health Home model

Data issues/caveats that affect outcome measures::

Substantial systems change for both consumers and providers of physical and mental health services in Maine.

Priority #: 6

Priority Area: Children – Quality Improvement

Priority Type: MHS

Population(s): SED (Adolescents w/SA and/or MH, LGBTQ, Rural, Homeless)

Goal of the priority area:

To continue in its role in ensuring the quality of services delivered by contracted providers.

Objective:

By the 2nd year of this grant , the percentage of increased access to services for children and youth served by OCFS who receive services that address their behavioral, emotional, and mental health issue will increase by 5%

Strategies to attain the objective:

Use of standardized contracting process across program areas, including residential, outpatient, case management, and home and community based services. Focus on the use and further development of systems for the recording, reporting, and analysis of data. Staff will analyze data collected in these systems and also review client charts, agency procedures, and quality improvement plans. Oversee the use of quality improvement outcome measures including the Child and Adolescent Needs and Strengths (CANS) and Youth Outcome Questionnaire (Y-OQ) assessment tools.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Children with SED enrolled in Behavioral Health Homes

Baseline Measurement: FY15 -343 children enrolled 3.7% of 18,644 SED Population

First-year target/outcome measurement: FY16 target 354 children enrolled 7%

Second-year target/outcome measurement: FY17 - targer 366 children enrolled 7%

Data Source:

MaineCare claims reporting system (MECMS)

Description of Data:

unduplicated counts of children 0-17 years of age.

Data issues/caveats that affect outcome measures::

Substantial systems change for children /families and providers of physical and mental health services in Maine.

Indicator #: 2

Indicator: Maintain/Increase percentage of crisis outreach intervention in community settings

Baseline Measurement: FY14 31% (1,430)

First-year target/outcome measurement: FY16- 35% (1,487) of crisis face to face assessment will occur in a location other than a hospital emergency room or crisis office

Second-year target/outcome measurement: FY17-40% (1,562) of crisis face to face assessment will occur in a location other than a hospital emergency room or crisis office

Data Source:

Information is from monthly childre's crisis provider statistical data reports. Information is compiled by the DHHS SAMHS

Description of Data:

Monthly crisis provider statistical data reports from the nune crisis program forming the statewide crisis services system

Data issues/caveats that affect outcome measures::

timely reporting by crisis providers.

Priority #: 7

Priority Area: Child -Evidence Based Practices

Priority Type: MHS

Population(s): SED (Adolescents w/SA and/or MH, Rural)

Goal of the priority area:

The goal is to stimulate a conversion from less effective service delivery methods and outcomes to new approaches for the treatment of specific emotional and behavioral needs of children and youth.

Objective:

To provide more effective services to treat specific emotional and behavioral need of children and youth

Strategies to attain the objective:

Continue to support current programs and practices in place that include Functional Family Therapy (FFT), Multisystemic Therapy (MST), Multisystemic Therapy ,Problem Sexualized Behaviors (MST-PBS),Trauma Focused Cognitive Behavior Therapy (TFCBT), Cognitive Behavior Therapy -Plus, Multidimensional Treatment Foster Care, the MATCH-ADTC: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), Child and Adolescent Needs and Strengths (CANS), and Youth Outcome Questionnaire (YOQ). Continue to focus on the expansion on the types of EBPs within the service delivery. Strategies include the recognition of and reimbursement for EBPs and promising practices through Maine Care policy.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Children with SED receiving Multi-Systemic Therapy (MST) by 3 % increase

Baseline Measurement: FY15 – 535 children received MST

First-year target/outcome measurement: FY16 target 551 children receiving MST (3% increase)

Second-year target/outcome measurement: FY17 568 children receiving MST (3% increase)

Data Source:

Service providers and DHHS Office of Continuous Quality Improvement

Description of Data:

Number served obtained by the service providers. Estimate of total SED is provided by the Maine Data Infrastructure Program (URS Table 16).

Data issues/caveats that affect outcome measures::

Priority #: 8

Priority Area: To provide youth with case management services to assist in transitioning to successful independent adulthood.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To provide youth with case management services to assist in transitioning to successful independent adulthood.

Objective:

By year 2 of this grant to increase the number of youth who participate in the TIP model of case management by 15%

Strategies to attain the objective:

Provision of the Transition to Independence (TIP) model of case management services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of new youth who participate in the TIP model of case management.

Baseline Measurement: In FY14 60 youth received TIP case management through The Moving Forward-Now is the Time – Healthy Transition Initiative .

First-year target/outcome measurement: : FY16 15% increase in youth served (78)

Second-year target/outcome measurement: FY17 15% increase in youth served (89)

Data Source:

The Moving Forward-Now is the Time – Healthy Transition Initiative evaluation database

Description of Data:

Data collected is participant specific.

Data issues/caveats that affect outcome measures::

None identified

Priority #: 9

Priority Area: Children – Statewide Youth Peer Support Network

Priority Type: MHS

Population(s): SED (Adolescents w/SA and/or MH, LGBTQ, Rural, Homeless)

Goal of the priority area:

To provide a statewide Youth Peer Support Network of services that are "youth-driven" i.e. youth have a primary decision making role in their own care as well as the policies and procedures governing care for all youth in their community.

Objective:

By the end of the 2 year grant , Youth Peer Support Network program participants demonstrate improvement in functioning/well-being

Strategies to attain the objective:

Continue to develop a statewide Youth Peer Support Network. Continue involvement of youth in state advisory boards.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Improved functionality and well-being through Recovery and Resiliency of individuals living with SMI, SED, or co-occurring Substance Abuse Disorder.
Baseline Measurement:	baseline to be established over the first year -revised % based on FY 14
First-year target/outcome measurement:	Youth Peer Support Network program participants who demonstrate improvement in functioning/well-being 5% increase (number)
Second-year target/outcome measurement:	Youth Peer Support Network program participants who demonstrate improvement in functioning/well-being 5% increase (number)

Data Source:

The six (6)-item Outcome Domain of the 2014 DHHS Adult Mental Health Consumer survey .

As a direct result of my current services:

- I am able to deal more effectively with daily problems.
- I am better able to control my life.
- I am better able to deal with crisis.
- I am getting along better with my family/friends.
- My housing situation has improved.
- My symptoms are not bothering me as much

Description of Data:

Percent of Youth Peer Support Network program participants who demonstrate improvement in functioning/well-being as measured by the six (6)-item Outcome Domain of the 2014 DHHS Adult Mental Health Consumer Survey (Appendix D) between baseline and six (6)-month follow-up, and at exit from the program

Data issues/caveats that affect outcome measures::

None identified.

Priority #: 10

Priority Area: Children – Statewide Family Peer Support Network

Priority Type: MHS

Population(s): SED (LGBTQ, Rural)

Goal of the priority area:

To provide a statewide Family Peer Support Network of services that are "family driven" i.e. families have a primary decision making role in the care of their children as well as the policies and procedures governing care for all children in their community.

Objective:

By the end of the 2 year grant , 80% of Family Peer program participants will demonstrate improvement in functioning/well-being

Strategies to attain the objective:

Continue to develop a statewide Family Peer Support Network. Continue involvement of family members in state advisory boards. Continue to support

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improved functionality and well-being through Recovery and Resiliency of individuals living with SMI, SED, or co-occurring Substance Abuse Disorder.

Baseline Measurement: With Baseline to be established over the first year - FY 14 604 (68.7% Well being Survey)

First-year target/outcome measurement: 75% - 659 Family Peer program participants who demonstrate improvement in functioning/well-being

Second-year target/outcome measurement: 80% - 703 Family Peer program participants who demonstrate improvement in functioning/well-being

Data Source:

Data Source: Percent of Family Peer program participants who demonstrate improvement in functioning/well-being as measured by the six (6)-item Outcome Domain of the 2014 Maine Youth and Family Consumer Survey

As a direct result of current services:

- My child is better at handling daily life.
- My child is better able to do things he or she wants to do.
- My child is better able to cope when things go wrong.
- My child gets along better with family members.
- My child is doing better in school and/or work.
- My child gets along better with friends and other people.

Description of Data:

Description of Data: Percent of Family Peer program participants who demonstrate improvement in functioning/well-being as measured by the six (6)-item Outcome Domain of the 2014 Maine Youth and Family Consumer Survey between baseline and six (6)-month follow-up, and at exit from the program:

Data issues/caveats that affect outcome measures::

None identified.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$211,580	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$3,091,582	\$0	\$0	\$0	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)		\$200,943	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$175,882	\$0	\$0	\$0	\$0	\$0
11. Total	\$0	\$3,679,987	\$0	\$0	\$0	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$0

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$0
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁶ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

²⁷ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁸ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁹ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>: <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

³⁶ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf.; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

<http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁹ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

⁴¹ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

⁴³ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴⁷ <http://www.nrepp.samhsa.gov/>

⁴⁸ Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>

⁴⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁵⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. The Health Care System and Integration

Footnote:

The office of Substance Abuse and Mental Health Services (SAMHS) is the designated State Public Mental Health Authority for adults in the State of Maine. One of SAMHS's primary responsibilities is to develop and maintain a comprehensive system of mental health services and supports for person age 18 and older with severe and persistent mental illness. The Office of Children and Family Services (OCFS) is the designated State Public Mental Health Authority for children and youth in the State of Maine. They too have a primary responsibility to maintain a comprehensive system of mental health services and supports for persons under age 18.

Leadership and staff at both state offices, SAMHS and OCFS, remain dedicated to develop ongoing linkages with programmatic changes implemented after the passing of the Affordable Care Act. For example, currently there are 22 Behavioral Health Homes with 52 sites in the State that offer M/SUD services, with 2100 consumers accessing services in a Health Home in FY14. So far, outcomes for FY14 show a decrease in the number of total ED visits, and an increase in primary care visits. In addition, we have one Federally Qualified Health Center in Maine that is also a Behavioral Health Home.

In addition, the State of Maine is proven as a national leader regarding Medicaid reimbursement services, Essential Health Benefits, nearly a decade ago. Maine is one of the first states in the country to adopt a Mental Health Parity Law. Compared to other states, our system of EHB provides an array of services for person with Mental Illness. This is documented in part through the State Health Facts section of the Kaiser Family Foundation's website, where Maine is documented as having the highest per capita spending for persons with Mental Illness.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. Health Disparities

Footnote:

Office of Multicultural Affairs

On November 6, 2012, Maine citizens were among the first in the country in voting to approve Marriage Equality for all. This substantial support and recognition of diversity in our state is further demonstrated by Maine's Department of Health and Human Services' Office of Multicultural Affairs.

In order to improve services to racial, ethnic, linguistic minorities, and specific cultural subpopulations in Maine, DHHS with the support of the Governor's Office, strategically established the Office of Multicultural Affairs (OMA). The office provides support to state agencies, non-governmental organizations, and community partners in order to develop sustainable projects and initiatives that will address the needs of the above mentioned multicultural communities. SAMHS implements the recommendations of OMA Sub-Cabinet, acknowledging the importance and need to provide strategic planning, policy development and program implementation of services to Maine residents who belong to racial, ethnic, linguistic, and specific cultural subpopulation minorities. These services assist recipients in the achieving educational, financial, and social self-sufficiency. SAMHS promotes mutual cooperation, exchange, and understanding among the various populations served which is vital to the provision of meaningful and effective service delivery.

Office of Health Equity

In addition, Maine DHHS's Center for Disease Control and Prevention's Office of Health Equity was established in 2006, with the goal of achieving the highest level of health for all people regardless of differences in social, economic or environmental conditions. The Office of Health Equity is comprised of four separate groups that focus on a specific area in the public health domain:

- Maine Families Home Visiting
- Women, Infants and Children (WIC)
- Minority Health & Special Populations
- Women's Health

Maine's Office of Health Equity program addresses disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services, and barriers to health care.

The office also:

1. Promotes the collection of health data by racial, ethnic, gender, LGBT, age, and primary language categories and strengthening infrastructure for data collection, reporting, and sharing;
2. Works to increase awareness of the major health problems of racial and ethnic minorities and factors that influence health;
3. Establishes and strengthens networks, coalitions, and partnerships to identify and solve health problems; develops and promotes policies, programs, and practices to eliminate health disparities and achieve health equality; and
4. Provides technical assistance, training, and seminars.

In order to accomplish the goals of this Office, the overall approach is to effect system changes within the Maine Center for Disease Control & Prevention (Maine CDC), the Department of Health and Human Services (DHHS), grantee agencies, and community partners. The primary strategies are leadership engagement and community collaboration. We work with, and fully engage with communities to address health inequities for its vulnerable populations; taking the knowledge and information obtained through our engagement with the communities back to the legislature and policy makers.

Cultural Competency and Access to Language Services:

CLAS Standards:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Interpretation Services (Communication Access). The Provider shall determine the primary language of individuals requesting services and ensure that the services are provided either by a bi-lingual clinician or with the assistance of a qualified interpreter when English is not the primary language. If not otherwise funded by MaineCare or some other source, the Provider shall obtain the service at its own expense. The client shall not be charged for this service.

Accessibility for the Deaf, DeafBlind, and Hard of Hearing. The Provider shall maintain and periodically test appropriate telecommunication equipment including TTY, videophone, or amplified telephone, or computer-based telecommunication programs, including IP-Relay services. Equipment or some form of access to relay services must be available and accessible for use by clients and staff for incoming and outgoing calls. The Provider shall ensure that appropriate staff has been trained in the use of the telecommunications devices and that if there is a TTY or video phone number, that the TTY telephone number is published on all of the Provider's stationery, letterhead, business cards, etc., in the local telephone books, as well as in the statewide TTY directory. Where no TTY or VP number exists, providers should assure that clients are advised to use relay services by placing such information on providers stationery, letterhead, and business cards. The Provider, at its expense, shall obtain the services of a qualified sign language interpreter or other adaptive service or device when requested by a consumer or family member. Interpreters must be licensed with the Maine Department of Professional and Financial Regulation in the Office of Licensing and Registration. The Provider shall document the interpreter's name and license number in the file notes for each interpreted contact.

Deaf, DeafBlind, and/or Severely Hard of Hearing. Providers who serve deaf, deafblind and/or severely hard of hearing consumers shall:

1. Provide visible or tactile alarms for safety and privacy (e.g., fire alarms, doorbell, door knock light);
2. Provide telecommunication access that is appropriate for the consumers' linguistic ability and preference and ensure the consumers have the relevant relay service, telephone numbers, or web sites readily available; and

3. Train staff in use and maintenance of all adaptive equipment in use in the program, including but not limited to hearing aids, assistive listening devices, videophone or TTY, fax machine, television caption controls, and alarms.

Provider Responsibilities: Deaf, DeafBlind, Hard of Hearing and/or Nonverbal. Providers who serve deaf, deafblind, hard of hearing, and/or nonverbal consumers for whom sign language has been determined to be a viable means of communication shall:

1. Provide ongoing training in sign language and visual gestural communication to all staff on all shifts who need to communicate meaningfully with these clients, and shall document staff attendance and performance goals with respect to such training;
2. Develop clear written communication policies for the agency and each program of the agency, including staff sign/visual gestural proficiency expectations and when and how to provide qualified sign language interpretation; and
3. Ensure that staff and provider case managers serving DeafBlind and dual sensory impaired consumers are appropriately trained to provide human guide, tactile wayfinding, and informal communication techniques as needed by the consumer.
4. Ensure that staff and provider case managers have a level of proficiency in sign language that is sufficient to communicate meaningfully with consumers OR
5. Hire an interpreter at all required check-ins at provider expense with the exception of situations where bilingual staff can provide their services directly in the language of the consumer.

Treatment of Rural vs Urban Inequities:

Access to care in poor and rural populations in Maine is often complicated. The State provides funding for transportation in rural areas to individuals with SMI and SED receiving primary, mental health, and behavioral health treatment.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3. Use of Evidence in Purchasing Decisions

Footnote

The re-organization of SAMHS and OCFS was centered on more efficiently and effectively delivering necessary and accountable services to persons in need. Specifically, SAMHS has designed the new office along three teams: 1) Prevention and Intervention; 2) Recovery and Treatment; and 3) Data, Quality Management, and Resource Development. These three teams have representation at the leadership level and work in an integrated manner, both at the inter and intra office functional levels.

Implementation of Evidence Based Practices and linkages to Medicaid, the single largest funding source, are very strong and consistent. This includes formal development and joint implementation and of performance measures and contracting, as well as implementation of these performance measures into formal Rule Making.

Monitoring of success occurs at multiple levels: through the Office of Continuous Quality Improvement, and within SAMHS's own team – Data, Quality Management, and Resource Development. These Offices work closely together in the design, development, implementation, review, and monitoring of the performance measures referenced above.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

4. Prevention for Serious Mental Illness

Footnote:

Comprehensive, population-based approaches to promoting mental health continue to be primarily focused on early identification and linkages to care for those with mental health needs, while the prevention of mental illness lacks Evidence-Based practices. The current efforts in serious mental illness prevention in Maine are focusing on communication and cooperation between the public health and mental health communities that target SMI/SED populations, with particular interest on the well-known cross connections between mental health and chronic disease, as well as the strong causal links with substance abuse. Maine has worked to address SMI/SED prevention needs by forging links between traditional medical providers and mental health practitioners, through pilot programs in federally qualified health centers and through screening education programs for MCDC sub-grantees and other medical providers. These pilot projects, which have included the co-location of services and coordination of care, show promise. Efforts to address mental health issues are also challenged by the underreporting and consequent under-treatment of these conditions, often due to the pervasive socio-cultural stigma attached to those who are diagnosed and treated for mental health issues. This stigma is part of the reason that persons with mental health issues often find themselves struggling to pay or find coverage for treatment, as health insurance plans often do not cover mental health-related issues as thoroughly as those traditionally seen as solely physical in nature. Importantly, policy approaches, including mental health parity laws for health insurance have made some inroads in this complex issue.

Selective activities and prevention service are targeted towards SMI/SED populations only. The Office of Children and Family Services (OCFS) undertake the bulk of these prevention activities and services. SMI/SED prevention activities and coordination with SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding have focused on using marketing and messaging that focused on the awareness of mental health, substance abuse, and dual-diagnosis conditions among Maine populations.

Environmental Factors and Plan

5. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)

Narrative Question:

The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside is over the FY 2015 level. The appropriation bill specifically requires the 10 percent set-aside to fund only those evidence-based programs that target FEP. The law specifically stated:

"...the funds from set-aside are only used for programs showing strong evidence of effectiveness and targets the first episode psychosis. SAMHSA shall not expand the use of the set-aside to programs outside of those that address first episode psychosis".

Previous appropriation language (P.L. 113-76 and P.L. 113-235) allowed the use of set aside funds for individuals with early SMI, including those without psychosis. However, the new language specifically requires states to focus their efforts only on FEP.

States that are currently utilizing FY 2016 set-aside funds for early SMI other than psychosis must now refocus their efforts to service only those with FEP. SAMHSA will allow states that already signed a contract or allocated money to their providers using the FY 2016 funds to complete these initiatives through the end of their contract or by the end of September 30, 2016, whichever comes first. States may continue to support these efforts using the general MHBG funds; however, the set-aside allocation must be used for efforts that address FEP. Nothing precludes states from utilizing its non-set-aside MHBG funds for services for individuals with early SMI.

If states have other investments for people at high risk of SMI, they are encouraged to coordinate those programs with early intervention programs supported by the MHBG. This coordination will help ensure high risk individuals are swiftly identified and engaged in evidence-based services should they develop into diagnosable SMI. Please note that the MHBG funds cannot be used for primary prevention or preventive intervention for those at high risk of SMI.

States can implement models which have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented.

SAMHSA and NIMH in conjunction with National Association of State Mental Health Program Directors (NASMHPD) will continue to ensure that technical assistance and technical resources are available to states as they develop and implement their plan.

States will be required to revise their two-year plan to propose how they will utilize the 10 percent set-aside funding to support appropriate evidence-based programs for individuals with FEP. Upon submission, SAMHSA will review the revised proposals and consult with NIMH to make sure they are complete and responsive. If a state chooses to submit a plan to utilize the set-aside for evidence-based services other than Coordinated Specialty Care (CSC) approach developed via the RAISE initiative, SAMHSA will review the plan with the state to assure that the approach proposed meets the understanding of an evidence-based approach. With consultation with NIMH as needed, the proposals will be either accepted, or requests for modifications to the plan will be discussed and negotiated with the State. SAMHSA will notify each State once the revised proposals are approved.

This initiative also includes a plan for program evaluation and data collection related to demonstrating program effectiveness. SAMHSA is also required within six months of the appropriations statute enactment to provide a detailed table showing at a minimum each State's allotment, name of the program being implemented, and a short term description of the program. Additional technical assistance and guidance on the expectations for evaluation, data collection and reporting will follow.

States must submit their plan revision request proposal into the FY 2016-2017 Block Grant Application under the following section:

Section III. Behavioral Health Assessment and Plan, C. Environmental Factors and Plan, #5. Evidence-Based Practices for First Episode Psychosis.

The state must revise the following for the 10 percent set-aside for first episode psychosis:

1. An updated description of the states chosen evidence-based practice for the 10 percent set-aside initiative.
2. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
3. A budget showing how the set-aside and additional state or other supported funds, if any, will be utilized for this purpose.
4. The states provision for collecting and reporting data, demonstrating the impact of this initiative.
5. Any foreseen challenges.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. Evidenced-Based Practices for Early Intervention (5 percent)

OCFS and SAMHS proposal and budget will continue to allocate the 5% increase of funds (\$91,552) provided by SAMHSA toward the training and development of First Episodic Psychosis (FEP) through the evidence based practice of nationally known agency Maine Medical Center's Portland Identification and Early Referral Program (PIER) which has a 12 year long record of community education, advanced treatment and rigorously demonstrated outcomes and results, helping Maine youth avoid onset or achieve unusually positive clinical functional outcomes when treated for an early first episode of psychosis. Our need assessment was driven by population density and the presence of a nationally known organization PIER which treats both the Adult and Children's Behavioral Health population. As a result, this model has been initially rolled out in Maine's largest city, Portland. The FEP population covers both offices and populations served by DHHS's Office of Substance Abuse and Mental Health Services (SAMHS) as well as the Office of Children and Family Services (OCFS). Funds have been split for the additional 5% in similar fashion as is done with the remainder of the block grant: 50/50 between SAMHS and OCFS.

Plan Implementation Status

July 1, 2015 was the start of the first contract period between PIER and the Offices of SAMHS and OCFS. The FEP budget proposal was implemented prior to by July 1, 2015.

Planned Activities for 2016 and 2017

In Stage 1, (Year 1), we will first meet with administrators and then identify clinicians within Adult and Child Psychiatry at MMC (representing Cumberland County) and at two CSI teams (representing York County) to participate in early psychosis and other major mental illnesses service delivery. These agencies will offer Multifamily Group (MFG) for families with a young person (age 16-25) experiencing a first episode. During this planning phase we will determine referral pathways for these families to these two agencies providing this evidence based intervention.

In Stage 2, (Years 1 & 2), we will conduct a three day MFG Training for the clinicians at MMC and CSI who will be running the groups. This will include psychiatric residents in training who will act as a third clinician in the group, and provide psychobiology education during the family workshop and medication management for the young people in the group.

In Stage 3, (Years 1 & 2), we will provide a large community outreach and education event to community and school based clinicians to teach them to identify early warning symptoms of major mental illness and tell them how to refer to either MMC or CSI for the family treatment. As a follow up to this large event, the trainers will join agency staff to provide some outreach events to targeted audiences within their catchment areas.

In Stage 4, (Years 1 & 2), the trainers will provide ongoing supervision monthly for both Multifamily Group and community outreach so that sites will stay on track with their goals for recruiting appropriate families and following the Multifamily Group model to fidelity standards.

In Stage 5, (Year 2), we will develop methods for reimbursement for ongoing community outreach and education within the state of Maine. We will also look at services reimbursement through MaineCare and private insurers.

Evidence-Based Prevention and Treatment Approaches for the Mental Health Block Grant (5 percent set-aside)

YEAR 1 BUDGET

Personnel

Position	FTE	Annual Salary	Total Salary
Research Coordinator (Donna Downing)	0.2	\$82,056.00	\$16,411.20
Consultant (Sarah Lynch)	0.2	\$73,777.60	\$14,755.52
Consultant (William McFarlane)	0.05	\$244,462.40	12,223.12
Director (Douglas Robbins)			1,000.00
Salaries			<u>\$44,389.84</u>
Fringe(33.46%)			\$14,852.84
Total Salary			<u>\$59,242.68</u>

General Expenses

Office Supplies			\$500.00
Travel/ Mileage			\$400.00
Program Materials			\$1,000.00
Total General Expenses			<u>\$1,900.00</u>

Event Expenses

Conference at USM (est. 200 people)

Registration--\$10/person			\$2,000.00
Room Rental			1,500.00
Food/ Refreshments			\$3,000.00
Total Event Expenses			<u>\$6,500.00</u>

MFG Training

Room Rental			\$450.00
Total MFG Training			\$450.00

SUB TOTAL

Indirects 10%			\$68,092.68
			<u>\$6,809.27</u>
TOTAL			<u>\$74,901.95</u>

Evidence-Based Prevention and Treatment Approaches for the Mental Health Block Grant (5 percent set-aside)

YEAR 2 BUDGET

Personnel

Position	FTE	Annual Salary	Total Salary
Research Coordinator (Donna Downing)	0.2	\$82,056.00	\$16,411.20
Consultant (Sarah Lynch)	0.2	\$73,777.60	\$14,755.52
Consultant (William McFarlane)	0.05	\$244,462.40	12,223.12
Director (Douglas Robbins)			1,000.00
Salaries			<u>\$44,389.84</u>
Fringe(33.46%)			<u>\$14,852.84</u>
Total Salary			\$59,242.68

General Expenses

Office Supplies			\$500.00
Travel/ Mileage			\$400.00
Program Materials			\$1,000.00
Total General Expenses			<u>\$1,900.00</u>

Event Expenses

Conference at USM (est. 200 people)

Registration--\$10/person			\$2,000.00
Room Rental			1,500.00
Food/ Refreshments			\$3,000.00
Total Event Expenses			<u>\$6,500.00</u>

MFG Training

Room Rental			\$450.00
Total MFG Training			\$450.00

SUB TOTAL

Indirects 10%			\$68,092.68
			<u>\$6,809.27</u>
TOTAL			\$74,901.95

Stage 1 - Planning Trainings at 2 Sites	Attendees	Staff	Yr 1 Target date	Yr 2 Target date
Preparation and Planning		McFarlane, Lynch, Downing	January-15	
Kick off meeting with 2 sites (MMC & CSI)	Administrators/ Clinic Directors	McFarlane, Lynch, Downing	January-15	
Follow up planning calls		McFarlane, Lynch, Downing	February-15	

Stage 2 - MFG Training	Attendees	Staff	Yr 1 Target date	Yr 2 Target date
Planning and Preparation		Lynch, Downing		
In Person Training (3 Days)	3 Clinicians x 2 MMC Sites and 2 CSI sites = 12 attendees	McFarlane, Lynch, Downing	March-15	March-16

Stage 3 - Large Community Outreach and Education Event	Attendees	Staff	Yr 1 Target date	Yr 2 Target date
Preparation (venue, invitation, registration, etc)		Lynch, Downing	Jan 2015 - March 2015	Jan 2016 - March 2016
Large scale Outreach Training (1/2 day)	Community and school based clinicians	McFarlane, Lynch, Downing	April-15	April-16
Joint outreach (Trainer + Agency staff)	Schools, Inpatient, Partial Hosp, Crisis Services, Community, PCP	Lynch, Downing, Clinicians from CSI/MMC	May 2015 - Sept 2015	May 2016 - Sept 2016

Stage 4 - Ongoing MFG and Community Outreach Supervision	Attendees	Staff	Yr 1 Target date	Yr 2 Target date
Ongoing Supervision for Community Outreach	2 Supervision Groups			
	6 Clinicians at MMC	Lynch, Downing	12 months	12 months
	6 Clinicians at CSI	Lynch, Downing	12 months	12 months
Ongoing Supervision for Multifamily Group (1 hour per month)	2 Supervision Groups			
	6 Clinicians at MMC	Lynch, Downing	12 months	12 months
	6 Clinicians at CSI	Lynch, Downing	12 months	12 months

Tape Review	4 groups x 3 tapes per group	Lynch, Downing	12 months	12 months
	(12 tapes x 2 hours = 24 hours)			

Stage 5 - Sustainability	Attendees	Staff	Yr 1 Target date	Yr 2 Target date
Partnering with the state on a statewide outreach and education campaign		McFarlane, Lynch, Downing, OFCS, SAMHS		October 2015 - Sept 2016
Exploring mechanisms for outreach and education reimbursement		McFarlane, Lynch, Downing, OFCS, SAMHS		October 2015 - Sept 2016
Exploring mechanisms for service reimbursement		McFarlane, Lynch, Downing, OFCS, SAMHS		October 2015 - Sept 2016

Evidence-Based Prevention and Treatment Approaches for the Mental Health Block Grant (5 percent)

SCOPE OF WORK

In Stage 1, (Year 1), we will first meet with administrators and then identify clinicians within Adult and Child Psychiatry at MMC (representing Cumberland County) and at two CSI teams (representing York County) to participate in early psychosis and other major mental illnesses service delivery. These agencies will offer Multifamily Group (MFG) for families with a young person (age 16-25) experiencing a first episode. During this planning phase we will determine referral pathways for these families to these two agencies providing this evidence based intervention.

In Stage 2, (Years 1 & 2), we will conduct a three day MFG Training for the clinicians at MMC and CSI who will be running the groups. This will include psychiatric residents in training who will act as a third clinician in the group, and provide psychobiology education during the family workshop and medication management for the young people in the group.

In Stage 3, (Years 1 & 2), we will provide a large community outreach and education event to community and school based clinicians to teach them to identify early warning symptoms of major mental illness and tell them how to refer to either MMC or CSI for the family treatment. As a follow up to this large event, the trainers will join agency staff to provide some outreach events to targeted audiences within their catchment areas.

In Stage 4, (Years 1 & 2), the trainers will provide ongoing supervision monthly for both Multifamily Group and community outreach so that sites will stay on track with their goals for recruiting appropriate families and following the Multifamily Group model to fidelity standards.

In Stage 5, (Year 2), we will develop methods for reimbursement for ongoing community outreach and education within the state of Maine. We will also look at services reimbursement through Mainecare and private insurers.

MULTIFAMILY GROUP AND COMMUNITY OUTREACH TRAINING DESCRIPTIONS

Family Psychoeducation (Multifamily Group Format)

Family psychoeducation is a method for training families to work together with mental health professionals as part of an overall treatment plan. The multifamily group is the “hub” of treatment for early first episode families. The original family psychoeducation model was designed for families and individuals with serious persistent illness. The model is used in the PIER Model because it has also been found to be successful in preventing serious illness during the early psychotic phases.

The family psychoeducation model has four treatment stages, which roughly correspond to the phases of an episode of schizophrenia, acute mania or severe major depression, from the acute phase through recuperation and rehabilitation.

They are:

- 1) Joining (Engagement)
- 2) Family Education Workshop
- 3) Community Reentry
- 4) Social/Vocational Re-engagement

At the conclusion of the 3 day Multifamily Group training, participants will be able to:

1. Describe the clinical purpose and evidence basis for multifamily group psychoeducation for clients diagnosed with psychosis and their families and supports.
2. Define the phases of MFG intervention: Joining, Family Psychoeducation Workshop, Problem-solving, Initial Recovery, Social/ Vocational Rehabilitation
3. Understand the timeline and preparation involved for starting a multifamily group
4. Identify 6-8 appropriate families for the MFG intervention.
5. Join with new families utilizing the guidelines for what to cover in these sessions and the competency checklist provided.
6. Create, plan and practice delivering the MFG educational workshop for families utilizing slides from the training and agency specific resources.

7. Teach the family guidelines by providing specific examples and linking the brain basis of symptoms to each guideline for family members and clients.
8. Incorporate the family guidelines in clinical practice with families in order to reduce stress and biological and psychological vulnerability.
9. Identify the purpose of groups one and two in setting the tone, creating a safe space and introducing new families to the MFG group.
10. Lead group one and two with a co-facilitator.
11. Review the problem-solving model with a co-facilitator and break down components of the MFG group process.
12. Co-lead an MFG group using the structured problem-solving format.
13. Explain each stage of the problem-solving process in terms of how it helps to improve family communication and address executive functioning challenges.
14. Participate in ongoing supervision with one of the MFG trainers with an expectation of videotaping MFG groups for evaluation and using the competency checklist in self evaluation.

**Requirements for Clinicians participating in MFG Training:
Certification for
MFG Practitioner**

1. Participation in three day MFG training workshop. Proof of attendance at all sessions.
2. Co-facilitate a MFG for 1 year or a minimum of 20 sessions.
3. Participate in group supervision with a *senior FPE* trainer for a minimum of ten monthly supervision sessions, with demonstration of competence and positive outcomes.
4. Required: Submit for review a minimum of three videotaped MFG sessions conducted with a co-facilitator over a 12-month period. This will include one joining session (this could possibly be an audio tape) and two problem-solving sessions occurring over a period of time to demonstrate improvement. The *workshop* can also be taped and forwarded for review along with a copy of the PowerPoint presentation and agenda from the workshop.
5. Feedback about each taped MFG session is given to trainee by a *Senior FPE* supervisor/trainer. Feedback will include fidelity to the model, recommendations for improvements and timelines for next taping.

6. Access to at least one on-site Master's level licensed clinician for local supervision of cases in MFG's.
7. Clinical Recommendation by ongoing on-site supervisor to move to next level for certification. Specific areas for improvement are shared with the practitioner, and if at the end of 1 year, the practitioner is not ready to move to the Supervisor Level, they will need to continue to be supervised for a minimum of three months, and provide one videotape to demonstrate a minimum of 80% on the competency checklist.

Community Outreach

The goal of community outreach is to reach those school and health care professionals who interact frequently with young people. Those community members are in a key position to detect early changes in a young person's functioning and behaviors. Once they are given appropriate information about early signs of psychosis, they can intervene on that person's behalf.

The goals of community outreach are to:

- Educate and train the provider community, particularly school-based professionals, primary care and pediatric physicians, and mental health clinicians about the early warning signs of severe mental illness. These professionals are usually receptive to outreach because they understand that early intervention can lead to better outcomes. Additional audiences include college health and counseling staff, residential life staff; mental health professionals, including hospital and community based psychiatrists, social workers, psychologists, and nurses; students in mental health professions; and community leaders from local businesses and employers.
- Teach community members (families, clergy, youth workers, students) how to identify young people who are showing either prodromal or active symptoms of major psychotic disorders.
- Establish a community-wide network of early detection and intervention for youth and young adults experiencing early psychosis. The medical and educational professionals who work directly with youth are usually receptive to this outreach. They tend to understand the benefits of early intervention and the positive outcomes that result from rapid referral to treatment.

At the conclusion of the Community Outreach training, participants will be able to:

- Understand the background and rationale for early intervention and prevention
- Learn the symptoms of the spectrum of prodromal to first episode psychosis
- Understand the purpose of outreach
- Describe the steps needed to begin community outreach
- Learn how to map your community
- Describe methods for identifying key audiences
- Describe how to establish a Steering Council
- Explain your plan for training key staff prior to outreach presentations
- Describe the process needed to refine messages for identified audiences
- Explain how you will deliver the outreach messages
- Describe methods you will use for evaluating your outreach efforts

Evaluation

In order to better understand the successes and challenges, both program and outcomes evaluations are necessary. The components of the evaluation for this program are:

Outcomes (Outreach)

- Numbers of and audiences for outreach presentations
- Outreach participant evaluations
- Outreach presentations to all key mental health referral sources
- Outreach presentations to 60% of all middle and high schools and colleges within the organization's service area.
- Outreach presentations to 50% of all pediatricians and family physicians with the organization's service area.

Outcomes (Families participating in MFG)

- Client engagement, accurate identification and retention
- Participation of clients and families in family psychoeducation
- Fidelity assessments for key treatment modalities
- Baseline and follow-up assessment results (positive and negative symptoms)
- Social and role functioning (participation in school and work)
- Clients' health and mental health care outcomes
- Psychosis conversion or relapse rates
- Hospitalizations

Other provisions for treatment or other type of service delivery:

Due to the set aside funds being under \$100,000.00 the total 5% set aside has been dedicated to education/training per SAMHSA webinar instructions:

National Council for Behavioral Health

Date: June 5, 2014

Time: 2:00 – 3:30pm ET

Topic: “Prep for Success: Lessons Learned in Implementing Models for Early Intervention in Psychosis”

State of Maine 10% Set Aside Planned Activities

Program Goal

Through this 1 year contract, the Department will achieve improvements in the identification of First Episodic Psychosis symptoms with individuals ages 15-25 and will create an opportunity for identified individuals to get into treatment early and significantly enhance their long-term outcomes. Maine will look to expand the services and supports that Maine Medical Center is providing through their Portland Identification and Early Referral (PIER) services by incorporating Youth and Family Voice within their services and supports. This will be done by partnering with a Youth Advocacy Organization to incorporate youth voice at the table. This will support and enhance the work that PIER is presently providing with a focus on serving adults, young adults and person of the transition age with First Episodic Psychosis. This person can ensure that youth guided care and youth voice are present in all aspects of treatment.

Local and Regional Impact –Brief Program Summary

Maine will look to expand the services and supports that Maine Medical Center is providing through their PIER program by incorporating Youth and Family Voice within their services and supports. This will be done by partnering with a Youth Advocacy Organization to incorporate youth voice at the table. This will support and enhance the work that MMC is presently providing with a focus on serving adults, young adults and person of the transition age with First Episodic Psychosis

Scope of Effort

Individuals ages 15-25 years of age experiencing First Episodic Psychosis.

Partners and Standards

Maine Medical Center's Portland Identification and Early Referral (PIER) Services has a 12 year long record of community education, advanced treatment and rigorously demonstrated outcomes and results, helping Maine youth avoid onset or achieve unusually positive clinical functional outcomes when treated for an early first episode. Youth M.O.V.E. Maine (YMM) started as a youth committee of THRIVE in 2005 under a SAMHSA system of care cooperative agreement awarded to the Maine's Department of Health and Human Services' Office of Child and Family Services. These youth advised on the tasks of the system of care grant by sitting on advisory councils, evaluation committees, and informing THRIVE on the development of the Trauma-Informed Agency Assessment.

Objectives, Key Activities and Measures

Objective 1: To continue to build program capacity and expansion with organizations that demonstrates readiness and committeemen to offer program model.

- 1.1 PIER to identify and submit for approval by the Department an agency readiness assessment.
- 1.2 PIER to identify two licensed community health agencies that will complete the MFG clinicians training and supervision. One agency is required to be located in York and one agency is required to be located in Cumberland County.
- 1.3 PIER to establish an implementation plan with each identified agency.
- 1.4 PIER to identify six clinicians three from each identified agency in York and Cumberland County) to participate in Multi Family Groups training and supervision.
- 1.5 PIER to conduct Multi Family Groups with two identified agencies and the six clinicians will complete the "Requirements for Clinicians participating in MFG Training".
- 1.6 PIER will insure each group of clinicians will identify a minimum of five (5) appropriate clients and families to participate in the Multifamily Groups prior to the start of the MFG training to reduce wait time for family participation.
- 1.7 PIER to provide a detailed report on outcomes from clients and families participating in the MFG for each quarter of the contract of the first year.

Detailing the following outcomes:

- Client engagement, accurate identification and retention
- Participation of clients and families in family psychoeducation
- Fidelity assessments for key treatment modalities
- Baseline and follow-up assessment results (positive and negative symptoms)
- Social and role functioning (participation in school and work)
- Clients' health and mental health care outcomes
- Psychosis conversion or relapse rates
- Hospitalizations and Re-Hospitalizations

- 1.8 PIER to develop pathways to referral for clients and families receiving MGF training at each agency identified.

Measure 1: 100 % of the clinicians in each group will identify a minimum of five appropriate clients and families to participate in the Multifamily Groups prior to the start of the MFG training to reduce wait time for family participation.

Target: 100 % Baseline/Actual: 3 for FY15

Measure 2: 100% of the clinicians will complete the three day MFG in person training.

Target: 100 % Baseline/Actual: 13 (3 from community agencies) for FY 2015

Measure 2: 100 % of the clinicians will complete the three day MFG training and MFG co facilitation under the supervision of PIER for one year.

Target: 100 % Baseline/Actual: 3 for FY 2015

Measure 4: 100 % of the clinicians completing the one year training under the supervision of PIER will demonstrate competence and positive outcomes as the end result of each 10 monthly supervision sessions

Target: 100 % Baseline/Actual: 3 clinicians for FY 2015

Measure 5: 100% of the clinicians will submit two video tapes of MFG sessions conducted with a co facilitator over a 12 month period.

Target: 100% Baseline/Actual: 3 clinicians in process for FY 15

Objective 2: PIER will conduct large one day training to a minimum of 125 participants that is free and accessible to the public.

1.1 Pier to conduct one large community event for a minimum of 125 community state wide stakeholders which is free and accessible that includes identifying the FEP system of care, be informed of the referral pathways, add a component of the MFG training and requirement to become certified in the MFG model, and recruitment of clinicians for the MFG training in this forum.

1.2 Following the community trainings, PIER will conduct surveys to demonstrate all participants are able to state that training improved their ability to identify early warning signs of psychosis, increase willingness to refer individual ages 15-25 for FEP and demonstrate competency in the pathway for referrals.

1.3 PIER and youth peer to develop social marketing and educational materials, brochures and PowerPoint presentations that included youth guided language and are vetting recipients of services, families of youth adult, college students and youth peers.

1.4 PIER and youth peer, after the large community outreach training, will develop a community networking system for referrals to the PIER program and develop referral pathways for First Episodic Psychosis population ages 15-25.

Measure 1: PIER will conduct surveys to demonstrate that 80% of all participants are able to state that training improved their ability to identify early warning signs of psychosis.

Target: 80 % Baseline/Actual: 39.7 % reported a significant change to identify early warning signs of psychosis as a result of this presentation.

Measure 2: PIER will conduct a survey to demonstrate that 80% of all participants are able to demonstrate competency in their ability to identify a pathway to referrals for person for ages 15-25 experiencing FEP.

Target: 80% Baseline/Actual: 67.5 % indicated a significant change in the knowledge of the referral process as a result of this presentation.

Objective 3: Based on the average of 19 years for referral to PIER program, PIER will conduct one monthly community training to targeted audiences in York and Cumberland County specifically targeting colleges, universities, behavioral health clinics, and law enforcement in York and Cumberland County that includes a pathway to referral information.

1.1 Each training conducted by PIER will be a minimum of one hour training with a youth peer facilitator.

1.2 PIER to follow up with an evaluation of the training and a survey is conducted with 100% of training participants to demonstrate knowledge of the improved ability to identify FEP /early warning signs and willingness to refer individual ages 15-25.

1.3 PIER will develop training that focus on community outreach training towards colleges, universities, health clinics, behavioral health homes, and law enforcement in York and Cumberland County that includes a pathway to referral information.

1.4 PIER, based on the average age of referrals is 19 years , will create curriculum inclusive of youth guided language that can be incorporated into a lecture series for higher education colleges classes/courses that teach social and behavioral sciences (BSW/MSW courses) , health and wellness, behavioral health, and mental health.

1.5 PIER and youth support partner, after each monthly community outreach training, will develop a community networking system for referrals to the MMC/PIER program and develop referral pathway for the individual ages 15-25.

1.6 PIER will offer a minimum one hour training to student health clinics, student and faculty advisors, guidance counselors and student dorm advisors that live in the dorms.

1.7 Following the community trainings, PIER will conduct surveys to demonstrate all participants are able to state that training improved their ability to identify FEP and increase willingness to refer individual ages 15-25.

Measure 1: 100% of training participants to demonstrate knowledge of the improved ability to identify FEP /early warning signs and willingness to refer individual age 15-25.

Target: 100 % Baseline/Actual: 39.7 7% indicated a significant change as a result of this presentation to identify early warnings of psychosis and 67.5 % indicated a significant change in the knowledge of the referral process as a result of this presentation. TBD new measure targeting colleges, universities, health clinics, behavioral health homes, and law enforcement in York and Cumberland County

Measure 2: 100% of all monthly community outreach trainings will be conducted by PIER to the targeted audience colleges, universities, health clinics, behavioral health homes, and law enforcement in York and Cumberland County

Target: 100 % Baseline/Actual: new measure TBD

Measure 3: PIER will conduct community outreach training to a 75% targeted audience of colleges, universities, health clinics, behavioral health homes, and law enforcement in York and Cumberland County that includes a pathway to referral information.

Target: 75 % Baseline/Actual: new measure TBD

Measure 4: PIER will conduct for a minimum one hour to a 75% target audience of student health clinics, student and facility advisors, guidance counselors and student dorm advisors that live in the dorms.

Target: 75% Baseline/Actual: new measure TBD

Measure 5: 75 % of PIER participants will not be hospitalized 6 months after discharge from PIER services.

Target: 75% Baseline/Actual: new measure TBD

Measure 6: 75% of PIER program participants will be enrolled in an educational or employed prior to discharge from PIER services.

Target: 75% Baseline/Actual: new measure TBD

Measure 7: 75% of PIER program participants will be connected to natural community supports prior to discharge from PIER services.

Target: 75% Baseline/Actual: new measure TBD

Objective 4: PIER will have a young adult with FEP to participate as a content expert related youth guided care and youth voice to enhance the PIER treatment team work.

1.1 PIER to insure that all young adults enrolled in PIER program will have 100% access to youth peer supports.

1.2 PIER and youth support partner to develop social marketing and educational materials, brochures and PowerPoints that include youth guided language that is vetting recipients of services, families, youth adult, college students and youth peers.

1.3 PIER and youth support partner to develop discharge criteria for youth and families that include addressing natural supports systems after discharge. The young adult content expert will provide support during this process.

1.4 Youth Move Maine will conduct one to two community programming group's specific to young people experiencing FEP. A survey will be conducted initially, to produce a programming structure that fits the needs of the individuals who will be participating.

1.5 Youth Move Maine will support a 1 .5 FTE to serve in the capacity for content expert /training for community training /education, co facilitator , development of community based program for FEP, and provide 1 to 1 peer supports services .

1.6 Youth Move Maine Peer will develop process and implement an exit survey based on family and youth driven practices and experience of satisfaction and report to the Department.

1.7 PIER and Youth Move Maine will support the young adult content expert working on the PIER team will receive training from PIER on FEP and MFG and to co facilitate community training on FEP in-conjunction with PIER .

Measure 1: PIER will meet 100% of access to peer youth supports attendance of clinicians from the two supervision groups for 12 consecutive months for one hour.

Target: 100 % Baseline/Actual: new measure TBD

Measure 2: 75% of young people attending community programming will report the training was beneficial through program evaluation.

Target: 75 % Baseline/Actual: new measure TBD

Measure 3: Youth Move will insure that 40% of referrals received from PIER will receive informal peer support by a youth support partner from Youth Move Maine.

Target: 40 % Baseline/Actual: new measure TBD

Measure 4:100% of youth will receive the survey upon completion or discharge from the program,

Target: 100 % Base line /Actual: new measure TBD

State of Maine's First Episodic Psychosis 10% Revision Plan

The State of Maine has been contracting with Maine Medical Center Portland Identification and Early Referral Program (PIER) as it relates to the 5% set aside MHBG dollars for youth, young adult from 15 -30 years of age.

Maine Medical Center Portland Identification and Early Referral Program (PIER)

Overview of the Organization

Maine Medical Center's Portland Identification and Early Referral Program (PIER) has a 12 year long record of community education, advanced treatment and rigorously demonstrated outcomes and results, helping Maine youth avoid onset or achieve unusually positive clinical functional outcomes when treated for an early first episode. It is unique in northern New England. A similar program at the Massachusetts Mental Health Center and Harvard University Medical School in Boston is currently directed by a co-founder of the PIER Program. The PIER Program has achieved national and international prominence as the model American program for preventing onset of psychotic and severe mood disorders. The State of Maine, Maine Health Access Foundation, The Robert Wood Johnson Foundation (RWJF), SAMHSA, NIMH and local foundations have provided funds to support MMC/PIER from its inception in 2000. The PIER program demonstrated a net 34 % reduction in hospitalizations for first-episode psychosis between 2000 and 2007 in the Greater Portland area, compared with the period prior to the program's establishment and to the other urban areas in Maine—Lewiston-Auburn, Augusta and Bangor. This was the first demonstration of incidence reduction in severe mental illness.

Between 2000 and 2012, PIER staff treated over 240 individuals who were found to be at-risk for psychosis (pre-psychosis or prodromal) or had an early psychotic level of symptoms upon initial evaluation. A multidisciplinary clinical team focused on preserving and increasing a youth's functioning, as well as helping families develop skills to reduce stress and other individualized coping skills.

Through this work at MMC/PIER have been providing the following under the current 5% set aside;

- Training for Family Psychoeducation (Multifamily Group Format). This is a method for training families to work together with mental health professionals as part of an overall treatment plan. The multifamily group is the "hub" of treatment for early episode families. The original family psych education model was designed for families and individuals with serious persistent illness. The model is used in the PIER Model because it has also been found to be successful in preventing serious illness during the early psychotic phases.
- Community Outreach. The goal of community outreach is to reach those school and health care professionals who interact frequently with young people. Those community members are in a key position to detect early changes in a young person's functioning and behaviors. Once they are given appropriate information about early signs of psychosis, they can intervene on that person's behalf. The goals of community outreach are to:
 - Educate and train the provider, community, particularly school-based professionals, primary care and pediatric physicians, and mental health clinicians about the early signs

of First Episodic Psychosis. Teach community members how to identify young people who are showing either of First Episodic Psychosis. .

- Establish a community-wide network of early detection and intervention for youth and young adults experiencing First Episodic Psychosis.

Maine will look to expand the services and supports that Maine Medical Center is providing through their PIER program by incorporating Youth and Family Voice within their services and supports. This will be done by partnering with a youth advocacy organization to incorporate youth voice at the table. This will support and enhance the work that MMC is presently providing with a focus on serving adults, young adults and persons of the transition age with First Episodic Psychosis.

Youth and Young Adult Voice: Overview of organization

In 2003 SAMHSA began looking at strategic ways to assure the inclusion of youth and young adults with identified mental health challenges to have a voice in the services and systems policies that support them in their journey of mental health wellness. By 2005, SAMHSA required through the Children's Mental Health Initiative, that all System of Care grantees would hire young adults who identify as having lived experience in child serving systems and utilize these systems and develop key strategies for developing and sustaining the advancement of youth guided care. Youth M.O.V.E (Motivating Others Thorough Voices of Experiences) National was the young adult advocacy organization to support this federal requirement by supporting local communities and organizations with training and technical assistance on the development, implementation and sustainability of their local youth movement. Aside from being a national young adult TA provider for several nationally funded initiatives they supported the development of a national network for the youth movement by expanding programming to local communities and states through the development of a chapter's affiliation process. Since 2008 when local communities were wanting to affiliate with the national movement YMN has grown to have over 15,000 youth members in 87 local chapters across 37 state, two tribes and the District of Columbia chapters started chapter networks. By uniting the voice of youth from across the country YMN has been recognized as a national leader in identifying and engaging youth in using their voice to create better services and support for those struggling with mental health to become more engaged in community and services through advocacy, leadership and the development youth peer support programs.

Youth Voice in Maine:

Youth M.O.V.E. Maine (YMM) started as a youth committee of THRIVE in 2005 under a SAMHSA system of care cooperative agreement awarded to the Maine's Department of Health and Human Services' Office of Child and Family Services and led by Tri-County Mental Health Services. The purpose of the youth committee was to bring together youth who had experience and involvement with child welfare, juvenile justice, and/or mental health services. Many of the youth that first worked with YMM were homeless and transition aged. These youth advised on the tasks of the system of care grant by

sitting on advisory councils, evaluation committees, and informing THRIVE on the development of the Trauma-Informed Agency Assessment.

In 2009, YMM began providing youth peer support as a subcontract of the Moving Forward Initiative (the first iteration of “Now Is the Time”) and in 2012 and 2014 peer support was expanded to include the Maine Youth Court program and Expand: ME, both SAMHSA funded programs awarded to THRIVE. Additionally, peer support started under Moving Forward will continue for an additional four years under the newly funded “Now is The Time” award. Over the last year, YMM has expanded across the state and currently has three Regional Coordinators developing programs and supporting youth.

From March of 2013-2014 YMM connected with over 150 youth across the State of Maine with over 1,000 hours of youth peer contact. Through the last state Block Grant, over the 2014-2015 contract year, YMM has engaged 908 unique youth (with 1508 total engagements) with over 3,000 hours of contact hours through programming and social engagement. The growth and presence of YMM continues to bring peer support and advocacy to Maine youth.

Youth M.O.V.E. Maine facilitates one-on-one relationships through peer support in the Youth Peer to Peer Curriculum (YPPC) and a blend of Intentional Peer Support, that promote positive self-efficacy for transition aged youth. This curriculum is an enhancement of Maine’s Certified Intentional Peer Support Training. The YPPC acknowledges the developmental considerations of young people by focusing on language, culture, and adolescent development. The YPPC is aimed at meeting youth needs and the challenges they face navigating systems. Ultimately, peer support is a successful intervention because of its accessibility and enhanced engagement.

Presently, the NITT grant contracts with Youth Move Maine to provide Youth Peer Supports to young adults and transitional youth enrolled in the project through the support of youth support partner. Presently they provide youth peer supports to those young people enrolled in Maine Medical Center PIER program. With the 10% set aside we would like to enhance the treatment young people are receiving by providing a young adult content expert who has lived experience with FEP. This person can ensure that youth guided care and youth voice are present in all aspects of treatment. The 10% set aside will also provide a 20 hour a week youth support partner position specific to those involved in PIER and FEP.

Maine’s Impact Statement

The overall impact of adding youth/young adult to the MMC/PIER program is to help establish an organizational culture and peer content expert within the program to include a peer voice to programmatic and services development appealing to youth and young adult and to reduce stigmatization of FEP.

The overall impact of adding youth/young adult to the Multi Family Group training with clinicians is for youth/ young adults in transition have family involvement with meaningful engagement and to use peers/family members as natural supports during treatment.

The overall impact of adding youth/young adult to community outreach trainings is to reach out to as many youth/young adult in various settings so that they can receive a formalized training structure and

youth/young adults experiencing FEP to access FEP information, become familiar with services and pathways to referrals/resources. As a result of these FEP educational trainings, attitudes, beliefs and behaviors will change.

Summary of PIER Planned Activities

Maine Medical Center /PIER:

- MMC/PIER to identify and submit for approval by the Department an agency readiness assessment.
- PIER to identify two licensed community health agencies that will complete the MFG clinicians training and supervision. One agency is required to be located in York and one agency is required to be located in Cumberland County.
- PIER to conduct an agency readiness assessment with each identified agency from York and Cumberland County.
- PIER to establish an implementation plan with each identified agency.
- PIER to identify six clinicians ,three from each identified agency in York and Cumberland County) to participate in Multi Family Groups training and supervision.
- Each group of clinicians will identify a minimum of five appropriate clients and families to participate in the Multifamily Groups prior to the start of the MFG training to reduce wait time for family participation.
- PIER to conduct a three day Multi Family Groups with two identified agencies and identified six clinicians.
- After the six clinicians complete the three day MFG, PIER will supervise the six clinicians for one year supervising clinicians conducting co facilitation MFG in their agencies and complete “The Requirements for Clinicians Participating in the MFG Training” for one year.
- PIER will train the Youth Move young adult content expert working on the PIER team and will receive training on FEP.
- PIER and the Youth Move young adult content expert to co- facilitate monthly community training on FEP.
- One Community outreach training per month, minimally one hour training with a peer facilitator and to follow up with an evaluation of the training and survey with 100% of training participants to demonstrate knowledge of the improved ability to identify FEP /early warning signs and willingness to refer individual age 15-25. The focus of this community outreach training will be towards colleges, universities, health clinics, behavioral health homes, and law enforcement in York and Cumberland County that includes a pathway to referral information.
- PIER,, based on the average age of referrals is 19 years,, will create curriculum that can be incorporated into a lecture series for higher education colleges classes/courses that teach social work (BSW/MSW courses) , health and wellness, behavioral health, and mental health. Also PIER will offer a minimum one hour training to student health clinics, student and facility advisors, guidance counselors and student dorm advisors that live in the dorms.

- Following the community trainings, PIER will conduct surveys to demonstrate all participants are able to state that training improved their ability to identify First Episodic Psychosis and increase willingness to refer individual ages 15-25...
- PIER will insure that all young adults enrolled in PIER program will have 100% access to youth peer supports.
- PIER to conduct one large community event for a 125 minimum of community state wide stakeholders that is free and accessible that includes identifying the FEP system of care, be informed of the referral pathways, add a component of the MFG training and requirement to become certified in the MFG model, and recruitment of clinicians for the MFG training in this forum. Following the community trainings, PIER will conduct surveys to demonstrate all participants are able to state that training improved their ability to identify early warning signs of psychosis and increase willingness to refer individual ages 15-25. .
- PIER and youth peer to develop social marketing and educational materials, brochures that are vetting recipients of services, family, youth adult, college students and youth peers.
- PIER and youth peer, after each monthly community outreach training, will develop a community networking system for referrals to the PIER program and develop referral pathway for First Episodic Psychosis.
- PIER and youth peer to develop discharge criteria for youth and families that include addressing natural supports systems after discharge.
- PIER to create, identify and report on all factors including insurance issues that disqualified individuals ages 15-25 years of age from the PIER program.
- PIER to create a referral and discharge process for individual ages 15-25 that do not qualify for the PIER program that includes tracking where the referrals are going to.
- PIER to report on their activities with a detailed report outline on how to sustain outgoing community outreach and education within the State of Maine.
- PIER to report on their activity in a detailed report outlining how services reimbursement through MaineCare and private insurers.

Overview of the Family Psychoeducation (Multifamily Group Format)

Family psychoeducation is a method for training families to work together with mental health professionals as part of an overall treatment plan. The multifamily group is the “hub” of treatment for early first episode families.

The original family psychoeducation model was designed for families and individuals with serious persistent illness. The model is used in the PIER Model because it has also been found to be successful in preventing serious illness during the early psychotic phases.

At the conclusion of the three day Multifamily Group training, participants will be able to:

- Describe the clinical purpose and evidence basis for multifamily group psychoeducation for clients diagnosed with psychosis and their families and supports.

- Define the phases of MFG intervention: Joining, Family Psychoeducation Workshop, Problem-solving, Initial Recovery, Social/ Vocational Rehabilitation
- Understand the timeline and preparation involved for starting a multifamily group
- Identify a minimum of five appropriate clients and families for the MFG intervention.
- Join with new families utilizing the guidelines for what to cover in these sessions and the competency checklist provided.
- Create, plan and practice delivering the MFG educational workshop for families utilizing slides from the training and agency specific resources.
- Teach the family guidelines by providing specific examples and linking the brain basis of symptoms to each guideline for family members and clients.
- Incorporate the family guidelines in clinical practice with families in order to reduce stress and biological and psychological vulnerability.
- Identify the purpose of groups one and two in setting the tone, creating a safe space and introducing new families to the MFG group.
- Lead group one and two with a co-facilitator.
- Review the problem-solving model with a co-facilitator and break down components of the MFG group process.
- Co-lead an MFG group using the structured problem-solving format.
- Explain each stage of the problem-solving process in terms of how it helps to improve family communication and address executive functioning challenges.
- Participate in ongoing supervision with one of the MFG trainers with an expectation of videotaping MFG groups for evaluation and using the competency checklist in self evaluation.

Overview of the Requirements for Clinicians participating in MFG Training:

Certification for MFG Practitioner-All trainings, supervision, co-facilitation, feedback sessions and videotaped sessions require proof of attendance

- Participation in three day MFG training workshop.
- Co-facilitate a MFG for one year or a minimum of 20 sessions.
- Participate in group supervision with a senior FPE trainer for a minimum of ten monthly supervision sessions, with demonstration of competence and positive outcomes.
- Required: Submit for review a minimum of three videotaped MFG sessions conducted with a co-facilitator over a 12-month period. This will include one joining session (this could possibly be an audio tape) and two problem-solving sessions occurring over a period of time to demonstrate improvement. The workshop can also be taped and forwarded for review along with a copy of the PowerPoint presentation and agenda from the workshop.
- Feedback about each taped MFG session is given to trainee by a Senior FPE supervisor/trainer. Feedback will include fidelity to the model, recommendations for improvements and timelines for next taping.
- Access to at least one on-site Master's level licensed clinician for local supervision of cases in MFG's.

- Clinical Recommendation by ongoing on-site supervisor to move to next level for certification. Specific areas for improvement are shared with the practitioner, and if at the end of one year, the practitioner is not ready to move to the Supervisor Level, they will need to continue to be supervised for a minimum of three months, and provide one videotape to demonstrate a minimum of 80% on the competency checklist.

Summary of Youth Move Maine Planned Activities

Youth Move Maine will serve in the capacity of content expert to the programing on young adult voice, engagement and provider of peer support services in the following ways;

- Youth Move Maine to provide a young adult with FEP to participate as a content expert related youth guided care and youth voice to enhance the PIER treatment team work. This peer support partnership will follow guidelines of the Youth MOVE Maine peer to peer model. Through the peer support relationship, young people will be able to explore different stages of self-advocacy, moving from basic awareness and engagement, to intrinsic motivation and purpose.
- Youth Move Maine will conduct one to two community programming groups specific to young people experiencing FEP. A survey will be conducted initially, to produce a programming structure that fits the needs of the individuals who will be participating.
- Youth Move Maine will insure that 40% of referral received from PIER will receive informal peer support by a youth support partner from Youth Move Maine.
- Youth Move Maine to support a 1.5 FTE to serve in the capacity for content expert /training for community training /education, co facilitator , development of community based program for FEP, and provide one to one peer supports services .
- The young adult content expert working on the PIER team and will receive training from PIER on FEP and to co-facilitate community training on FEP in-conjunction with PIER.
- Youth Move Maine will create and offer youth voice to community training, curriculums, brochures, educational materials, and pathways for referrals to PIER and for individual that do not qualify for PIER program.
- Youth Move Maine Peer would develop process and implement an exit survey based on family and youth driven practices and experience of satisfaction and report to the Department.

Budget: Data collection and Quality Management activities will use a portion of the funding set aside for these purposes. Additionally, DHHS will apply our flat rate administrative fee of 8%. The remaining funds will be split 50/50 between SAMHS and OCFS for the above mentioned purposes. See table below:

8% Admin Fee	\$16,075
Data Quality Management (10%)	20,094
SAMHS	82,387
OCFS	82,387
TOTAL	<hr/> \$200,943

The State's provision for collecting and reporting on data for the 10% set aside planned activity is through the Departments contracts with PIER and Youth Move Maine that includes quarterly reports to the Department on performance measures that demonstrates this 10% set aside initiative. Please refer to separate attachment for detailed 10% Set Aside Planned Activities that includes: priorities, goals, objectives, strategies, performance indicators and target measures.

DRAFT

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

Footnote:

Under SAMHS Housing Programs , to the greatest extent practicable, SAMHS empower consumers with tenant-based housing vouchers which enhance individual choice, independence, and control over where a person lives and what services (if any) such a person decides to receive. Independent housing vouchers represent a foundation of recovery and hope. Systems of care are recognizing that access to safe, decent, and affordable housing is a medical necessity for many persons with disabilities. Independent housing vouchers: deliver real therapeutic value; promote consumer empowerment; support both civil and disability rights; and are demonstrated to be radically cost effective when compared to high cost, high intensity, institutionalized care. Such vouchers can be used in either the community or group settings—at the consumer’s discretion. These vouchers are a logical extension of the concept, Money Follows the Person in which the consumer directs their own care and in this case, their housing as well.

Within the structure of Case Management Services, the community integration worker supports the consumer in the development of an Individual Support Plan (ISP) to identify the consumer’s goals, supports, resources, and unmet needs.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity

Footnote:

SAMHSA's SABG and MHBG are designed to provide states with the flexibility to design and implement activities and services to address the complex needs of individuals, families, and communities impacted by mental health disorders, substance use disorders, and associated problems. The goals of the Block Grant programs are consistent with SAMHSA's vision for a high-quality, self-directed, and satisfying life. The components of a healthy life are the four dimensions of recovery.

Additional aims of the Block Grant programs reflect SAMHSA's role as a public health agency: 1) Increase prevention and wellness activities, 2) increase access to evidence based mental health services, and 3) improve the use of data through surveillance activities, analysis, and continuous quality improvement to inform service planning and decision making.

In keeping with SAMHSA's aims, SAMHS has created three objectives for this funding cycle and related efforts. Both the SAMHSA aims and the Maine SAMHS's objectives can be traced back to the SAMHSA National Outcome Measures. Our objectives specifically include:

1. Increase Prevention and Wellness activities at the DHHS and Provider level. Further promote linkages by and between the Office of Substance Abuse and Mental Health Services and the office of Child and Family Services to include enhanced coordination with the Substance Abuse Prevention and Treatment Block Grant. Carry forward and support with Block Grant and other resources Prevention and Wellness activities in the provider and consumer communities.
2. Increase utilization and Evidence-Based Practices. Fund and support both promising and evidence-based practices using Block Grant and other resources.
3. Increase Access and Capacity. Fund and support specific and necessary services targeting uninsured and underinsured individuals supported by Block Grant and other resources.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

8. Tribes

Footnote:

SAMHS is working with internally established liaisons for collaboration and input from the tribes on both our Mental Health and Substance Abuse Prevention and Treatment Block Grants. Staff within our office is already sharing information and ideas regarding improving linkages with the Tribal communities in Maine. The consumer run, Quality Improvement Council has also reach out to the Maine Tribal community for their representation and membership on the QIC. More work needs to be done in this arena and both the QIC and SAMHS continue to proactively conduct outreach to Maine's tribal communities.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

10. Quality Improvement Plan

Footnote:

Since the merger of our former legacy offices, SAMHS has created a revised and update CQI/TQM plan that integrates Mental Health and Substance Abuse measures. The updated CQI Plan is attached to this application.

Maine Office of Substance Abuse and Mental Health Services

Quality Management Plan and Compendium of Services 2013-2018

Table of Contents

Chapter	Page
<u>1 - Introduction and Overview</u>	5
<u>2 - Terms and Definitions</u>	7
<u>3 - Quality Management System</u>	14
<u>FACTS</u>	14
<u>Process Improvement</u>	15
<u>Tools Used By SAMHS to Measure Quality</u>	16
<u>Risk Analysis</u>	19
<u>4 - Administration</u>	21
<u>SAMHS Organizational Chart</u>	21
<u>Pillars</u>	25
<u>SAMHS Partners</u>	26
<u>5 - Metrics, Measures and Standards</u>	28
<u>Consent Decree</u>	28
<u>Settlement Agreement</u>	28
<u>Consent Decree Plan</u>	28
<u>Consent Decree- Progress Report</u>	28
<u>SAMHSA’s National Outcome Measures</u>	29
<u>Performance Measures</u>	29
<u>6 - Data and Quality Management Systems</u>	30
<u>Data Systems</u>	Appendix 2
<u>Surveys</u>	Appendix 3
<u>Quality Management Review Forms</u>	Appendix 4
<u>Assessment Tools</u>	Appendix 5
<u>7 - Prevention Services</u>	31
<u>Drug-Free Workplace Program, WorkAlert, and Healthy Maine Works</u>	32
<u>Evidenced Based Prevention Panel</u>	33
<u>Enforcing Underage Drinking Laws (EUDL)</u>	34
<u>Fetal Alcohol Spectrum Disorder/Drug Affected Baby Coordination</u>	36
<u>Higher Education Alcohol Prevention Programs (HEAPP)</u>	38
<u>Healthy Maine Partnerships (HMP)</u>	40
<u>Parent Media Campaigns</u>	41
<u>Mental Health Prevention</u>	42
<u>Maine Youth Action Network (MYAN)</u>	44
<u>Problem Gambling Prevention</u>	45
<u>Student Intervention and Reintegration Program (SIRP)</u>	46
<u>Vet Corps Program</u>	47

8 - Intervention Services	48
<u>Crisis Mobile</u>	49
<u>Crisis Residential</u>	59
<u>Driver Education and Evaluation Program</u>	62
<u>Projects for Assistance in Transition from Homelessness</u>	66
9 - Treatment Services	72
<u>Assertive Community Treatment (ACT)</u>	73
<u>Behavioral Health Home Organization (BHHO)</u>	76
<u>Community Integration Services (CI)</u>	79
<u>Co-Occurring Treatment</u>	82
<u>Individual and Group Counseling</u>	84
<u>Community Rehabilitation Services (CRS)</u>	85
<u>Day Support Services</u>	86
<u>Specialized Group Services – Dialectical Behavior Therapy (DBT)</u>	89
<u>Detoxification: (Measured By Day) ASAM Level III 7-D</u>	90
<u>Daily Living Support Services (DLSS)</u>	92
<u>Drug Court Case Management</u>	94
<u>Differential Substance Abuse Treatment (DSAT)</u>	95
<u>Extended Care ASAM Level III.3 (Measured By Day)</u>	98
<u>Halfway House ASAM Level III.1 (Measured By Day)</u>	100
<u>Intensive Outpatient (IOP)</u>	102
<u>Service Setting: Adolescent Intensive Outpatient</u>	105
<u>Medication Assisted Treatment (MAT)</u>	107
<u>Psychiatric Medication Services (Med Management)</u>	109
<u>Methadone Maintenance Services (Opiate Agonist) – (Measured By 1 Day)</u>	111
<u>Non-Intensive Outpatient (OP)</u>	112
<u>Specialized Group Services - Recovery Workbook Group</u>	117
<u>Residential Rehabilitation - Adolescent: (Measured By Day) ASAM Level III.5</u>	118
<u>Residential Rehabilitation</u>	120
<u>Residential Treatment (PNMI)</u>	123
<u>Emergency Shelter (Measured By Day)</u>	125
<u>Skills Development Services</u>	126
<u>Specialized Direct Services</u>	127
<u>Specialized Group Services - Trauma Recovery and Empowerment Group (TREM)</u>	131
<u>Women’s Residential Treatment Services</u>	132
<u>Specialized Group Services - Wellness Recovery Action Planning (WRAP)</u>	136
10 - Recovery Services	138
<u>CIT Training</u>	139
<u>Employment Specialist</u>	143
<u>Portland Recovery Community Center</u>	145
<u>Self-Help/Peer Support</u>	146
<u>Long-Term Employment Supports</u>	149
<u>Warm Line</u>	151

[Certified Intentional Peer Support](#) 156

Appendices

I. [Appendix I - Contract Agreements](#) 160

[APS Healthcare](#) 161

[Memorandum of Understanding with Maine State Housing Authority HMIS](#)..... 166

II. [Appendix II - Data Systems](#) 171

[Knowledge-Based Information Technology \(KIT\)](#)..... 172

[Prescription Monitoring Program \(PMP\)](#)..... 176

[Web Infrastructure for Treatment Services \(WITS\)](#) 180

[Enterprise Information System \(EIS\)](#) 181

[Service Encounter Database](#)..... 182

[Driver Education Evaluation Programs \(DEEP\)](#) 183

III. [Appendix III - Surveys](#)..... 184

[Maine Integrated Youth Health Survey \(MIYHS\)](#) 185

[Substance Abuse Client Satisfaction Survey](#)..... 188

[Mental Health Well-Being Survey](#) 190

IV. [Appendix IV - Quality management Review Forms](#)..... 191

[Substance Abuse On-Site Visit/Contract Monitoring](#) 192

[Class Member Treatment Plan Review](#) 201

[Subrecipient Monitoring Worksheet](#)..... 207

V. [Appendix V - Assessment Tools](#)..... 211

[Adult Needs and Strengths Assessment \(ANSA\)](#) 212

[Level of Care Utilization System \(LOCUS\)](#)..... 215

Chapter 1

Introduction and Overview

This report provides a framework for the Maine Office of Substance Abuse and Mental Health Services in the Maine Department of Health and Human Services to organize, communicate, monitor, and continually improve the full range of behavioral health services under its purview.

In the rapidly changing world of healthcare delivery, this document attempts to be more than just an outline of quality management initiatives undertaken by SAMHS, but rather it documents the variety and complexity of services and systems that synergistically work to ensure that people with mental health and substance abuse needs are addressed in a systematic manner. As systems of care become more highly structured and accountable to a variety of stakeholders, it is important for SAMHS to identify its approach to ensuring quality care.

Both clinical outcome quality and consumer services quality are important to SAMHS. In this document, you will find information on evidence based services that are becoming the standard for service delivery. Performance based contracting measures are the norm at DHHS to better ensure that services are delivered with fidelity. In addition, SAMHS is ever cognizant of the need for consumer satisfaction with the services provided at the state and local levels. Both the Substance Abuse Client Satisfaction Survey and the Mental Health Well Being Survey are conducted annually to receive stakeholder feedback.

Quality should serve as a common paradigm for all service delivery at SAMHS. Through a strong quality management program, SAMHS is addressing the major needs of all stakeholders, stabilizing its partnership across the service delivery spectrum, building strong coalitions of partners to address the shifting landscape of health care delivery, and is nimble to manage change.

Quality Management and Improvement is dynamic. This report is written in 2014/2015 and will live, breathe, change and grow over time. What will be constant over time are the following quality management principles and goals:

- To improve the quality of behavioral health care and service provided to consumers through a comprehensive and ongoing system of monitoring measurable performance indicators;
- To maintain a process for adopting and updating evidence-based practices for both preventive guidelines and non-preventive (i.e. acute and chronic) clinical guidelines for behavioral health related conditions with dissemination to providers to assist in determining level of care;

- To promote communication with providers of care about quality activities, providing feedback on results of plan-wide and practice-specific performance assessments, and collaboratively developing improvement plans;
- To disseminate information to the public on provider performance to promote Member empowerment and informed decision making;
- To ensure that the quality of care and service delivered by providers meet standards established by us and relevant regulatory agencies, and that providers maintain continuous, appropriate, and effective quality improvement programs through ongoing oversight activities and regular performance assessments;
- To document and report the results of monitoring activities, barrier analyses, recommendations for improvement activities, and other program activities to the appropriate SAMHS staff;

Chapter 2

Terms and Definitions

Adolescent Intensive Outpatient - Intensive outpatient treatment for Adolescents is a component that provides an intensive and structured program of substance abuse evaluation, diagnosis, and treatment services in a setting that does not include an overnight stay.

Adult Needs and Strengths Assessment (ANSA) - The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Agency for Health Care Research and Quality (AHRQ) - Their mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used.

APS Healthcare - A Behavioral Health Utilization Management System for services currently purchased through the State's Office of MaineCare Services and administered by the Adult Mental Health Services, Children's Behavioral Health Services, and the Office of Substance Abuse.

Assertive Community Treatment (ACT) - ACT is a self-contained service with a fixed point of responsibility for providing treatment, rehabilitation, and support services to persons who satisfy the specific eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02 for whom other treatment approaches have been unsuccessful.

Behavioral Health Home Organization (BHHO) - A Behavioral Health Home is a community-based mental health organization that has been approved by MaineCare to provide Section 92 services for adults and children who are eligible for such services. A BHHO offers care management of both physical and mental health needs as well as the use of Health Information Technology to link services.

Community Integration (CI) - Community Integration Services involve the identification, assessment, planning, linking, monitoring, and evaluation of services and supports needed by a person who satisfies the eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02.

Co-Occurring Treatment - People who have experienced both an emotional/psychiatric and an alcohol or drug related issue are said to be persons with “co-occurring conditions” or disorders.

Community Rehabilitation Services - Services include individualized combinations of community integration, daily living support and skills development. This service supports the development of the necessary skills for living in the community and promotes recovery and community inclusion.

Consent Decree Process Improvement – A model of process improvement in accessing Community Integration services, with focus on Consent Decree requirements such as wait lists, times to assignment, as well as MHRT/C redesign and other strategies. This process is based on “Plan, Do, Study, Act” cycles of improvement.

Consent Decree Settlement Agreement - The Settlement Agreement came out of a fifteen count complaint filed by the plaintiffs (patients at the Augusta Mental Health Institute) on February 27, 1989. The Settlement Agreement was developed to address the allegations of the Complaint and to provide an appropriate remedy.

Consumer Council of Maine - is an independent, public instrumentality established by Maine law (Title 34-B, §3611). The CCSM is responsible for providing an independent and effective consumer voice into mental health public policy, services, and funding decisions.

Crisis Intervention Team (CIT) - Programs that are designed to improve the way law enforcement and the community respond to people experiencing mental health crises.

Crisis Mobile - Crisis Intervention Services are immediate crisis-oriented on-scene services oriented toward the amelioration and stabilization of acute emotional disturbances to ensure the safety of a consumer or society.

Crisis Residential - This service is a short term, highly supportive, supervised residential setting where an individual in psychiatric crisis can become stabilized and readjust to community living.

Critical Incident - A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of any person.

Daily Living Support Services (DLSS) - The services provide personal supervision and therapeutic support to assist members to develop and maintain the skills of daily living.

Day Support Services - Day Supports Services, formerly known as “day treatment,” focus on training designed to assist in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

Detoxification - These programs provide a planned regimen of 24 hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting.

Differential Substance Abuse Treatment (DSAT) - This treatment is an evidenced based practice that addresses the different needs of men and women in substance abuse treatment, but also the individual level of substance use severity.

Driver Education and Evaluation Programs (DEEP) - It is the legislatively mandated (5 MRSA c.521, Sub-c. V) Operating Under the Influence (OUI) countermeasures programs in the state of Maine.

Drug Court Case Management - The key goals of most drug courts are to reduce drug use and associated criminal behavior by engaging and retaining drug-involved offenders in programmatic and treatment services; to concentrate expertise about drug cases into a single courtroom; to address other defendant needs through clinical assessment and effective case management; and to free judicial, prosecutorial and public defense resources for adjudicating non-drug cases.

Drug Free Workshop Program - A focus is to reduce the effects of substance abuse on workplaces. The program provides tools and materials to worksites, including WorkAlert and Healthy Maine Works; both are web-based tools for employers.

Emergency Shelter - Shelter is a service which provides food, lodging and clothing for abusers of alcohol and other drugs, with the purpose of protecting and maintaining life and providing motivation for alcohol and drug treatment.

Employment Specialist - The Employment Specialist will perform multiple types of activities directed at helping consumers obtain employment, maintain employment, and improve their employment-related skills.

Enforcing Underage Drinking Laws (EUDL) - Focuses on reducing underage drinking through increased enforcement of laws. Programs funded include Party Patrols, undercover compliance checks, Card ME program; Project Sticker Shock; Responsible Beverage Server Training.

Enterprise Information System (EIS) - It is a web based mental health client level data collection tool. EIS collects data from not only state staff but agency provider information is received and fed into EIS.

Evidence Based Prevention Panel - This panel exists as a resource for prevention providers across the state to submit a proposal for their program to be recognized in the state as an Evidenced Based program.

Extended Care ASAM Level III.3 - Extended care is a service that provides a long-term supportive and structured environment for people who are substance use dependent with extensive substance use debilitation.

Fetal Alcohol Spectrum Disorder/Drug Affected Baby (FASD/DAB) - Maine has a state coordinator who is housed at SAMHS and collaborates with statewide stakeholders on issues related to substance use during pregnancy.

Halfway House ASAM Level III.1 - Halfway house is a community-based, peer oriented residential program that provides low intensity clinical services to support recovery from substance use disorders.

Healthy Maine Partnerships - 9 lead community based coalitions (who further fund an additional 18 coalitions statewide), whose focus is public health promotion and prevention.

Higher Education Alcohol Prevention - This prevention program is a statewide initiative for the prevention/reduction of high risk drinking in Maine's institutions of higher education.

Homeless Management Information System (HMIS) - A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

Individual and Group Counseling - This service includes professional assessment, counseling, and therapeutic services to adults, the purposes of which are to promote positive orientation, relief of excess stress, and growth toward more integrated and independent levels of functioning. Services utilize a variety of individual and group treatment modalities and are provided by trained, licensed professionals.

Intensive Outpatient (IOP) - Intensive outpatient treatment is a component that provides an intensive and structured program of substance abuse evaluation, diagnosis, and treatment services in a setting that does not include an overnight stay.

Knowledge-Based Information Technology (KIT) - It's an online data management system that allows grantees to enter in their information/data that allows project officers to monitor their work in relation to contract deliverables.

Level of Care Utilization System - The American Association of Community Psychiatrists (AACCP) developed the Level of Care Utilization System (LOCUS) as a tool to provide mental health clinicians and service providers with a systematic approach to the assessment and determination of the service and support needs of individuals with mental health challenges.

Long-Term Employment Supports - Long Term Employment Supports (LTES) is a goal-oriented service with specific individualized plans that identify the type, level, and duration

of supports. LTES are services provided to a person who is working in a competitive employment setting, and who requires support to keep that job.

Maine Integrated Youth Health Survey - A survey encompassing topics of risk and asset (protective) influences on student behavior for a comprehensive look at youth well-being for elementary, middle and high school students.

Maine Youth Action Network (MYAN) - SAMHS provides funding to the MYAN program to support their work with youth as a form of prevention. MYAN's mission is to empower and prepare youth and adults to partner for positive change by offering them training, networking and leadership opportunities.

Medication Assisted Treatment (MAT) - Medication Assisted Treatment of Substance Use Disorders (e.g. Buprenorphine, naltrexone, acamprosate, Vivitrol, etc.) is primarily and specifically intended to help stabilize addiction related symptoms.

Mental Health and Well-Being Survey - The survey captures consumer satisfaction regarding Community Integration and Behavioral Health Home services and treatment

Methadone Maintenance Services (Opiate Agonist) - Methadone is administered in accordance with federal and state laws and regulations that govern methadone administration, including the Maine Office of Substance Abuse and Mental Health Services of the Department of Health and Human Services, the Center for Substance Abuse Treatment (Division of the Substance Abuse and Mental Health Services Administration), the US Drug Enforcement Agency, and US Food and Drug Administration and the State Pharmacy Board, and Accreditation Bodies.

National Council on Alcoholism and Drug Dependence, Inc. (NCADD) - The organization is set up to fight "the stigma and the disease of alcoholism and other drug addictions." NCADD also assists in the education of Americans that "alcoholism and other drug addictions are preventable and treatable.

National Outcome Measures - SAMHSA has developed 10 NOMs domains in collaboration with the States. These domains are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities.

Non-Intensive Outpatient (OP) - Outpatient is a component that provides assessment, diagnosis, treatment, and after-care services in a non-residential setting.

Parent Media Campaigns - Provides information and education through messages that are disseminated via radio, television, online advertisements, brochures, internet resources, and the like.

Performance Measures - Helps us understand, manage, and improve what our organizations do. A performance measure is composed of a number and a unit of measure.

The number gives us a magnitude (how much) and the unit gives the number a meaning (what).

Portland Recovery Community Center - The center supports those who are recovering from alcohol and drug related problems, from every recovery pathway; and family members and friends of people struggling with addiction.

Prescription Monitoring Program (PMP) - The Prescription Monitoring Program is a web-based system that aids in the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substance prescriptions.

Problem Gambling Prevention - This program provides education and information dissemination across the state on the signs and symptoms of Problem Gambling while also providing information and resources on how to gamble responsibly.

Projects for Assistance in Transition from Homelessness (PATH) - Outreach and Engagement services, to literally homeless persons with a serious mental illness, or co-occurring serious mental illness and substance use disorder.

Psychiatric Medication Services (Med Management) - Services that are directly related to the prescription, administration, education, and/or monitoring of medications intended for the treatment and management of the symptoms of mental illness.

Quality Improvement Council - A Council that is to ensure that all people served by the Department of Health and Human Services in the State of Maine might proclaim Maine as providing the nation's highest standard for quality service in an environment of respect and empowerment.

Residential Rehabilitation Level III.5 - Residential rehabilitation services are designed to treat persons (specifically women and their children) who have significant social and psychological problems.

Residential Rehabilitation -Adolescent ASAM Level III.5 - Residential rehabilitation services are designed to treat adolescents who have significant social and psychological problems.

Residential Treatment (PNMI) - A Residential Treatment community residence [formerly Private Non-Medical Institution (PNMI)] is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, and treatment services to four or more residents in single or multiple facilities or scattered site facilities.

Self Help/Peer Support - Peer Support Specialists will utilize the principles of Recovery and Intentional Peer Support by using information, skills and resources they have gained in their recovery to help others.

Service Encounter Data (SED) - It was designed to provide contract management a way to validate and confirm grant payment invoices that they receive from Mental Health Agencies.

Skills Development Services - Skills Development Services are teaching-based services that assist people who satisfy the specific eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02 to increase their independence by learning the skills necessary to access community resources.

Specialized Group Services - Specialized Group Services consist of education, peer, and family support, provided in a group setting, to assist the members to focus on recovery, wellness, meaningful activity, and community tenure.

Student Intervention and Reintegration Program (SIRP) - This education program for adolescents focuses on alcohol and drug prevention and intervention. SIRP teaches the PRIME for Life Under 21 Program, provided by the [Prevention Research Institute, Inc. \(PRI\)](#), and is designed to influence behaviors using a research-based persuasion protocol.

Substance Abuse and Mental Health Services Administration (SAMHSA) - The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Substance Abuse Customer Satisfaction Survey - The Substance Abuse Client Satisfaction Survey evaluates the satisfaction of clients from substance treatment facilities.

Vet Corps Program - The Prevention team provides support to three Healthy Maine Partnerships for the implementation of this program. Vet Corps is program to assist coalitions and communities to increase capacity to better serve the substance abuse and behavioral health services needs of military service members and their families.

Warm Line - A peer support telephone warm line is staffed by paid peer supporters trained in Intentional Peer Support. It is designed for the purpose of engaging with adult mental health consumers and developing mutual relationships and connections that lead to growth, change and development of natural supports in one's own community.

Web Infrastructure for Treatment Services (WITS) - The Web Infrastructure for Treatment Services was legislatively mandated by the State Legislature in P.L. 1983 c. 464. It is also required by the U.S. SAMHSA that the Maine Office of Substance Abuse and Mental Health Services (SAMHS) submit substance abuse treatment data to their Treatment Episode Data Set (TEDS) on a monthly basis. WITS is the vehicle used to comply with that reporting.

DRAFT

Chapter 3

Quality Management System

FACTS AND FIGURES

The Office of Substance Abuse and Mental Health Services has looked to National entities, such as the Agency for Healthcare Research, the National Council on Alcoholism and Drug Dependence and Substance Abuse and Mental Health Services Administration to direct our Quality Management Plan.

According to the Agency for Healthcare Research and Quality (AHRQ)

<http://www.ahrq.gov/index.html>

About one in four adults in the United States suffers from a mental disorder in a given year, with about six percent suffering from a serious mental illness. These problems typically take a toll on overall health. For example, patients diagnosed with a serious mental disorder die 25 years earlier than the general population. Related behavioral issues such as substance abuse or domestic violence also remain persistent problems. For example, nearly one-third of U.S. adults suffer from some type of mental illness or substance abuse. In addition, an estimated 1.3 million women are physically abused by their intimate partners each year and about 1 million abused children are identified each year. Care costs for these problems are significant. Mental disorders were one of the five most costly conditions in the United States.

According to the National Council on Alcoholism and Drug Dependence, Inc. NCADD

<http://www.ncadd.org/index.php/for-the-media/alcohol-a-drug-information>

The cost and consequences of alcoholism and drug dependence place an enormous burden on American society. As the nation's number one health problem, addiction strains the economy, the health care system, the criminal justice system, and threatens job security, public safety, marital and family life.

Addiction crosses all societal boundaries, affects every ethnic group, both genders, and people in every tax bracket. Today, however, Americans increasingly recognize addiction as a disease -- a disease that can be treated.

The scope of the problem:

Alcoholism

- Alcohol is the most commonly used addictive substance in the U.S. 17.6 million people, or one in every 12 adults, suffer from alcohol abuse or dependence along with several million more who engage in risky drinking patterns that could lead to alcohol problems. More than half of all adults have a family history of alcoholism or problem drinking, and more than seven million children live in a household where at least one parent is dependent or has abused alcohol.

Drug Dependence

- According to the National Survey on Drug Use and Health (NSDUH), an estimated 20 million Americans aged 12 or older used an illegal drug in the past 30 days. This estimate represents 8% percent of the population aged 12 years old or older. Additionally, the nonmedical use or abuse of prescription drugs--including painkillers, sedatives, and stimulants--is growing, with an estimated 48 million people ages 12 and older using prescription drugs for nonmedical reasons. This represents approximately 20 percent of the U.S. population.

Federal Substance Abuse and Mental Health Services Administration’s Strategic Initiatives

The following six Initiatives will guide SAMHSA’s work for the future:

<http://store.samhsa.gov/leadingchange/feedback/SAMHSA-Leading-Change%202-0.pdf>

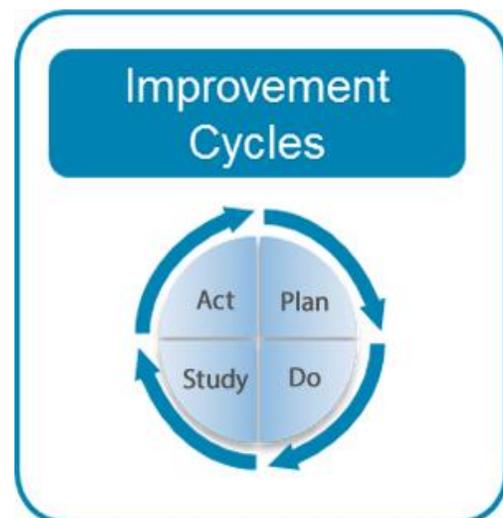
1. Prevention of Substance Abuse and Mental Illness
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
5. Health Information Technology
6. Workforce Development

Process Improvement

SAMHS utilizes process improvement models which provide an organizational and systematic framework to improve quality.

Consent Decree Process Improvement is a model of process improvement for accessing Community Integration services with focus on Consent Decree requirements such as wait lists and times to assignment. This process is based on “Plan, Do, Study, Act” cycles of improvement.

LEAN includes focus on improving workflow and reducing waste and duplication which is supported throughout the Department.



TOOLS USED BY SAMHS TO MEASURE QUALITY:

Community Rehabilitation Services Survey

A face to face survey of clients who receive CRS services was conducted in February 2013. Interviews with 126 consumers were conducted and chart reviews were performed for an additional 10 consumers who were not available to be interviewed. The purpose of the survey was to determine whether residents understood the service delivery parameters of the CRS services as related to linkages to housing services. Seventy-five percent of leases indicated there were no linkages between housing and services however 59% of treatment plans mandated that a linkage be in place. The consumers perceived a seamless/no barriers transition from PNMI funded beds to CRS services. Hence there was no disruption in consumer services and care but did not allow consumers to control the choice over where to reside. All providers and consumers were educated about the separation of services from housing as part of the survey process.

Contract Performance Outcome Measures

SAMHS has instituted contract performance measures for five service areas for FY13 contracts and fourteen service areas for FY14 contracts. Where appropriate, the measures are in alignment with standards under the Consent Decree Plan. In a meeting with the DHHS Office of Quality Management, we agreed on a three year schedule for full implementation of measures; year one will be to validate the measures, year two to establish baselines, year three to test full implementation. At that point the measures may be put into Maine Care rule as well as being standardized for all SAMHS provider contracts. If a performance measure is not valid a new measure will be developed and the three year process will start on that new measure. The data collected is used in the Consent Decree report, is posted on the SAMHS website, and is used to drive the discussion during a Contract Review/Site Visit. Current Performance Measures are found in Appendix 4.

Crisis Reports

At the directive of the Commissioner, SAMHS revised its Crisis Reports and required individual encounter reporting as of July 1, 2013. All of the prior crisis data variables continued to be reported but now on an individual level. Providers will still report the aggregate number of telephone calls they receive. SAMHS staff worked with the Maine Crisis Network providers to create variables for the crisis screening/assessment reasons for face to face encounters. Meetings were held with providers and technical assistance has been provided by the Data and Quality Management staff. Individual crisis reporting means enhanced knowledge and assessment of this group of clients and new data matching ability with MaineCare and other data sources. With this enhanced data knowledge and data matching ability SAMHS will be able to make good sound data driven decisions for crisis clients. The data collected through the Crisis Reports is used for the Consent Decree and Performance Measures. It is also being sent to the Maine CDC.

Critical Incident Reporting

SAMHS had three systems and portals for providers to report on critical incidents involving consumers. These systems and portals are a legacy from the merger of Adult Mental Health Services and the Office of Substance Abuse. A new system has been devised to combine the three legacy systems. There is now one form which is accessible online that is submitted to a single portal. Procedures to review and provide feedback to agencies have been developed to ensure consistent messaging to reporting agencies. The webinar training has been posted on the SAMHS website. A spreadsheet was being used to gather this data but it is now being entered into EIS. Now that it is in EIS SAMHS is able to run reports.

Housing Quality Standards

Quality Management and agency staff have undertaken Housing Quality Standard reviews of the Residential Treatment and Supported Housing portfolios on an annual basis. These federal, U.S. Department of Housing and Urban Development standards provide a baseline review of health and safety conditions in the living settings for more than 3,000 people. This is reported at time of move in and annually thereafter to several data systems including: Maine's HMIS; a proprietary database; and HUD Annual Progress Reports.

Mental Health Rehabilitation/Crisis Service Provider Review

The Mental Health Rehabilitation/Crisis Service Provider (MHRT/CSP) certification was developed by the crisis providers (Maine Crisis Network) over the past several years in collaboration with DHHS - adult mental health and children's behavioral health and the USM Muskie School. The MHRT/CSP is now ready to be implemented with providers. A review team consisting of two representatives from the Maine Crisis Network, two representatives from Children's Behavioral Health and two representatives from SAMHS worked together to conduct reviews at contracted agencies. Muskie staff are overseeing and organizing the review process. They have collected the data and have generated a summary report.

NIATx Quality Improvement Initiative

NIATx has been deployed in six provider agencies to address wait list and time to assignment issues in provider agencies. SAMHS has contracted with a NIATx trainer who is providing on-site training and technical assistance. The model involves targeted changes using a rapid improvement methodology. A SAMHS central office NIATx team has been formed and has been trained in using the model with employees. The Data/Quality Management Office is addressing the data needs for providers and central office staff to ensure they have the necessary data/quality management tools to measure their successes. It is anticipated that in FY15, the number of agencies using NIATx will be expanded. There is now a NIATx project in conjunction with Muskie addressing Workforce Development regarding recruitment of Mental Health Rehabilitation Technician/Community (MHRT/C). This is in the beginning phase of this initiative therefore we expect it will involve a number

of change cycles. Another proposed NIATx project is a workflow project regarding the Supported Housing program.

SAMHS Website - Reports

During the first week of July 2013, SAMHS started posting on its website mental health Crisis Management and Waitlists reports from APS Healthcare. Providers had been notified of this change at the monthly stakeholder calls. In addition, providers were notified by email when the initial reports were posted. The schedule for posting reports is done on a weekly basis.

SAMHS Website – Redesign

This substantive project will need resource allocation from all SAMHS pillars with management and coordination through the Quality Management and Resource Development team. The re-design involves both visionary and technical skills. Currently one of SAMHS staff is taking additional technical skills training in order to move this initiative along.

Site Visits

On site agency reviews are a critical component of Quality Management and provide agencies with opportunities for Technical Assistance. These contractual reviews often include details as granular as specific record reviews and as general as longitudinal compliance with performance measures, contract measures, and consent decree terms.

Wait List Reporting

On a weekly basis, the Data/Management staff updates graphs of the number of people on waitlists for CI, ACT and DLSS. Also, graphs for time to assignment are produced that provide further information on these three services. Two new reports were developed and distributed as of July 1, 2013. The first report is by service, by provider which lists number on waitlist by agency, and the length of time on the waitlist. The second report is a YTD comparison with the prior year for Community Integration services. These reports are sent to management and field service staff to monitor trends. The Community Integration reports listing the top ten agencies who have had consumers on the waitlist the longest have been identified and the Field Service Specialist and Managers have been in contact with each agency. The top ten Consumers who have been waiting the longest have been identified and are being contacted by SAMHS staff to determine what the Consumer would like to do. Also a letter has been developed by APS Healthcare which goes out to each agency when a Consumer is on the list for more than 30 days.

On a monthly basis the WITS system reports the waitlists for Hospital (Other than Detoxification), Short-term Residential Rehab (30 days or less), Extended Care, Halfway House, Adolescent Residential Rehabilitation Transition, Consumer Run Residence, Non-Intensive Outpatient, Intensive Outpatient, Detoxification (Ambulatory), Adolescent

Outpatient, Adolescent Intensive Outpatient, Opioid Replacement Therapy, Hospital (Detox) and Free Standing Inpatient (Detox).

Below is a list of the priority populations in order of priority:

1. Pregnant Injection Drug User
2. Pregnant Substance Abuser
3. Injection Drug User (within last 5 years)
4. Male/Female Substance Abuser
5. All others (affected family members, ACOs, etc.)

RISK ANALYSIS

SAMHS follows Federal HIPAA regulations <http://www.hhs.gov/ocr/privacy/>

SAMHS staff is required to use the Risk Analysis listed below before sending any information over the internet.

HIPAA Security Risk Analysis – Electronic Protected Health Information

What is Protected Health Information? PHI means health information that is created or received by a healthcare provider, health plan (including MaineCare) or healthcare clearinghouse (translates claims) that relates to the physical or mental health of an individual, the provision of services to the individual or payment for services, that can reasonably be used to identify an individual.

Electronic PHI (ePHI) is PHI that is created, transmitted or maintained electronically.

De-identified data: If the following identifiers are removed, data is not covered by HIPAA protections.

1. Names;
2. Street address, city, county, precinct, zip code;
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. E-mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;

11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data);
19. HIPAA Security Risk Analysis;
20. Risk Analysis 164.308(a)(1) “implement policies and procedures to prevent, detect, contain and correct security violations”;
21. Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information held by the provider;
22. Vulnerability=weakness in system design, implementation, controls that could result in a breach;
23. Threat=potential for exploitation of a vulnerability (natural, human, environmental):
24. Risk=probability that a threat will trigger a vulnerability resulting in an adverse impact (breach, violation of protections). Your goal is to determine risks to information assets that create, receive, maintain and transmit ePHI, then prioritize those risks from highest-to-lowest and, ultimately make risk management decisions that include implementing additional reasonable and appropriate safeguards;

SAMHS also follows 42 CFR part2 for Substance Abuse information
<http://www.law.cornell.edu/cfr/text/42/part-2>

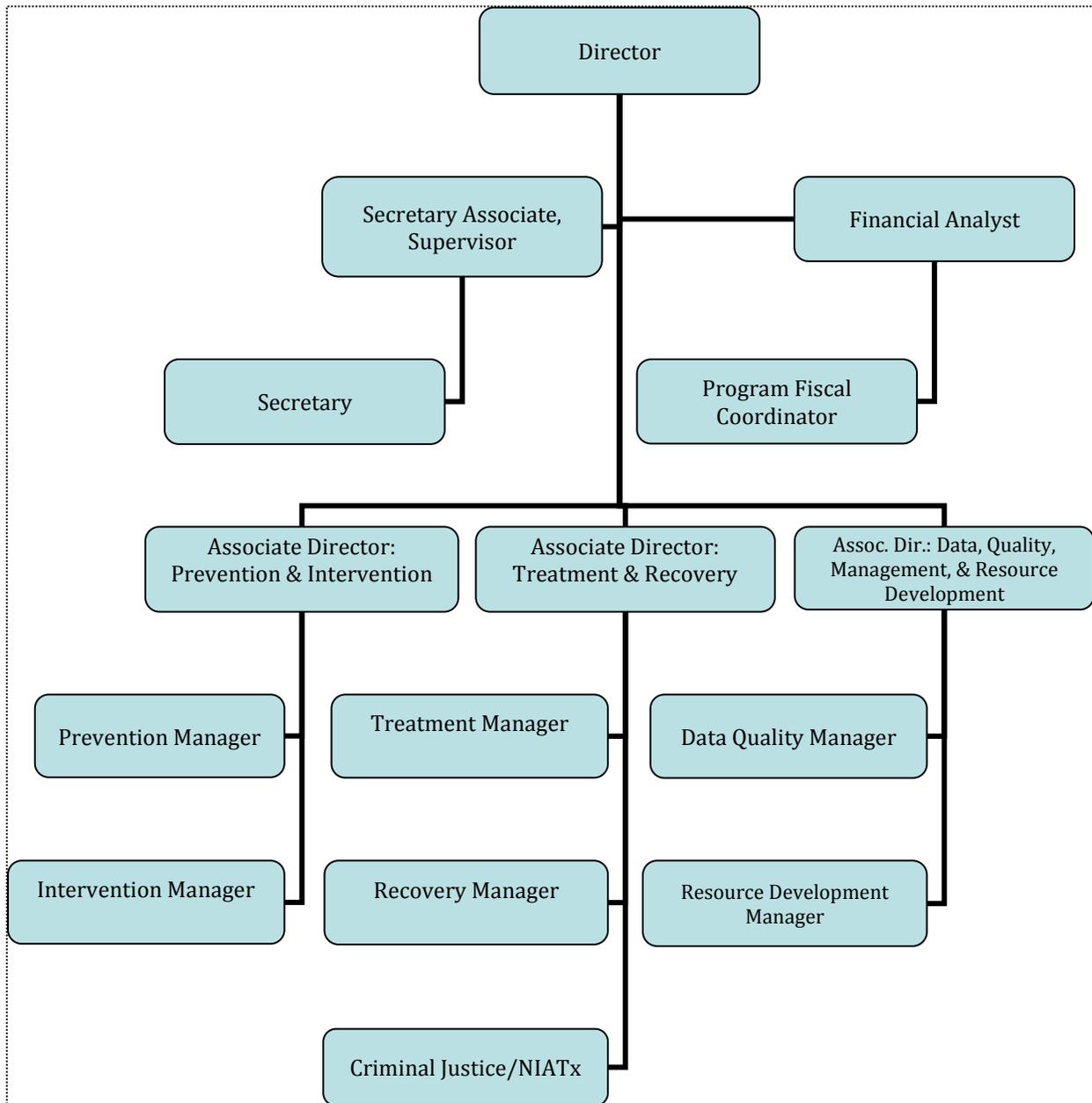
The State of Maine Office of Information Technology: States that any time changes are deployed to a system, an assessment is done to determine if any significant changes have been made that would warrant a security test. We typically request a security test every couple of years if one has not been done. The servers are scanned monthly by the security team. We are preparing for the first HIPAA risk assessment; the DHHS HIPAA officer will determine how frequently they need to be updated.

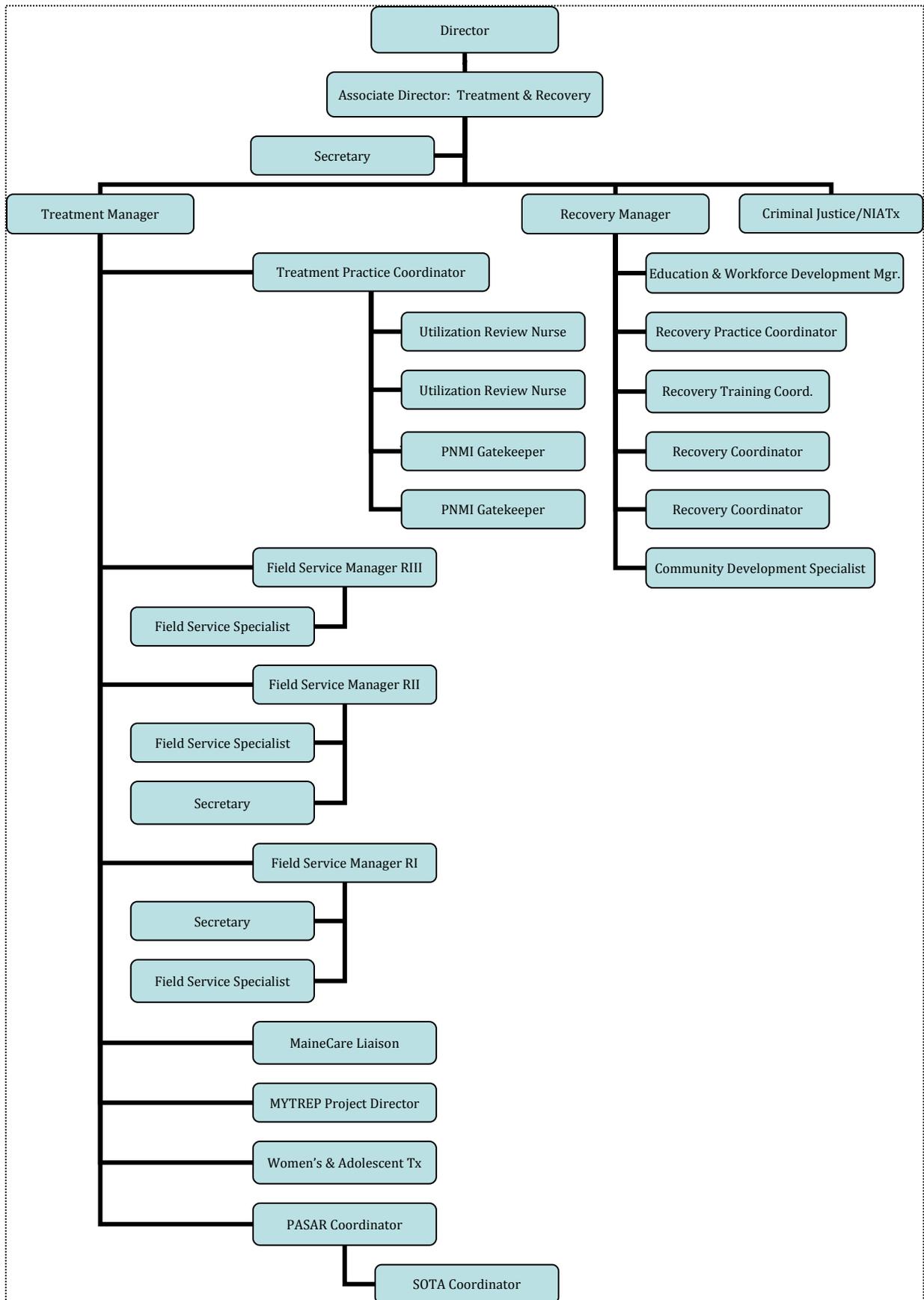
External data systems: Have a Business Associate Agreement, a DHHS Memorandum of Understanding or a Confidentiality Statement embedded in Rider B of their contract. See Appendix 1 for specific agreements.

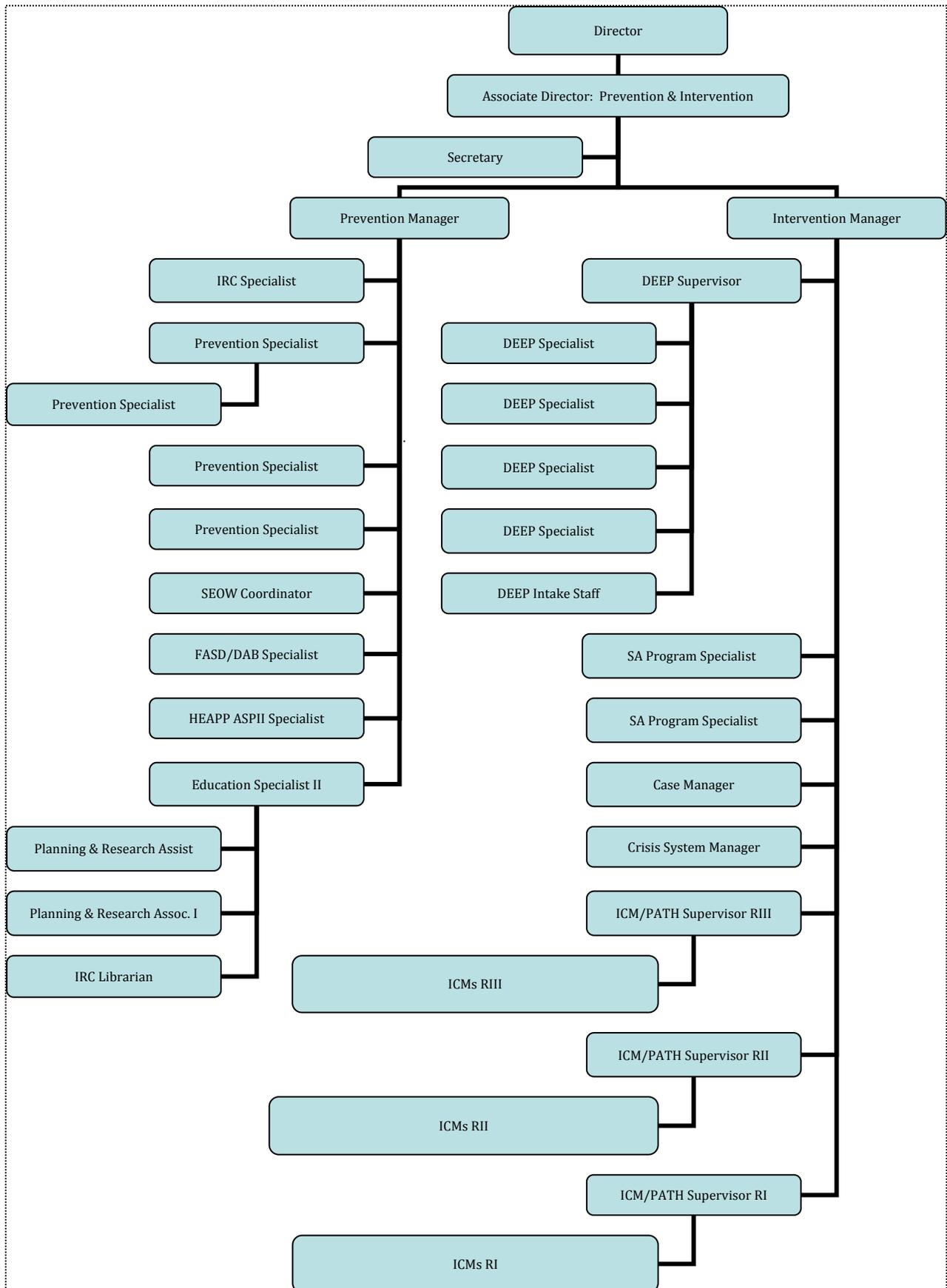
Chapter 4

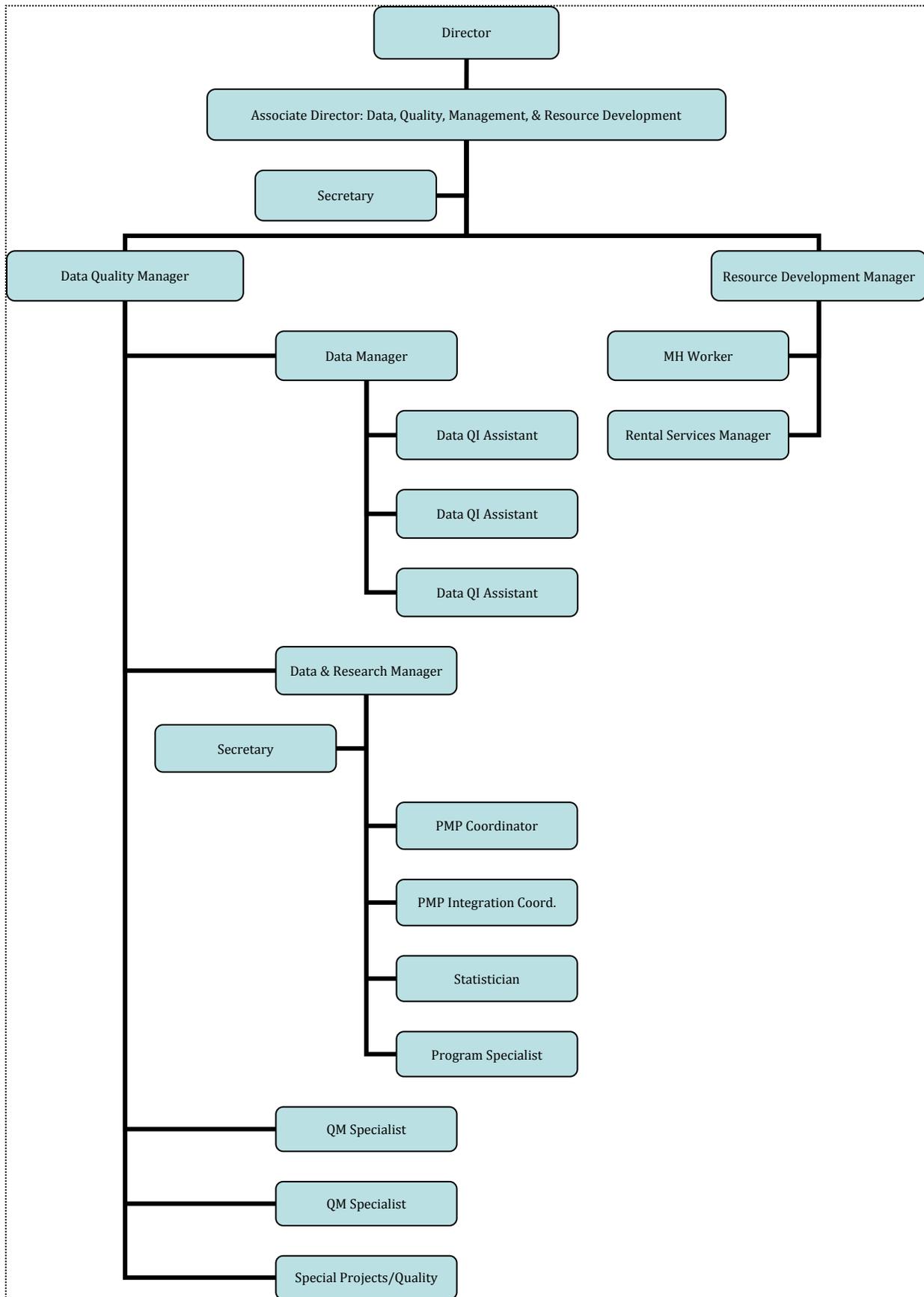
Administration

SAMHS ORGANIZATIONAL CHART









PILLARS

The Office of Substance Abuse and Mental Health Services has borrowed from its federal cousin, Substance Abuse and Mental Health Services Administration, an organizational structure which emphasizes a recovery model that is organizationally built upon pillars of: Prevention, Intervention, Treatment and Recovery with an underpinning from Quality Management and Resource Development.

Prevention Services

The SAMHS prevention team defines prevention as the active, assertive process of creating conditions that promote well-being, while keeping problems associated with substance use/abuse and mental health from occurring.

Intervention Services

Intervention efforts seek to prevent, reduce or decrease the numbers of occurrences or use of substance abuse and/or mental health service needs. At SAMHS, Intervention includes four major programs: CRISIS, CRISIS MOBILE, and DEEP.

Treatment Services

Treatment is a therapeutic process to reduce or eliminate the symptoms and side effects of mental illness or substance abuse through direct observation, assessment, examination and therapeutic intervention.

Recovery Services

A journey of healing and transformation that enables a person to live a meaningful, satisfying and contributing life in a community of his or her choice. Recovery is an individual process, a way of life, an attitude, and a way of approaching life's challenges. The need is to meet the challenges of one's life and find purpose within and beyond the limits of the illness while holding a positive sense of identity.

Quality Management Services

Quality Management Services at SAMHS supports all teams and pillars identified above through the use and application development of information technologies and business processes. The QM team is a key stakeholder in bringing greater accountability to all contracts and is increasing the focus on consumer outcomes in all activities supported by the office. Substantial programs include the Mental Health Block Grant and all Supported Housing Services as well as PATH (Projects for Assistance in Transition from Homelessness).

SAMHS PARTNERS

Consumer Council of Maine

- The Consumer Council System of Maine (CCSM) is an independent, public instrumentality established by Maine law (Title 34-B, §3611).
- The CCSM is responsible for providing an independent and effective consumer voice into mental health public policy, services, and funding decisions.
- The CCSM consists entirely of past/present recipients of mental health services (consumer/peers), including all Statewide Consumer Council representatives and paid staff.
- The Consumer Council is also a requirement of the Consent Decree. Superior Court, Civil Action, Docket No. 89-88

State-wide Quality Improvement Council

QIC is to ensure that all people served by the Department of Health and Human Services in the State of Maine might proclaim Maine as providing the nation's highest standard for quality service in an environment of respect and empowerment.

The mission of the QIC is to advise the Commissioner on issues of system implementation that have state-wide impact and serve as the mandated advisory board for purposes of advising the Department relative to the federal Community Mental Health Block Grant (Federal Public Law 102-321).

§3609. State-wide Quality Improvement Council

The commissioner shall designate persons to be members to serve on a state-wide quality improvement council to advise the Commissioner on issues of system implementation that have state-wide impact. The Commissioner shall appoint such other members to serve on the council as required by law. [2007, c. 286, §9 (AMD).]
DRC, Sub Abuse Comm.

{The QIC may have been repealed—double check statute}

The Maine Association of Substance Abuse Programs, Inc.

MASAP is a non-profit membership organization recognized state-wide and nationally as the voice of substance use and addiction in Maine. MASAP represents and advocates for the continuum of substance use and addiction services throughout Maine, from prevention through treatment to recovery.

Disability Rights Center

DRC provides individuals with information about their rights and service systems, and represents individuals at meetings and hearings by providing legal services to individuals and groups. In addition, DRC works for systemic change and offers trainings on individual rights and developing advocacy skills. We also act as a referral service for individuals we are unable to directly assist.

Chapter 5

Metrics, Measures and Standards

SAMHS uses a variety of metrics, measures and standards each unique to specific services. The following paragraphs give a brief description and a link where you may obtain more information.

CONSENT DECREE

Settlement Agreement

http://www.maine.gov/dhhs/samhs/mentalhealth/consent_decree/amend_rule/home.html

The Settlement Agreement came out of a fifteen count complaint filed by the plaintiffs (patients at the Augusta Mental Health Institute) on February 27, 1989. The Settlement Agreement was developed to address the allegations of the Complaint and to provide an appropriate remedy.

The Settlement Agreement contains 131 pages with 303 specific paragraphs which provide direction to the Department of Health and Human Services.

Consent Decree Plan

http://www.maine.gov/dhhs/samhs/mentalhealth/consent_decree/cd-plan/index.shtml

The Consent Decree Plan was developed to assist the DHHS to demonstrate substantial compliance with the Settlement Agreement. The Consent Decree Plan contains 98 pages and includes 41 pages of Compliance Standards and reporting metrics.

Consent Decree- Progress Report

http://www.maine.gov/dhhs/samhs/mentalhealth/consent_decree/archive.html

DHHS Office of Substance Abuse and Mental Health is required to report to the court quarterly regarding compliance and progress toward meeting specific standards as delineated in the Settlement Agreement, the Consent Decree Plan and the Compliance Standards.

SAMHSA's National Outcome Measures

<http://integratedrecovery.org/wp-content/uploads/2010/08/SAMHSA-National-Outcome-Measures.pdf>

SAMHSA has developed ten NOMs domains in collaboration with the States. These domains are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities.

The development and application of NOMs is a key component of the SAMHSA initiative to set performance targets for State and Federally funded initiatives and programs for substance abuse prevention and mental health.

SAMHS uses the NOMs for both the Substance Abuse and Mental Health Block Grants. The reports on Substance Abuse Block Grant reports on Employment/Education, Stability in Housing, Crime and Criminal Justice, Abstinence, Retention, Social Consecutiveness and Access. The Mental Health Block Grant reports on the number of Severely Mentally Ill (SMI) persons receiving services, SMI receiving Housing First services, Re-admissions to psychiatric hospitals, SMI employed in competitive jobs, SMI enrolled in Behavioral Health Homes and Assertive Community Teams that coordinate with psychiatric hospital care.

Performance Measures

R:\SAMHS Team\Agency Monitoring Team\PERFORMANCE MEASURES\ FY15 SAMHS Performance Measures\SA_MH_TxPerformMeasSFY15.xlsx

Twenty five Performance Measures have been developed for thirteen Mental Health services while fifty three Performance Measures have been developed for eleven Substance Abuse services. The SAMHS team continues to develop and modify measures as Evidence Based Best/Promising Practices are developed both in Maine and across the country.

Chapter 6

Data and Quality Management Systems

DATA SYSTEMS

[See Appendix II](#)

KIT
Prescription Monitoring Program
WITS
EIS
DEEP
Service Encounter DB
External: HMIS, APS,

SURVEYS

[See Appendix III](#)

Maine Integrated Youth Health Survey
Mental Health and Well Being Survey
Substance Abuse Customer Satisfaction Survey

QUALITY MANAGEMENT REVIEW FORMS

[See Appendix IV](#)

Substance Abuse
ACT
Consent Decree
Housing
Under revision: Community Integration, Daily Living Support Services and Outpatient
Therapy

ASSESSMENT TOOLS

[See Appendix V](#)

ANSA
LOCUS

Chapter 7

Prevention Services

The SAMHS prevention team defines prevention as the active, assertive process of creating conditions that promote well-being, while keeping problems associated with substance use/abuse and mental health from occurring.

Prevention Services focus around four general categories: Increasing awareness and knowledge through communications, education, and training; improving social norms; improving regulation/policy and their enforcement; and reducing availability/access. Currently the SAMHS prevention team funds/offers the following services and programs:

1. Drug-Free Workplace Program - WorkAlert and Healthy Maine Works.
2. Enforcing Underage Drinking Laws (EUDL) - Compliance checks, Card ME program; Project Sticker Shock; Responsible Beverage Server Training.
3. Healthy Maine Partnerships (HMP) - Coalition based public health promotion and prevention.
4. Higher Education Alcohol Prevention Programs (HEAPP) - Prevention of Underage and high-risk drinking on Maine's campuses and the surrounding communities.
5. Maine Youth Action Network (MYAN) - Empower and prepare youth and adults to partner for positive change by offering them training, networking and leadership opportunities.
6. Problem Gambling Prevention - Education and information dissemination.
7. Student Intervention and Reintegration Program (SIRP) - This education program for adolescents focuses on alcohol and drug prevention and intervention.
8. Parent Media Campaigns - Information and education.
9. Fetal Alcohol Spectrum Disorder/Drug Affected Baby (FASD/DAB) Coordination- Providing information and education statewide on FASD/DAB.
10. Evidenced Based Prevention Panel - Resource for prevention providers to submit programs for review to potentially be deemed evidenced based.
11. Vet Corps Program- Increase capacity to better serve needs of military service members and their families.

PROGRAM/SERVICE: DRUG-FREE WORKPLACE PROGRAM, WORKALERT, AND HEALTHY MAINE WORKS

Description of Program/Service:

Drug-Free Workplace Program – Focus is to reduce the effects of substance abuse on workplaces. The program provides tools and materials to worksites, including WorkAlert and Healthy Maine Works; both are web-based tools for employers.

Evidence Based/Promising Practice Standards:

DFW Program includes the 5 components (policy, education, training, EAP, drug testing) that have been indicated in successful programs.

Drug-Free Workplace Program –

1. **DFW:** <http://www.drugfreeworkplace.gov/pdf/workplace-kit.pdf>
2. **HMW:** Local HMP Survey Report FY 2009-2010 - <http://mainehearthealth.org/sites/default/files/Healthy%20Maine%20Works%20Local%20HMP%20Survey%20Report.pdf>

Data: Do we collect data on this program?

Drug Free Workplace – only if an HMP uses or if SAMHS does outreach

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: EVIDENCED BASED PREVENTION PANEL

Description of Program/Service:

Evidenced Based Prevention Panel- This panel exists as a resource for prevention providers across the state to submit a proposal for their program to be recognized in the state as an Evidenced Based program. The panel includes SAMHS staff, community and statewide stakeholders.

Evidence Based/Promising Practice Standards:

Evidenced Based Prevention Panel- SAMHSA/CSAP guide for Identifying and selecting evidence-based interventions. Page 19 of <http://store.samhsa.gov/shin/content/SMA09-4205/SMA09-4205.pdf>

Data: Do we collect data on this program?

No

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: ENFORCING UNDERAGE DRINKING LAWS (EUDL)

Description of Program/Service:

Prevention Services focus around four general categories: Increasing awareness and knowledge through communications, education, and training; improving norms; improving regulation/policy and their enforcement; and reducing availability/access. Currently the SAMHS prevention team funds/offers the following services and programs:

Enforcing Underage Drinking Laws – Focuses on reducing underage drinking through increased enforcement of laws. Programs funded include Party Patrols, undercover compliance checks, Card ME program; Project Sticker Shock; Responsible Beverage Server Training.

Evidence Based/Promising Practice Standards:

All the items below that are “programs” have one standard, and that is the program should be implemented with fidelity in the population the program was designed for and in which it has been evaluated. I will note these using the word “fidelity” next to the program.

1. Compliance check and enforcement – (fidelity)
<http://www.thecommunityguide.org/alcohol/lawsprohibitingsales.html>
<http://www.thecommunityguide.org/alcohol/overservice.html>
2. RBS training – (fidelity)
http://www.thecommunityguide.org/alcohol/beverage_service.html
3. Card ME –
http://www.maine.gov/dhhs/samhs/osa/prevention/community/licensee/car_dme/researchtheory.htm
4. Project Sticker Shock –
<http://www.maine.gov/dhhs/samhs/osa/prevention/youth/sticker.htm>
<http://www.dontletminorsdrink.com/downloads/Project%20Sticker%20Shock.pdf>

Data: Do we collect data on this program?

Data is collected for this program through Survey Monkey. Data collected includes: Number of on- and off-premise checks and number passed; number of officers on details number of hours; for party patrols, surveillance, and deterrence details collect the number of juvenile citations written by infraction type, number of minor violations (18-20 year olds) by infraction type, and number of adult (over 21) by infraction type; any media that law enforcement participates in due to this, collect number of newspaper articles, TV spots, and paid advertising. In addition, there is a written summary of the work performed. Data is stored in survey monkey. Semi-annually they collect: Check list of the types of checks/surveillance performed and the agencies involved in the checks; number of on- and off-premise compliance checks and those that passed; number by type of citation written

DRAFT

during that period; number of educational activities by type; yes/no if a type of media occurred; yes/no on types of educational activities; yes/no on any policy changes; and summary of how they feel things are going.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: FETAL ALCOHOL SPECTRUM DISORDER/DRUG AFFECTED BABY COORDINATION

Prevention Services focus around four general categories: Increasing awareness and knowledge through communications, education, and training; improving norms; improving regulation/policy and their enforcement; and reducing availability/access. Currently the SAMHS prevention team funds/offers the following services and programs:

Description of Program/Service:

Fetal Alcohol Spectrum Disorder/Drug Affected Baby Coordination- Maine has a state coordinator who is housed at SAMHS and collaborates with statewide stakeholders on issues related to substance use during pregnancy. A part of this project includes developing educational messages that provide information on the risks and dangers of use during pregnancy, the consequences of use, and how to find resources and supports for those children who may be born drug exposed, affected, or demonstrating an FASD. This coordinator facilitates a statewide FASD/DAB task force and collaborates with hospitals, treatment providers, child welfare, medical professionals, and others to reduce the number of children in Maine born exposed to substances.

Evidence Based/Promising Practice Standards:

Training Source for Providers:

Northeast addiction Technology transfer center. (2012) *Effective Risk Management Strategies in Outpatient Methadone treatment: Trainers Manual*. Pittsburgh, PA. NIAAA. (2009). How to screen for heavy drinking. National Institutes of Health. FASD Prevention Tool Kit for Women's Health Care Providers. http://www.cdc.gov/ncbddd/fasd/acog_toolkit.html.

Data: Do we collect data on this program?

From the FASD/DAB logic model they list the following short term measures they will collect:

- Numbers of:
 - media messages disseminated;
 - women receiving the messages;
 - educational opportunities provided;
 - participants educated;
 - medical providers trained;
 - women receiving SBIRT;
 - pregnant women receiving universal substance abuse screening;
 - women receiving treatment information;
 - providers who offer gender specific substance abuse treatment;
 - Task force meetings held;

DRAFT

- Stakeholders participating in the task force;
- Cross training events.

Measures collected within SAMHS.

From the FASD/DAB logic model they list the following intermediate measures they will collect:

- Number of:
 - Women who report substance use during pregnancy (PRAMS);
 - Healthcare providers trained to discuss the risks of substance use to their patients as part of their protocols (SAMHS);
 - Providers who make appropriate SA treatment referrals for women (WITS, PRAMS);
 - Babies born exposed to substances prenatally (MHDO/MCDC);
 - Women engaged in substance abuse treatment and maintain recovery (WITS);
 - Stakeholders who collaborate on FASD/DAB initiatives.

Increase awareness about the importance of FASD/DAB.

From the FASD/DAB logic model they list the following long-term measures they will collect:

- Reduction in the number of substance exposed infants

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: HIGHER EDUCATION ALCOHOL PREVENTION PROGRAMS (HEAPP)

Description of Program/Service:

Higher Education Alcohol Prevention Programs - This prevention program is a statewide initiative for the prevention/reduction of high risk drinking in Maine's institutions of higher education. The HEAPP program focuses specifically on environmental change around underage and high-risk drinking on Maine's campuses and the surrounding communities, public policy affecting the issue, and capacity/willingness for change. This program funds campus community coalition development; addressing alcohol availability and advertising; social norm marketing campaigns; campus policy enforcement; screening and brief intervention.

Evidence Based/Promising Practice Standards:

1. Campus-Community Coalition – While this is not a program (so it does not contain a fidelity rubric) there are common components that make up successful coalitions. Raynor, J. (2011, March). What makes an effective coalition? Evidence based indicators of success. TCC Group.
 - a. Wolff, T. (2001). A practitioners guide to successful coalitions. *American Journal of Community Psychology*, 29(2), 173-191.
2. Availability and Advertising – This is not a program, availability is a risk factor that has an association to increased alcohol use, as does advertising. So part of their work is to try to reduce availability and pro-drinking advertising on and around campus.
3. Social Norms Marketing – (fidelity) Research is mixed on this strategy. **DeJong, W., Schneider, S.K., Towvim, L.G., Murphy, M.J., Doerr, E.E., Simonsen, N.R., et al.** (2009). A multisite randomized trial of social norms marketing campaigns to reduce college student drinking: A replication failure. *Substance Abuse*, 30 (2), 127-140.
 - a. **Moreira, M.T., Smith, L.A., & Foxcroft, D.** (2009). Social norms interventions to reduce alcohol misuse in university or college students. *Cochrane Database of Systematic Reviews* 2009, 3
 - b. **Schneider,S., Towvim, L.G., & DeJong, W. (2005).** The social norms marketing research project: Results for Study 1. *The Report on Social Norms*, 4 (5).
4. Policy Enforcement – Enforcement is another risk factor for increased use (lack of enforcement).

5. Screening and Brief Intervention – (fidelity) BASICS (brief alcohol screening and intervention for college students) - <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=124>.
 - a. Butler, L.H., Correia, C.J. (2009). Brief alcohol intervention with college student drinkers: face to face versus computerized feedback. *Psychol Addict Behavior*, 23(1). Pp 163-7.
 - b. Fachini, A., Aliane, P.P., Martinez, E.Z., and Furtado, E.F. (2012). Efficacy of brief alcohol screening intervention for college students (BASICS): a meta-analysis of randomized controlled trials. *Substance Abuse Treatment, Prevention, and Policy*, 7:40.

Data: Do we collect data on this program?

HEAPP – Collect data through Survey monkey, same as EUDL. Collect the same types of counts as EUDL. Plus collect yes/no for having 2 or more coalition meetings during a semester, including sector representatives who attended. Collect yes/no answers with details for the following: if they participated in a community-based SA prevention activity; if the campus conducted municipal, state, or campus policies; activities to reduce access or high risk drinking environments; activities to change normative environment at school; AOD-free events; high risk drinking or alcohol abuse policy violations interventions; educational activities implemented; number of alcohol violations by type of violation per semester; Media exposure; and general narrative.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: HEALTHY MAINE PARTNERSHIPS (HMP)

Description of Program/Service:

Healthy Maine Partnerships – Nine lead community based coalitions (who further fund an additional 18 coalitions statewide), whose focus is public health promotion and prevention. They implement evidence based environmental substance abuse prevention strategies, using the funds SAMHS provides to work on underage drinking, high risk drinking, prescription drug misuse/abuse, and marijuana use prevention. 2014 contracts include education and information dissemination on Marijuana; awareness and education on Prescription Drugs (also may implement SIRP, Vet Corp, and Problem Gambling).

Evidence Based/Promising Practice Standards:

Some of the strategies the HMP's implement can be found within this guide, Chinman, M., Imm, P., Wandersman, A. (2004) Getting to Outcomes, 2004: Promoting accountability through methods and tools for planning, implementation, and evaluation. http://www.rand.org/content/dam/rand/pubs/technical_reports/2004/RAND_TR101.pdf Coalitions: State and Community Interventions. (2007). Best Practices for comprehensive tobacco control programs, users guide. US DHHS, Center for Disease Control & Prevention.

The HMP's are required to use SA prevention strategies that are evidence based, as identified by SAMHSA evidence Based Prevention Guide.

Objectives showing in KIT:

- Improve responsible retailing practices by liquor licensee's;
- Increase perception among youth that they would be caught if they used alcohol;
- Increase awareness about the risk of underage alcohol use and high risk drinking in young adults;
- Increase awareness about the risk and harm of marijuana use; and
- Increase community engagement in addressing prescription abuse.

Data: Do we collect data on this program?

HMP – Collect data through KIT system. No measures in contracts.

Counts collected in KIT depend on the strategy chosen by the HMP as there are different counts for each individual strategy.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: PARENT MEDIA CAMPAIGNS

Description of Program/Service:

Parent Media Campaigns- Provides information and education through messages that are disseminated via radio, television, online advertisements, brochures, internet resources, and the like.

Evidence Based/Promising Practice Standards:

The “program” has one standard, and that is the program should be implemented with fidelity in the population the program was designed for and in which it has been evaluated. I will note this using the word “fidelity” next to the program.

Parent Media Campaigns- Social marketing. (fidelity)

- Guide to Community Preventive Services - Health communication & social marketing. www.thecommunityguide.org/healthcommunication/campaigns.html
- Derzon, J.H., and Lipsey, M.W. (2002). A meta-analysis of the effectiveness of mass communication for changing substance-use knowledge, attitudes, and behavior. In W.D. Crano and M. Burgoon (Eds.), *Mass Media and Drug Prevention: Classic and Contemporary Theories and Research* (pp. 231-258). Mahwah, NJ: Lawrence Erlbaum.

Data: Do we collect data on this program?

The Parent Media Campaign is a universal environmental strategy implemented through information dissemination. Counts are collected for the number of messages disseminated and the number of channels through which the messages are broadcast. The KIT Performance Based Prevention System is utilized to collect these counts.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: MENTAL HEALTH PREVENTION

Prevention Services focus around four general categories: Increasing awareness and knowledge through communications, education, and training; improving norms; improving regulation/policy and their enforcement; and reducing availability/access.

Prior to 2014, Prevention in SAMHS did not include MH programs. Utilizing the following resources among others, the SAMHS Prevention Team is actively working to integrate MH prevention/promotion into the work they fund:

- Catalano, R.F., Hawkins, J.D., Berglund, L., Pollard, J.A., and Arthur, M.W. (2002). Prevention science and positive youth development: Competitive or cooperative frameworks? *Journal of Adolescent Health, 31*, 230-239.
- Durlak, J.A., and Wells, A.M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology, 25*, 115-152.
- Durlak, J.A., Weissberg, R.P., Taylor, R.D., and Dymnicki, A.B. (2007). *The Effects of School-Based Social and Emotional Learning: A Meta-Analytic Review*. Unpublished manuscript, Loyola University, Chicago, IL.

Description of Program/Service:

Develop and disseminate educational messages and materials to the public conveying that everyone has mental health and it is important for people to take care of themselves like with physical health. The purpose is to 1) reduce stigma as well as provide people with tools to prevent mental illness; 2) provide materials to educate people how to take care of themselves, how to find help, and reminding people that reaching out for help is a sign of strength. Work will be carried out through partnering with other state agencies including the Office of Child and Family Services, and we also have partners including NAMI Maine at the table and members of the Consumer Council of Maine.

Evidence Based/Promising Practice Standards:

Prevention team will use evidence-based social marketing and media communication strategies in disseminating educational messages to increase awareness about mental health, taking care of oneself, and where to go for help.

The US CDC notes media communications performed in a specific manner as being an effective means in improving awareness. CDC's *Best Practices for Comprehensive Tobacco Control Programs—2014*. http://www.cdc.gov/tobacco/stateandcommunity/best_practices/

Data: Do we collect data on this program? If yes, what are the data measures (cite source, i.e. NOM, Contract Performance, Consent Decree)?

There are currently no NOMs developed for the prevention arm of Mental Health. Although there are a couple NOMs on the substance abuse prevention side that could be considered in the future, such as number of persons receiving an evidence-based practice.

SAMHS pays for the collection of mental health questions in the annual Behavioral Risk Factor Surveillance System (BRFSS). The following four questions (these are optional questions offered by the federal BRFSS that Maine has decided to include and pay for) will be in the 2015 Survey:

- Over the last 2 weeks, how many days have you had little interest or pleasure in doing things?
- Over the last 2 weeks, how many days have you felt down, depressed or hopeless?
- Has a doctor or other healthcare provider EVER told you that you have an anxiety disorder (including acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, posttraumatic stress disorder, or social anxiety disorder)?
- Are you now taking medicine or receiving treatment from a doctor or other healthcare provider for any type of mental health condition or emotional problem?

SAMHS works with the Maine CDC and the Maine Department of Education on the Youth Risk Behavior Survey (YRBS). Through this collaboration the questions below will help track need and changes in risk in High School Student population:

- During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
- During the past 12 months, when you felt sad or hopeless, from whom did you get help?

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: MAINE YOUTH ACTION NETWORK (MYAN)

Description of Program/Service:

Maine Youth Action Network (MYAN)- SAMHS provides funding to the MYAN program to support their work with youth as a form of prevention. MYAN's mission is to empower and prepare youth and adults to partner for positive change by offering them training, networking and leadership opportunities.

Evidence Based/Promising Practice Standards:

U.S. CDC. Best Practices User Guide: Youth Engagement - State and Community Interventions. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

- Increase retail price of alcohol;
- Decrease minor's access (by Development of and advocacy for, alcohol- and drug-free policies that restrict youth access to alcohol and other drugs);
- Increase alcohol- and drug-free ordinances (by Development of and advocacy for, alcohol- and drug-free policies in communities, businesses, and schools);
- Decrease consumption of alcohol and drugs (by enforcement of alcohol and drug policies); and
- Conduct mass media or counter marketing campaigns.

Recommends the following public health outcomes: 1. Decrease Consumption; 2. Reduce access and availability; 3. Prevent initiation.

Data: Do we collect data on this program?

In SFY2014 contract: Conduct 1 Summit (up to 300 youth and adults); 1 skill building training per PHD with 4 sessions each; Mentor 10-16 geographically diverse youth on leadership skills; Produce 4 newsletters per year; Recruit 100 new online community members; Have at least 7,000 unique visitors and 11,000 web visits on website; Recruit at least 50 new people in email network; Add at least 80 new Facebook fans.

MIYHS can be used to measure some of the promising practices above;

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: PROBLEM GAMBLING PREVENTION

Description of Program/Service:

Problem Gambling Prevention- This program provides education and information dissemination across the state on the signs and symptoms of Problem Gambling while also providing information and resources on how to gamble responsibly. SAMHS is a gambling neutral agency.

Evidence Based/Promising Practice Standards:

<http://www.jogoremoto.pt/docs/extra/x5qah9.pdf>

Fortunately, there is considerably more literature on the utility of public information/awareness campaigns for other health behaviors that contain lessons for the prevention of problem gambling (Byrne, Dickson, Derevensky, Gupta, & Lussier, 2005). In general, research has found that sustained information/awareness initiatives have significant potential to improve people's knowledge and/or change their attitudes at a community-wide level (Centre for Addiction and Mental Health [CAMH], 1999; Duperrex, Roberts, & Bunn, 2006; Grilli, Ramsay, & Minozzi, 2004; Sowden & Arblaster, 2005). Indeed, population surveys have long been known to show that mass media are in fact the leading source of information about important health issues, such as weight control, HIV/AIDS, drug abuse, asthma, family planning and mammography (Chapman & Lupton, 1994).

Data: Do we collect data on this program?

Problem Gambling Prevention – Collect data through the KIT system. No measures in contract.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

Maine Statute: Title 5 Part 25 Chapter 521 §20006-B – an established fund to be used to support gambling addiction analysis, prevention, and treatment.

PROGRAM/SERVICE: STUDENT INTERVENTION AND REINTEGRATION PROGRAM (SIRP)

Description of Program/Service:

Student Intervention and Reintegration Program (SIRP)- This education program for adolescents focuses on alcohol and drug prevention and intervention. SIRP teaches the PRIME for Life Under 21 Program, provided by the [Prevention Research Institute, Inc. \(PRI\)](#), and is designed to influence behaviors using a research-based persuasion protocol.

The aim of SIRP is to empower youth to make healthy decisions and reduce risk for problems. SIRP focuses on two measurable behavioral prevention goals: reducing the risk of alcohol and drug problems throughout their lifetime and reducing high-risk choices.

Evidence Based/Promising Practice Standards:

The “program” has one standard, and that is the program should be implemented with fidelity in the population the program was designed for and in which it has been evaluated. I will note this using the word “fidelity” next to the program.

PRIME for Life Under 21 Program – (fidelity) Rosengren, D. B., Crisafulli, M. A., Nason, M., and Beadness, B. (2013) A review of the empirical support for PRIME For Life. Technical Report. Prevention Research Institute. Lexington, KY. [Prevention Research Institute, Inc. \(PRI\)](#), and is designed to influence behaviors using a research-based persuasion protocol. NREPP, <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=12>

Data: Do we collect data on this program?

SIRP Grantees have to participate in at least 3 of 6 TA calls and attend SAMHS 2013 Provider Day. Data is collected in KIT monthly regarding number of youth served. In addition, there is an evaluation component to this program whereby a contracted evaluator is collecting data on the effectiveness of this program.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

PROGRAM/SERVICE: VET CORPS PROGRAM

Description of Program/Service:

Vet Corps Program- In collaboration with CADCA, the Prevention team provides support to three Healthy Maine Partnerships for the implementation of this program. Vet Corps is program to assist coalitions and communities to increase capacity to better serve the substance abuse and behavioral health services needs of military service members and their families. Another goal is to increase access to services for National Guard and Reservists. The coalitions are required to provide office space/support for the VetCorps member, provide orientation and training within 1 month of service, and participate in evaluation.

Evidence Based/Promising Practice Standards:

Vet Corps Program- This is a new program developed by AmeriCorp and CADCA, launched in 2011. The Overall goal of the national program is to place 100 military veterans to serve as AmeriCorp members across 28 states (Maine is one of them). The aim of this program is to increase community capacity to provide substance abuse prevention and treatment for veterans and service members.

Data: Do we collect data on this program?

Vet Corp – Collect data through KIT system. No measures in contract. Only states they will provide monthly progress reports.

Mandate: Is there a legal mandate for this service?

While there is not a legal mandate for providing prevention services, the SAPT Block Grant requires that at least 20% of the grant be used for prevention. The grant does not specify the type of programs that need to be provided.

Chapter 8

Intervention Services

Intervention efforts seek to prevent, reduce or decrease the numbers of occurrences or use of substance abuse and/or mental health service needs. At SAMHS, Intervention includes four major programs: CRISIS, CRISIS MOBILE, DEEP and PATH.

PROGRAM/SERVICE: CRISIS MOBILE

Description of Program/Service:

Crisis Intervention Mobile Response services are a part of an integrated crisis system within a geographic area for children and adults. The integrated crisis system shall include not only the DHHS contracted crisis providers (Mobile Crisis Response and Crisis Stabilization Units and Residences for adults and youth) and all the hospitals (with or without psychiatric units) in the geographic area. While there may continue to exist separate organizations providing services, from the consumer's and family's perspective the system is to be seen and feel as one system, as though it is one entity providing the services.

Crisis Intervention Services are immediate crisis-oriented on-scene services oriented toward the amelioration and stabilization of acute emotional disturbances to ensure the safety of a consumer or society. "On-scene" can mean a variety of locations including member homes, shelters, and emergency rooms. There is an expectation that providers will provide services in the least restrictive setting, including at home, in a shelter, or at school. Emergency rooms should be used only as a last resort for crisis intervention. Services are provided and available 24 hours per day, 7 days per week. Covered services include direct telephone contacts with both the member and the member's parent or guardian or adult's member's guardian when at least one face-to-face contact is made with the member within seven (7) days prior to the first contact related to the crisis resolution service. The substance of the telephone contact(s) must be such that the member is the focus of the service, and the need for communication with the parent or guardian without the member present must be documented in the member's record. A treatment episode is limited to six (6) face-to-face visits and related follow up phone calls over a thirty (30) day period after the first face to face visit.

A component of this service may be a telephone service which is the point of entry for crisis intervention services.

Incorporated into this agreement are the following:

1. The Crisis Service system minimum requirements
2. MOU minimum requirements
3. The Crisis Service Standards of November 30, 2006.

Evidence Based/Promising Practice Standards:

American Association for Emergency Psychiatry Standards

Retrieved from AAEP website at: <http://www.emergencypsychiatry.org/>.

Accessibility

- There will be a 24-hour phone with a listed number.
- There will be 24-hour walk-in capability.
- There will be coordination with those doing outreach in the community (e.g. police, fire, rescue, etc.).
- No one will be denied care due to lack of ability to pay.
- Transfer to and from the service will be based on written policies.

Staffing

1. A mental health professional will be designated to direct the psychiatric emergency component.
2. The mental health professionals staffing the psychiatric emergency service will have documentation of training and experience in psychiatric emergency and crisis work.
3. Staff without documented training in emergency psychiatry will be supervised by staff that have that training and experience.
4. Mental health professionals may include a psychiatrist (at least at the PGY 2 I level, registered nurses, psychiatric social workers, and clinical psychologists.
5. Mental health workers without advanced degrees will act under the supervision of licensed mental health professionals.
6. Security officers will work with the mental health professionals to protect the safety of patients, staff, other professionals, and families.
7. A psychiatrist will be available 24 hours a day, and there will be a psychiatrist who serves as Medical Director of the unit who will be responsible for the quality of the medical care provided.
8. One of the mental health professionals will be assigned to coordinate the care of each patient in the service.
9. Medical consultation will be readily available.
10. Laboratory and x-ray technicians will be available when needed.
11. A list of translators for the most commonly encountered languages will be maintained and available.

Management

1. Patients will have their vital signs taken and recorded upon arrival.
2. Initial signs and symptoms will be reviewed promptly to prioritize needed care.
3. A log will be kept of phone calls including: nature of call, name of caller, time and date of the call, actions suggested or taken, and the name of the staff member receiving the call.
4. A log will be kept of all walk-ins including: names, nature of the patient's problem, time and date of arrival, persons accompanying them and disposition.

5. An evaluation will be done on all cases including: a mental status examination; vital signs and a screening medical examination, a medication history; a history of recent psychiatric care and a brief psychosocial assessment.
6. There will be a documented effort to contact all current sources of mental health care. Available interventions will include crisis assessment and intervention work with family and friends, medication assessment and resources for detoxification from alcohol (or other drugs either on site, or easily accessible).
7. Patients should not stay more than 23 hours in the psychiatric emergency service, unless there are licensed emergency services holding beds or psychiatric inpatient beds within the service.
8. A comprehensive list of dispositions should be available, including: voluntary and involuntary hospitals, respite care, out-patient treatment, home visiting services, day treatment, drug and alcohol programs, geriatric resources, child and adolescent services, intellectually disabled resources and social services.
9. Transportation resources and information will be available in order to ensure safe referral of PES patients.
10. Reference materials will be immediately available for the psychiatric emergency staff, including: a policy and procedure manual which will include guidelines for patient assessment (medical and psychiatric), involuntary treatment (where appropriate), transfer, consultation and referral, as well as a disaster plan. There will be basic pharmaceutical, psychiatric and medical texts available for ready reference.
11. Records will be kept on each patient seen. Every effort should be made to standardize patient assessments.
12. A quality assurance and improvement program will include review and reporting of adverse events (including drug reactions and death or injury in the service or within 72 hours of discharge), as well as ongoing efforts to assess and improve the quality of care delivered.

Facility-Equipment

1. Patients will have easy access to information about patients' rights, patients' advocates, and medication risks, benefits, and side effects. Patients will be made aware of this information both verbally and by clearly visible signs.
2. There will be a private room available for the evaluation of psychiatric emergency patients, in order to respect the patient's dignity and privacy.
3. There will be a room to restrain and seclude potentially dangerous patients in order to ensure the safety of all those within the service.
4. There will be immediate access to basic emergency medical services.
5. There will be a separate room for staff to discuss cases with other professionals (in person and on the phone).

The basic needs of all patients and relatives will be met including: toileting, washing, protection of property, and food and drink.

American Association of Suicidology Standards

Retrieved from AAS website at: <http://www.suicidology.org/>

The AAS evaluation focuses on seven areas, each with its separate standards. These areas are:

- Area I: Administration and Organizational Structure
- Area II: Training Program
- Area III: General Service Delivery System
- Area IV: Services in Life-threatening Crises
- Area V: Ethical Standards and Practice
- Area VI: Community Integration
- Area VII: Program Evaluation

The standards for each area follows:

Area I: Administration and Organizational Structure

Explanatory Statement

The Administration and Organizational Structure provides three important lines of authority. It functions as the official decision making body concerning agency policy.

It is responsible for the operation and monitoring of agency services. It establishes and helps maintain liaison with other community services. Therefore, the quality of the Administration and Organizational structure is vital to the stability of the agency, a key factor in insuring consistency and continuity, and, ultimately, the quality and effectiveness of the agency's program. Agency administration should be responsible to a board or parent governmental body. For example, an agency which has no formal system of getting advice from or measuring its accountability to governing boards and consumer groups run the risk of jeopardizing its program's effectiveness, relevance, continued funding and community support.

Administration determines personnel policies, job descriptions and performance requirements, which in turn directly affect the quality of service delivered to clientele. It is the administration which is responsible for initiating, supporting, and implementing program evaluation and outcome recommendations. Administrations should also maintain current financial records according to the prescription of established laws and regulations.

The Components of Administration and Organizational structure are:

1. Governance
2. Program Management
3. Accountability: Administrative, Personnel and Financial
4. Physical Setting

Area II: Training Program

Explanatory Statement

The desired end product of a training program is a worker with the requisite knowledge, attitudes, and skills to perform at a minimum accepted standard level of service on behalf of those in crisis.

Seven standards apply to training programs for crisis workers. These standards may also apply to front line crisis workers such as nurses, clergy, police or others whose routine work brings them into contact with persons in life-threatening or other crises, even though their full time occupation may not be crisis work.

The importance of training standards cannot be overemphasized. As high quality service delivery is related to the skill of workers, so is the skill of workers related to training. Training activity should be evaluated in terms of behavioral outcomes. As a result, application of a training standard to a prospective worker's previous training might result in the reduction of training time for some trainees and extension of training time for others. The application of behaviorally stated training standards can have significant implications for planning the agency's budget. Some costly training might be eliminated in one agency. Another director may decide to increase the budget allocation for training and thereby reduce other waste such as a disproportionate unit of service cost which evaluation reveals is related to inadequate training of workers. Also, the expenditure of money in aimless activity of poorly trained workers might be invested instead in a highly qualified trainer.

These standards are derived from the experience of trainers in the field of crisis intervention.

The total training time is an essential aspect of thorough planning. Needs of trainees should be determined by pre- and post-evaluation. In general, a minimum of 40 hours of training is indicated for those without previous formal training in suicidology, crisis management, and mental health counseling. The 40 hours should include a minimum of 32 hours formal training plus eight hours of co-worker experience prior to 'independent assignment'. Further experience with a co-worker is recommended, when indicated, by a trainee's needs. The co-worker experience should include active, supervised participation in management of at least three crisis situations.

If less than 40 hours of training is required, there should be evidence obtained that the worker has acquired the required knowledge, attitudes and skills through other sources, e.g. a university sponsored crisis course with supervised clinical practice.

Components of the training program area are:

1. Planned Curriculum Objectives
2. Planned Curriculum Content and Bibliography
3. Planned Curriculum Methodology

4. Screening
5. Pre- and Post-Evaluation of Trainees
6. Qualification of Trainers
7. Quality Assurance for Crisis Workers

Area III: General Service Delivery

Explanatory Statement

Just as there exists a wide variety of life crises (e.g. suicide, sexual assault, etc.) and situational issues (e.g. being severely mentally disabled) so are there a variety of effective service modalities in crisis intervention practice. The evaluation standards in this area relate to:

1. To what degree is a program willing and prepared to offer necessary help during crisis, and;
2. How well is the program organized for the efficient and effective practice of crisis intervention?

This section is designed to evaluate a crisis center's ability to respond to its clients.

Standards for the five (5) components of General Service Delivery

System includes:

1. Telephone response
2. Walk-In Services
3. Outreach service (Internet Service)
4. Follow-up, and
5. Client Record Keeping

If, for example, a program does not provide walk-in counseling and outreach services itself, it must be able to secure such help for its callers from other community agencies. (See Area VI: Community Integration) The crucial question is that quality care is available immediately, 24 hours a day.

Area IV: Services in Life-Threatening Crises

Explanatory Statement

Provision of effective services to people in life-threatening crises is the most important objective of the American Association of Suicidology. Crisis intervention services offer an effective means of reducing harm to oneself or others by providing primary suicide prevention, bereavement assistance to survivors of suicide, prevention and intervention around assault, and community information about these issues. Secondary prevention and intervention are also provided for persons who have attempted suicide, for the chronically

self-destructive person, and for victims of violence, since these critical events increase one's vulnerability to crisis.

Components of services in life-threatening crises are:

1. Lethality assessment
2. Rescue services
3. Victims of violence or traumatic death services
4. Suicide survivor services
5. Community education

Area V: Ethical Standards and Practice

Explanatory Statement

Human rights and client protection are basic issues whether the organization is rendering human service area treatment, training or research. A code of ethics covers a variety of issues. Of particular concern is that organizations promoting a particular religious or treatment orientation are open and honest about this orientation with the community and their clients.

Since 1966, the Public Health Services, DREW, has had a policy requiring specific administrative procedures for the protection of human subjects in activities supported by grants and contracts. In 1974, DREW issued a set of regulations and essentially codified these policies. All professional organizations have developed codes of ethical behavior for persons providing professional services. Local and regional associations maintain Ethics Committees to insure that when reports of violations by practicing members of the association are received, there is a formal investigation and appropriate action is taken.

To be certified by the American Association of Suicidology crisis programs must operate according to ethical standards.

Components dealing with ethical issues are:

1. Code of Ethics;
2. Records Security;
3. Confidentiality;
4. Rescue Procedures; and
5. Advertising and Promotional Methods.

Area VI: Community Integration

Explanatory Statement

Integrating crisis services into the community is crucial because integration facilitates reaching all potential clients in the target community. It also promotes acceptance of the

crisis program by both consumers and providers while enhancing the possibility of identifying with, and becoming part of the community's total care system. Community or service area is defined as all the persons in a specific geographic area. This identified population can be divided into consumers and providers of services.

Community integration is a reciprocal process between the crisis program, consumers and providers directly or indirectly related to crisis services.

Community integration process consists of the following four key elements.

1. Knowledge: The pool of information the crisis service, consumers and providers have about each other which forms the basis for present and future collaboration and utilization.
2. Communication: A verbal or written method of exchanging and obtaining information, promoting collaboration and utilization.
3. Collaboration: Working together for the purpose of teaching mutual goals.
4. Utilization: The actual use of available services.

To ensure that this reciprocal process exists, the following five community integration components have been defined:

1. Consumers,
2. Emergency Resources,
3. Resource Data,
4. Professional Resources, and
5. General Community Resources.

Area VII: Program Evaluation

Explanatory Statement

Evaluation is an important element of service delivery. In the broadest sense, program evaluation tells providers whether what they are doing is effective. It offers a mechanism through which programs can be examined, monitored and changed when indicated by evaluation outcomes. In this way evaluation becomes a critical and useful administrative tool.

Evaluation can give staff information about needs, about the results of the effort (amount of time, materials, money, human resources) that has gone into responding to these needs. Such evaluations (done on an ongoing and/or periodic basis) provide the staff or vendors information about whether these effects are desirable in relation to the needs and whether they were worth the effort it took to produce them.

The critical importance of program evaluation is highlighted by the increasing emphasis on providers' accountability to consumers and funding bodies for quality service.

Any service program should ask itself three basic evaluation questions:

1. Are our program objectives reasonable, given the condition and need of the community and its citizen?
2. Is our program meeting its objectives, and if so, at what costs:
3. What else is happening within the program and as a result of the program:

To help answer these questions, program evaluation should include the following:

1. A means to determine that every program activity is related to the program's objectives.
2. A method to evaluate the programs:
 - a. Activity: Resources available to and used by the program and activities planned and carried out by the program.
 - b. Achievement: Changes which take place in people who have been involved in the program. We are usually concerned with changes in clients, but changes in staff may also be considered.
 - c. Adequacy: Program impact on the community's total needs.
 - d. Efficiency: A determination of the cost in resources (personnel, funds, materials and facilities) in attaining the objectives.

In summary, each objective needs to be evaluated in terms of activity, achievement, adequacy and efficiency.

The Standards for Program Evaluation include the following components:

1. Program Objectives
2. Content Evaluation
3. Evaluation Scope
4. Evaluation, Implementation, and
5. Utilization

Data: Do we collect data on this program?

A Review of Adult Mental Health Mobile Crisis Programs- February 2008

Crisis Reports /Consent Decree required

No more than 20-25% of the face to face contacts result in psychiatric hospitalization.

90% of Crisis phone calls requiring face to face assessments are responded to in an average of 30 minutes from the end of the phone call.

90% of all face to face assessments result in resolution for the Consumer within eight hours of initiation of the face to face assessment.

DRAFT

90% of all face to face contacts in which the client has a Community Support Worker, the worker is notified of the Crisis.

Performance-Based Contract Measure:

No more than 25% of initial face to face contacts result in psychiatric hospitalization.

The Provider shall meet the performance standard above on a cumulative basis over the course of fiscal year 2013 or the Provider shall reduce the percentage of face-to-face initial assessments of individuals in crisis that result in psychiatric hospitalization by at least 20% cumulative over the course of fiscal year 2013 from the level achieved in fiscal year 2012.

The percentage of initial assessments of consumers in crisis which result in inpatient psychiatric hospitalization and the percentage of initial assessments of consumers that occur in hospital Emergency Departments shall be based on the Monthly Crisis Reports.

Mandate: Is there a legal mandate for this service?

Services are provided in accordance with the MaineCare Provider Agreement, definitions and rules as specified in the MaineCare Benefits Manual, Chapter 101, Chapter 1, General Administrative Policies and Procedures and Chapters II & III, Section 65, Behavioral Health Services.

In addition Providers of Crisis Intervention Services will adhere to the Crisis Services Standards which are attached and all staff will complete the Mental Health Rehabilitation Technician/Crisis Services Provider (MHRT/CSP) curriculum and be certified as a MHRT/CSP. Staff providing Crisis Services must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered; Supervisors of MHRT staff must be clinicians as defined in 65.02-9, within the scope of their licensure.

PROGRAM/SERVICE: CRISIS RESIDENTIAL

1303 Crisis Stabilization Unit/Crisis Residential Services

This service is a short term, highly supportive, supervised residential setting where an individual in psychiatric crisis can become stabilized and readjust to community living. Components of crisis residential services include:

1. Providing screening and assessment i.e. suicide risk assessment
2. monitoring behavior
3. providing therapeutic interventions including medications, supportive counseling, supervision to assure personal safety
4. participating and assisting in planning for and implementing crisis and post-crisis stabilization activities, including coordination with other community-based services

Description of Program/Service:

Services are provided in accordance with the MaineCare Provider Agreement, definitions and rules as specified in the MaineCare Benefits Manual, Chapter 101, Section 1, General Administrative Policies and Procedures and Chapters II & III, Section 65, Behavioral Health Services.

Crisis Stabilization Services are provided to an individual during a psychiatric emergency to address mental health and/or co-occurring mental health and substance abuse conditions for a time-limited post crisis period, in order to stabilize the person's condition.

1. Assure safety
2. Short-term, highly supportive, and supervised residential setting where an individual in psychiatric crisis can become stabilized and readjust to community living
3. Monitoring of behaviors
4. Therapeutic Interventions including medications
5. Supportive counseling
6. Coordination with other community-based services, and supervision to assure personal safety
7. Services are provided by MHRT I staff or above and are directly supervised by an independently licensed mental health professional
8. Providers of Crisis Stabilization Unit Services will adhere to the Crisis Services Standards

General Crisis Requirements

1. Crisis Service System Minimum Requirements, November 2008; and
2. DHHS Mental Health Crisis Services Standards of November 30, 2006.

DRAFT

3. Crisis Service System Memorandum of Understanding (MOU) Minimum Requirements

Evidence Based/Promising Practice Standards:

There are many models but there doesn't appear to be any evidence based information.

Data: Do we collect data on this program?

Performance-Based Contract Measure Data Source:

APS HealthCare Reports: 85% of individuals will have no psychiatric hospitalizations 30 days following the discharge from a Crisis Stabilization Unit.

Mandate: Is there a legal mandate for this service?

Consent Decree requires that we gather data which we do through APS Healthcare (see above).

PROGRAM/SERVICE: DRIVER EDUCATION AND EVALUATION PROGRAM

DEEP or the Driver Education and Evaluation Programs are legislatively mandated. (5 MRSA c. 521mSub-c.V) Operation under the influence (OUI) counter measures program in the State of Maine. The goal of the program is to lessen the incidence of injury, disability and fatality that results from alcohol and other drug related motor vehicle crashes and to reduce the risk of re-offense for OUI.

Description of Program/Service:

1. The 20 hour risk Reduction Program is for Adults, 21 years or older.
2. The 16-hour Under 21 Program is for individuals who were under 21 during the time of the offense and under 21 when they register for a program.
3. The Completion of Treatment Program is a treatment option for offenders who wish to enter directly into treatment for an alcohol or other drug problem.
4. The Out of State Program is for those out of State who wish to meet Maine's requirements while residing in another State.
5. The Military Program is for those who are working through their branch of the military service to meet Maine's requirements for a driver's license.

Evidence Based/Promising Practice Standards:

The Change Companies

Tel: (775) 885-2610 • toll-free: (888) 889-8866 • fax: (775) 885-0643
5221 Sigstrom Drive, Carson City, NV 89706 • www.changecompanies.net

In 2010, approximately 1,850 completed course evaluations were submitted to The Change Companies® from the State of Vermont" CRASH course.

http://healthvermont.gov/adap/treatment/documents/VT2010CRASH_AnnualReport.pdf

PRIME For Life

PRIME For Life (PFL) is a motivational intervention used in group settings to prevent alcohol and drug problems or provide early intervention. PFL has been used primarily among court-referred impaired driving offenders, as in the two studies reviewed for this summary. It also has been adapted for use with military personnel, college students, middle and high school students, and parents. Different versions of the program, ranging from 4.5 to 20 hours in duration, and optional activities are available to guide use with various populations.

Based on the Lifestyle Risk Reduction Model, the Transtheoretical Model, and persuasion theory, PFL emphasizes changing participants' perceptions of the risks of drug and alcohol use and related attitudes and beliefs. Risk perception is altered through the carefully timed

presentation of both logical reasoning and emotional experience. Instructors use empathy and collaboration (methods consistent with motivational interviewing) to increase participants' motivation to change behavior to protect what they value most in life. Participants are guided in self-assessing their level of progression toward or into dependence or addiction. PFL also assists participants in developing a detailed plan for successfully following through with behavior change. Multimedia presentations and extensive guided discussion help motivate participants to reduce their substance use or maintain low-risk choices. Individual and group activities are completed using participant workbooks.

Study 1

Beadnell, B., Nason, M., & Rosengren, D. B. (2009). Comparative impact of PRIME

Perceived risk for alcoholism or addiction was assessed using two scales based on items included in a self-administered questionnaire developed for the study. The "tolerance is protective" scale was derived from the mean of two items: "High tolerance protects people from having problems with alcohol" and "People who handle alcohol are less likely to develop alcoholism." The "risk for addiction" scale was derived from the mean of four items: "I could become an alcoholic," "If I drink as much as I have in the past, I could develop alcoholism," "If I use drugs as much as I have in the past, I could become addicted," and "I should drink less." The response categories for these items were 1 (strongly agree), 2 (agree), 3 (uncertain), 4 (disagree), and 5 (strongly disagree).

Participants in the study were individuals who had been referred to a State-mandated alcohol and drug education program following involvement in drug-related offenses such as driving while intoxicated (DWI), underage drinking, or drug possession. The majority were individuals who had received their first DWI conviction and were required to complete a program as a condition of driver's license reinstatement. Participants were assigned to the PFL program or to a comparison group that received a standard intervention about general topic areas and guidelines related to DWI. PFL participants had significantly greater decreases in scores on both scales, indicating greater improvement in the accuracy of their risk estimation (p values $< .001$). Effect sizes were small for both the "tolerance is protective" scale ($\eta^2 = 0.036$) and the "risk for addiction" scale ($\eta^2 = 0.040$).

The percentage of participants self-assessing with alcohol- or drug-related problems was measured at pretest and posttest using two items from a self-administered questionnaire developed for the study: "Have you ever had an alcohol or drug-related problem?" and "I have alcoholism or drug addiction." Response categories were "yes," "no," and "unsure."

Participants in the study were individuals who had been referred to a State-mandated alcohol and drug education program following involvement in drug-related offenses such as DWI, underage drinking, or drug possession. The majority were individuals who had received their first DWI conviction and were required to complete a program as a condition of driver's license reinstatement. Participants were assigned to the PFL program or to a

comparison group that received a standard intervention about general topic areas and guidelines related to DWI.

This study found that self-identification of drug or alcohol problems increased more among PFL participants than among participants receiving the standard intervention. For the retrospective item, 10% of both groups responded at pretest that they had ever had an alcohol- or drug-related problem. In comparison, at posttest, 14% of the PFL group and 7% of the comparison group indicated they had ever had an alcohol- or drug-related problem ($p = .007$). For the item asking about current alcoholism or drug addiction, 2% of the PFL group and 4% of the comparison group responded "yes" at pretest ($p = .21$), compared with 4% of the PFL group and 0% of the comparison group at posttest ($p = .05$).

Study 2

Lowenkamp, C. T., Latessa, E., & Bechtel, K. (2007). A statewide, multisite, outcome evaluation of Indiana's Alcohol and Drug Programs. University of Cincinnati, Division of Criminal Justice, Center for Criminal Justice Research. Submitted to the Indiana State Judicial Center, Indianapolis, Indiana.

Recidivism was assessed by examining 1-year re-arrest rates. The analyses included any arrest, misdemeanor, felony, or incarceration indicated in court records during the year after discharge from the program or completion of probation.

In a statewide evaluation study, data on individuals who had participated in PFL following an impaired driving conviction were compared with data on probationers who participated in a court-designated alcohol or drug program other than PFL following a substance use-related offense. This study found that PFL participants had a significantly lower 1-year re-arrest rate relative to the comparison group ($p < .05$). Eighty-one percent of the PFL group was not re-arrested within 1 year after the discharge date, while 71% of the comparison group was not rearrested within 1 year following completion of probation.

Data: Do we collect data on this program?

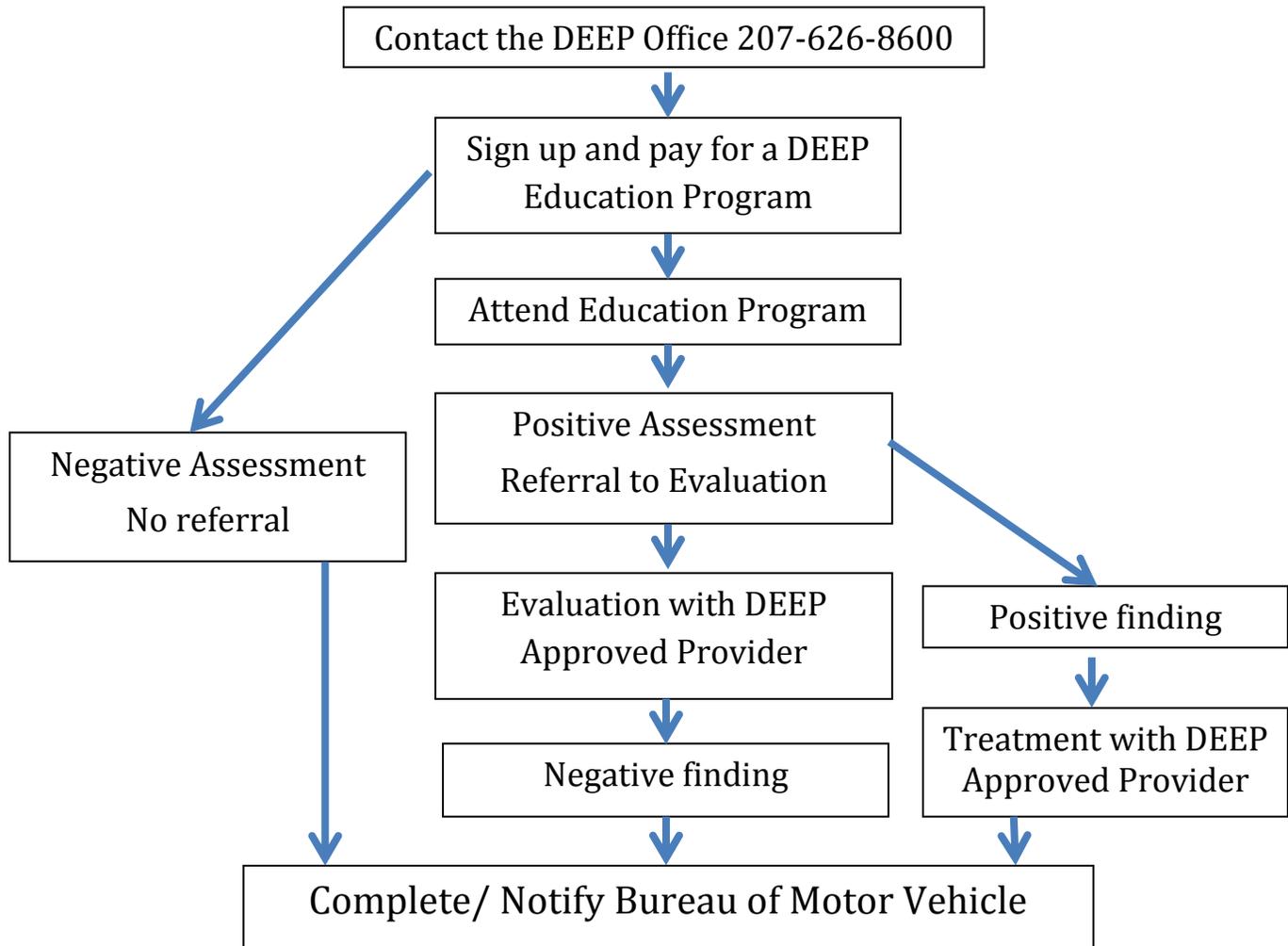
1. Payment History – Shows the amounts of payments that DEEP clients have paid for DEEP services.
2. Recent Activity Report – Totals of open cases, recently closed cases and recently opened cases.
3. Class Schedule Reports – List of providers and their clients scheduled for a class.
4. Provider Summary Report – List of providers and totals of their clients.
5. DEEP Approved Providers and Agencies– List of all providers and where they are located.
6. Client Demographic Report – Clients broken down by County and State.
7. Repeat Offenders Report – List of re-offenders and how long since their last OUI offence.
8. Second Opinion Report – A list of Clients who had a second evaluation as to whether or not they should attend DEEP.

9. Completed Cases report – A report on the number of complete case by date range.
10. Evaluation History Report – A report on individuals who have received a new evaluation and the results.
11. Provider by Locations with Clients – A list of all current providers with a list of their clients.
12. BMV Summary Report – A list of all clients who have completed DEEP sent to BMV.
13. Class Roster Report – A class roster of clients that are scheduled to complete DEEP by Provider.
14. Daily Money Report – List of clients and the money they have sent in to pay for their DEEP.
15. Open Class Report – List of all clients who have applied to DEEP to attend a class.
16. Treatment History Report – List of clients who have attended DEEP and which provider gave them the DEEP course.

Mandate: Is there a legal mandate for this service?

DEEP, or Driver Education and Evaluation Programs, are legislatively mandated. (5 MRSA c. 521mSub-c.V) Operation under the influence (OUI) counter measures program in the State of Maine.

SAMHS Driver Education and Evaluation Program DEEP Client



PROGRAM/SERVICE: PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS

Projects for Assistance in Transition from Homelessness (PATH) will fund Outreach and Engagement services, preferably to literally homeless persons with a serious mental illness, or co-occurring serious mental illness and substance use disorder. A PATH client is defined as a person;

1. who is literally homeless (preference) or at imminent risk of becoming homeless and has a serious mental illness or a co-occurring serious mental illness and substance use disorder,
2. who receives services in some measure with Federal PATH funds, and
3. for whom a clinical or other formal record has been prepared, indicating formal enrollment (a client record in either HMIS or the DHHS template attached will meet the standard for item #3.)

Description of Program/Service:

Outreach workers respond to homeless persons' immediate needs for food, clothing, shelter, and medical care. They typically carry with them items to hand out to homeless persons, which may include: healthy snacks, water, blankets, clothing like underwear and outer wear to protect against the weather, condoms, flashlights, toothbrushes and toothpaste, feminine hygiene products, sewing kits, self-care kits for common illnesses, cards with names and emergency phone numbers, resource lists of homeless shelters, mental health and substance abuse centers, food pantries, free medical facilities, and legal aid.

Outreach workers may also act as a source of support if, through the relationships they build, the homeless person begins to open up and share their reasons for living on the street. If the homeless person is a runaway youth, outreach workers can help the youth communicate with family and return home, if appropriate; if not, an outreach worker can help a young person find a more stable living situation.

If, upon engagement, the homeless person appears to have a serious mental illness or co-occurring serious mental illness and substance use disorder, the individual should be referred to appropriate systems of care which may include the Regional Office of Adult Mental Health or DHHS Office of Children and Family Services district Office.

Evidence Based/Promising Practice Standards:

No evidence based or promising practice standards. Reporting is based on Federal requirements.

Data: Do we collect data on this program?

PATH Activity Reports, due at least quarterly and in electronic format

1. Provider must utilize the State of Maine's, Homeless Management Information System (HMIS) (see explanation of system) through Service Point as administered by MaineHousing; and
2. Submit annual data through a Federal Web site

Homeless Management Information System (HMIS):

An electronic data system which tracks and documents homelessness across the United States and in Maine. Maine's PATH program requires full and complete utilization of this system for all persons who receive both outreach/engagement services as well as PATH Enrolled services.

Currently, the Maine State Housing Authority is the authorized HMIS Administrator in Maine. To promote coordination of benefits, services and necessary monitoring of PATH requirements, appropriate interagency agreements will be in place and client releases of information will be obtained so that HMIS data may be appropriately shared among PATH agencies. To facilitate utilization of Maine's HMIS:

- a. All PATH grantees must enter into an HMIS/PATH Agency Participation Agreement(s) and other documents with MaineHousing and DHHS as appropriate.
- b. All PATH outreach workers must have access to a dedicated laptop/tablet computer, preferably with high speed wireless (3G minimum) internet connection or readily available wireless/wired connection to a secure network(s) with internet access.
- c. All PATH outreach workers must also be equipped with a unique assigned email and cell phone which they can access regularly.

Performance Based Contracting Measure Goals and Indicators

To comply with federal requirements for PATH, and to better coordinate existing services to the target population, the Department will collect and report client level information on all PATH supported activities. The Department expects to receive monthly electronic PATH activity reports.

- Goal 1:** The agency will ensure comprehensive data collection on enrolled PATH consumers.

Performance Indicator:

90% of Enrolled PATH clients will have at least 100% of PATH universal data elements completed in HMIS.

Data Source:

HMIS Reporting

Goal 2: Enrolled PATH clients will have increased access to, and utilization of, Main-Stream Resources specifically including:

Performance indicators:

1. Housing Resources: 80% of all PATH enrolled participants will apply for a housing resource;
2. Medical Resources: 80% of all PATH enrolled participants will apply for or already be enrolled in MaineCare and/or medical services provided by the Veterans Administration;
3. Behavioral Health Resources: 80% of all PATH enrolled participants will apply for or already be enrolled in a MaineCare and/or other behavioral health care related resource or a Veterans Administration service resource.
4. Income Resources: 80% of all PATH enrolled participants who are not currently enrolled in SSI/SSDI/VA benefits will apply for SSI/SSDI utilizing the SOAR method and/or Veterans Administration benefits. Date of Application and Date of Acceptance will be measured.
5. Employment/Education: 19% of all PATH enrolled participants will apply for or already be enrolled in work or education.

Data Sources:

PATH and HMIS Reporting

Government Performance and Results Act (GRPA Measures):

Goal 3: PATH providers will be trained on SSI/SSDI Outreach, Access, Recovery (SOAR).

Performance indicator:

100% of the PathFinders/PeerNavigators will receive training on SSI/SSDI Outreach, Access, and Recovery (SOAR) to ensure eligible homeless clients are receiving benefits which is a key output of the program:

Data Sources:

Agency report
SOAR Data Set

Goal 4: The project will increase the percentage of PATH enrolled homeless persons who receive community mental health services. The goal for the twelve month period is 700.

The PATH legislation mandates that PATH targets persons with serious mental illness (SMI) who may also experience a co-occurring substance use disorder who are homeless or at risk of homelessness. This measure reflects the PATH program's legislative intent to provide a link to mental health and/or substance abuse community-based services.

In 2009, SAMHSA initiated efforts to change the way PATH grantees reported on persons served/enrolled for the PATH Annual report. Grantees reported on all persons served with Federal and State match funds and not just persons served with Federal PATH funds only (as was done in the past). This change was initiated in order to better align PATH data collection efforts with the U.S. Department of Housing and Urban Development's (HUD) Homeless Management Information System (HMIS), an outcome-based reporting system.

Data Source:

PATH Annual Report/HMIS

Goal 5: The project will increase the number of homeless persons contacted: Target for this twelve month operational period is 1,700.

This measure captures the number of homeless persons contacted by PATH providers. Persistent and consistent outreach and the introduction of services at the client's pace are important steps to engaging homeless persons with serious mental illness (SMI) and to beginning the process of linking them to housing, mental health, substance abuse, case management and other supportive services.

Data Source:

PATH Annual Report/HMIS

Goal 6: The project will increase the percentage of contacted homeless persons with serious mental illness who become enrolled in services. The target is set at 55%.

Performance indicator: this measure is an indicator of the rate of enrollment for PATH-eligible individuals. PATH enrollment is defined as:

1. The individual is determined to be "PATH Eligible,"
2. The PATH worker (PeerNavigator/PathFinder) established engagement with the individual (the individual has agreed to work towards a goal with the PATH worker),
3. The PATH worker opened an individual file that contains:
 - a. Demographic information,
 - b. Documentation of PATH eligibility,
 - c. Mutual agreement for the provision of services, and
 - d. Services provided

In 2007, the calculation for this measure was revised to more accurately reflect only those eligible for services: persons who are experiencing serious mental illness and who are homeless or at imminent risk of homelessness.

Data Source:

PATH Annual Report/HMIS

Goal 7: Average Federal cost of enrolling a homeless person with serious mental illness in services

This measure supports the mission and purpose of the PATH program to outreach to and link clients to services in an efficient manner. This will be a single computation at the end of twelve months.

Data Source:

PATH Annual Report/HMIS

E: Other DHHS measures and performance targets.

DHHS requires all PATH providers to implement the following required additional performance targets.

Of all homeless persons whom outreach is conducted, 50% will be PATH eligible.

100% of PATH enrolled persons will have at least one of the following Main-Stream goals in place, which was not in place at time of initial engagement, within three months of PATH enrollment:

1. Housing Resource
2. Medical Resource

DRAFT

3. Income Resource
4. Service Resource
5. Employment/Education Resource

Data Source:

PATH Annual Report/HMIS

Mandate: Is there a legal mandate for this service?

No

Chapter 9

Treatment Services

Treatment is a therapeutic process to reduce or eliminate the symptoms and side effects of mental illness or substance abuse through direct observation, assessment, examination and therapeutic intervention.

Characteristics of treatment include:

- Professional licensed or certified staff
- Screening
- Clinical assessment
- Diagnostic evaluation
- Intake and discharge planning
- Service planning
- Clinical intervention
- Medication prescription and clinical monitoring
- Group and individual therapy

PROGRAM/SERVICE: ASSERTIVE COMMUNITY TREATMENT (ACT)

Description of Program/Service:

Assertive Community Treatment (“ACT”) is a self-contained service with a fixed point of responsibility for providing treatment, rehabilitation, and support services to persons who satisfy the specific eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02 <http://www.maine.gov/sos/cec/rules/10/ch101.htm> for whom other treatment approaches have been unsuccessful.

Using an integrated service approach, Assertive Community Treatment merges clinical and rehabilitative staff expertise to assist members with: symptom stability, relapse prevention, maintenance of safe, affordable housing in normative settings that promote well-being; establishment of natural support networks to combat isolation and withdrawal; minimizing involvement with the criminal justice system; and services to enable the person to function at a worksite. ACT teams will be responsible to respond and provide direct support to consumers in crisis 24/7.

Evidence Based/Promising Practice Standards:

SAMHSA offers an “Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT”

Provides tools to implement the evidence-based practices of Assertive Community Treatment (ACT), which offers customized, community-based services for people with mental illness. Includes a DVD, a CD-ROM, brochures in English and Spanish, and a PowerPoint presentation.

Pub id: SMA08-4345

Publication Date: 10/2008

Format: Kit

Audience: Professional Care Providers, Program Planners, Administrators, & Project Managers

Series: Evidence-Based Practices KITs

Population Group: People with Mental Health Problems as Population Group, Homeless

<http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Fidelity Standards:

Assertive Community Treatment (ACT) provides an individualized intensive integrated service that is:

- Delivered by a multi-disciplinary team of practitioners.

- Available twenty-four (24) hours a day, every day, three hundred and sixty five (365) days a year.
- Delivered primarily in the community and not in an office based setting.
- Assertive interventions, including street outreach, are employed by the team as appropriate.
- Provide at least on average, per member, three (3) face-to-face contacts with the member per week, or as clinically required.
- Medication services to include 1 face-to-face per month.
- Employment assistance.
- Housing assistance.
- Implementation of crisis management plan.

Data: Do we collect data on this program?

Performance-Based Contract Measure Goal:

ACT teams assume clinical responsibility for all members of the team. Measures proposed here use the reduction of psychiatric hospitalization as the goal for keeping people in the community, who are moving towards a less restrictive setting.

Performance-Based Contract Measure:

- 95% or more of participants will have initiated hospital admissions with the ACT program.
- 95% or more of participants will have initiated hospital discharges planned jointly with the ACT program.
- 65% or more of participants will have a decrease in or no psychiatric hospitalizations in the last quarter.

Performance-Based Contract Measure Data Source: APS CareConnection and/or SAMHS Quality Management record review.

Contract Standards:

Agency Community Support Census / Staffing Quarterly Report shall indicate the following:

- At a minimum, 15% of ACT Team clients should be employed at any given time. ACT must meet fidelity standards established by the Office of Substance Abuse and Mental Health Services (SAMHS).
- The minimum overall staffing ratio for an ACT team is one (1) staff person to ten (10) members. Administrative staff is excluded from calculation of the staffing ratio.
- Employment specialists on ACT teams are to focus on employment functions with the expectation that 90% of the employment specialists' work time will be devoted to vocational/employment support related tasks.

DRAFT

APS Healthcare also provides reporting regarding “Average Length of Stay in Adult Assertive Community Treatment,” which includes MaineCare members and Courtesy Reviews done by APS. What This Report Measures: Average length of stay and median length of stay of members discharged from Adult Assertive Community Treatment services during the month. Members may be discharged more than once.

Mandate: Is there a legal mandate for this service?

Consent Decree

Program/Service: Behavioral Health Home Organization (BHHO)

Description of Program/Service:

A BHHO is a community-based mental health organization that is licensed in the state of Maine, and that has been approved by MaineCare to provide Section 92 services for members (both adults and children) eligible for such services. A Behavioral Health Home offers:

- Care Management of physical and mental health needs
- Care Coordination and health promotion
- Help in transitional care, including follow up
- Support to help self-manage physical and mental health conditions
- Referral to other services
- The use of Health Information Technology to link services

Health Homes have a number of features that make them different from typical case management services: Data-driven: data is used in Health Homes to identify members who need additional support in order to manage their care, and is also used to provide feedback to providers on both utilization and key quality benchmarks. Population-based: tools, such as patient registries, are used to identify needs across the member panel. Integrated: physical and behavioral health needs must be included in the person's plan of care. Outcomes-oriented: Health Homes are measured in a variety of ways to determine the impact they are having on members receiving the service.

Services are provided in accordance with MaineCare definitions and rules as specified in the MaineCare Benefits Manual in Chapter II, Section 92

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Evidence Based/Promising Practice Standards:

Cite source and then enumerate the standards

Evidence-based care. The best available evidence guides treatment decisions and delivery of care. Both the behavioral health agency and its health provider partner (if applicable) must deliver evidence-based services. Some of the resources for evidenced-based practices are:

- [http://www.integration.samhsa.gov/HalfStates do PCMH-HA 11-12 full.pdf](http://www.integration.samhsa.gov/HalfStates%20do%20PCMH-HA%2011-12%20full.pdf)
- <http://www.medicare.gov/State-Resource-Center/Medicare-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>
- [http://www.integration.samhsa.gov/integrated-care-models/Behavioral Health Integration and the Patient Centered Medical Home FI NAL.pdf](http://www.integration.samhsa.gov/integrated-care-models/Behavioral_Health_Integration_and_the_Patient_Centered_Medical_Home_FI_NAL.pdf)
- [http://www.integration.samhsa.gov/clinical-practice/CIHS Health Homes Core Clinical Features.pdf](http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf)

- <http://www.chcs.org/resource/designing-medicaid-health-homes-individuals-opioid-dependency-considerations-states/>

Data: Do we collect data on this program? If yes, what are the data measures (cite source, i.e. NOM, Contract Performance, Consent Decree)?

Performance-Based Contract Measure Goals:

- Objective 1: Increased timely access to Behavioral Health Home Services
- Objective 2: Reduction of Inpatient Hospitalizations

Performance-Based Contract Measures:

Objective 1: Increased timely access to Behavioral Health Home Services

Measure 1: 90% of Eligible individuals who are hospitalized in a psychiatric unit or psychiatric hospital at the time of referral will be assigned to a Behavioral Health Community Support Worker within two days of application.

Measure 2: 90% of Eligible individuals who are not hospitalized in a psychiatric unit or psychiatric hospital at the time of referral will be assigned to a Behavioral Health Home Community Support Worker within three days of application.

Measure 3: 95% of all eligible non hospitalized individuals who are not assigned within three days will be assigned to a Behavioral Health Home Community Support Worker within seven days of application.

Objective 2: Reduction of Inpatient Psychiatric Hospitalizations.

Measure 1: 95% of Behavioral Health Home recipients who have been in service for 6 (six) or more months will have no psychiatric hospitalization days during the past 6 (six) months.

The Department will additionally monitor Behavioral Health Home outcomes using CMS-required Behavioral Health Home (BHHO) quality measures.

The Provider is not responsible for generating BHHO Quality Metrics reports, but the Provider agrees to participate in using the reports to monitor and improve the care being provided.

Provider baseline performance for the quality measures will be established within the first 12 months of operation.

Center for Medicaid Services (CMS) Quality Metrix:

MaineCare will develop quarterly Behavioral Health Homes quality measures reports to provide feedback to the Health Homes and monitor progress in these areas.

Goal 1: Reduce Inefficient Healthcare Spending

Goal 2: Improve Chronic Disease Management

Goal 3: Promotion of Wellness and Prevention

Goal 4: Recovery and Effective Management of BH Conditions

Goal 5: Promote Improved Experience of Care for Consumers/ Families

MaineCare will work with partners to identify technical solutions to capture clinical data for certain measures, and will also use existing data resources (i.e., Enterprise Information System, annual surveying tools) for measure calculation.

Performance-Based Contract Measure Data Source:

- APS CareConnection
- MaineCare Claims Data

Mandate: Is there a legal mandate for this service?

The purpose of this Agreement is to fulfill certain requirements of the Bates v. DHHS consent decree by providing Behavioral Health Home services in a certain manner to individuals who meet the general eligibility requirements for MaineCare as stated in the MaineCare Eligibility Manual and the specific eligibility requirements for this service as stated in the MaineCare Benefits Manual, Chapter 2, Section 92.

PROGRAM/SERVICE: COMMUNITY INTEGRATION SERVICES (CI)

Description of Program/Service:

Community Integration Services involve the identification, assessment, planning, linking, monitoring, and evaluation of services and supports needed by a person who satisfies the eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02. Community Integration Services involve active participation by the member or guardian. The services also involve active participation by the member's family or significant other, unless their participation is not feasible or is contrary to the wishes of the member or guardian. These services are provided flexibly and on an as-needed basis. These services may not be provided in a group. Services are provided in accordance with MaineCare definitions and rules as specified in the MaineCare Benefits Manual in Chapter 101, Chapters 2 and 3, Section 17 <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Evidence Based/Promising Practice Standards:

Although there are no evidence based practice standards for Community Integration services, there is evidence based practice for Intensive Case Management:

<http://summaries.cochrane.org/CD007906/intensive-case-management-for-people-with-severe-mental-illness>

Intensive case management for people with severe mental illness:

Dieterich M, Irving CB, Park B, Marshall M. Published Online: February 16, 2011. Severe mental illnesses are defined by diagnosis, degree of disability and the presence of some abnormal behavior. They include schizophrenia and psychosis, severe mood problems and personality disorder, and can cause considerable inconvenience over a long period of time both for the people that are affected by them, and for their families and friends.

Until the 1970s it was common for those suffering from these disorders to stay in an institution for most of their lives, but now in most of the countries of the world, they are managed in the community with one of several different styles of intervention. Intensive Case Management (ICM) is one such intervention. It consists of management of the mental health problem and the rehabilitation and social support needs of the person concerned, over an indefinite period of time, by a team of people who have a fairly small group of clients (less than 20). It also offers 24 hour help and sees clients in a non-clinical setting.

This review compares ICM with non-Intensive Case Management (non-ICM; where people receive the same package of care but the professionals have caseloads of more than 20 people) and standard care (where people are seen as outpatients but their support needs are less clearly defined). Thirty-eight trials were found in the United States, Canada, Europe or Australia involving 7,328 people in total.

When ICM was compared to standard care, those in the ICM group were significantly more likely to stay with the service, have improved general functioning, get a job, not be homeless and have shorter stays in hospital (especially when they previously had very long stays in hospital). There was also a suggestion that it reduced the risk of death and suicide. If ICM was compared to non-ICM, the only clear difference was that those in the ICM group were more likely to be kept in care. There are no trials comparing non-ICM with standard care.

One of the drawbacks of this review is that the healthcare and social support systems of these countries are quite different, so it was quite difficult to make valid overall conclusions. In addition, much of the data on quality of life, and patient and career satisfaction was not able to be used because the trials used many different scales of measuring these things, some of which were not validated. The development of such an overall scale and its validation would be very beneficial in producing services that people liked.

Data: Do we collect data on this program?

Performance-Based Contract Measure Goal:

These measures focus on the reduction of psychiatric hospitalization use as an indicator to gauge the effectiveness of CI Services.

Performance-Based Contract Measure:

1. 95% of CI recipients who have been in service for 6 (six) or more months will have no psychiatric hospitalization days during the past 6 (six) months.
2. 45% of CI recipients who have been in service for 2 (two) or more quarters will show a decrease in community integration units used each subsequent quarter.

Performance-Based Contract Measure Data Source:

- APS CareConnection
- MaineCare Claims Data

Other Performance Measures (Consent Decree):

Persons with MaineCare coverage who are also class members seeking services who are hospitalized in a psychiatric unit or psychiatric hospital will be assigned a community integration worker within two days of application. See definitions at Section 17. 01-5, <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Persons with MaineCare coverage who are also class members seeking services who are not hospitalized in a psychiatric unit or psychiatric hospital will be assigned a community integration worker within three days of application.

DRAFT

Persons with MaineCare coverage who are not class members will be assigned a community integration worker within seven days of application.

Application means the date on which the request for a worker was made by the consumer or person acting on behalf of the consumer. The application date could be the date of the phone call to the community support service provider or receipt of the written application, which ever first occurs.

The above time frames should not be interpreted to be the date that the first face to face contact occurs. Assigned means the date that the consumer was assigned a community support worker not the date the consumer first saw the community support worker. It is expected that the consumer will be seen face to face by the worker within a reasonable time period after assignment.

If the provider does not have the capacity to achieve the time-line above they will seek to link the consumer with another organization which has capacity and provide notification to APS Healthcare using the Contact for Services Notification Form.

http://www.qualitycareforme.com/documents/provider_providermanual_appendixB.pdf

APS Healthcare also provides reporting on “Average Length of Stay in Adult Community Integration,” which includes MaineCare members and Courtesy Reviews done by APS. What This Report Measures: Average length of stay and median length of stay of members discharged from Community Integration services during the month. Members may be discharged more than once.

Mandate: Is there a legal mandate for this service?

Yes. Class members are entitled to Community Integration Services under the AMHI Consent Decree.

PROGRAM/SERVICE: CO-OCCURRING TREATMENT

Description of Program/Service:

At least one mental disorder as well as an alcohol or drug use disorder.

People who have experienced both an emotional/psychiatric and alcohol or drug related issue are said to be persons with “co-occurring conditions” or disorders. ‘Mental health issue’ refers to different kinds of brain disorders; for example, depression (lasting feelings of sadness or helplessness), bipolar disorders (extreme mood swings – highs and lows), or schizophrenia (a partial or complete break from reality) are all examples of disorders where brain chemistry is unbalanced. ‘Alcohol or drug related issue’ refers to the use of alcohol or any illegal drug in a harmful or dangerous way. Not being able to limit or control the use of substances is also considered a brain disorder.

Many people with co-occurring disorders have experienced trauma. The effects of trauma can often affect the way the world is experienced. People with mental health, substance abuse, and trauma frequently have physical health issues as well. Co-occurring conditions can include a number of difficult experiences that improve when a person embraces and develops their own ongoing journey of self-discovery/recovery.

Evidence Based/Promising Practice Standards:

<http://europepmc.org/abstract/MED/16996389>

As the model for treating co-occurring disorders in addiction treatment settings becomes articulated, service systems need data on prevalence, current practice, and barriers to the implementation of evidence-based practices. A self-report survey was administered to 453 addiction treatment providers (43 agency directors, 110 clinical supervisors, and 300 clinicians) from a single state system of care. Data on prevalence estimates, treatment practices, and barriers to implementing services for co-occurring disorders were obtained. The three groups estimated that several co-occurring disorders were extremely common: mood disorders (40%-42%), anxiety disorders (24%-27%), posttraumatic stress disorder (24%-27%), severe mental illnesses (16%-21%), antisocial personality disorder (18%-20%), and borderline personality disorder (17%-18%). Practice patterns for patients with these co-occurring disorders differed widely, from referral to mental health programs to provision of integrated treatment. Common barriers to providing services to persons with co-occurring disorders were lack of psychiatric personnel and resources. Comprehensive surveys of an addiction treatment service system can rapidly and economically produce estimates of prevalence, current practices, and barriers to evidence-based practices. This objective information is critical for systems intending to enhance services to persons with co-occurring disorders.

Data: Do we collect data on this program?

Indicator **Minimal Standard**

Program performance must be at or above the minimal level on 5 of the following 9 performance indicators (primary clients only), monitored on a quarterly basis:

- Abstinence/drug free 30 days prior to discharge.....70%
- Reduction of use of primary substance abuse problem60%
- Maintaining employment90%
- Employability 3%
- Not arrested for any offense.....95%
- Not arrested for an OUI offense during treatment95%
- Participation in self-help during treatment50%
- Completed Treatment.....45%
- Referral to Mental Health Services 100%

Tracking Only

Average Time in Treatment for Completed clients (Weeks)

Completed Treatment - Affected Others

GAF Improvement

GAF Improvement - Affected Others

Populations

Services to target populations listed below (primary clients only) will be monitored on a semi-annual basis for information only:

- Female
- Age 0-19
- Age 50+
- Corrections
- Homeless
- Co-existing Disorders of Mental Illness and Substance Abuse
- History of Injection Drug Use
- Poly Drug Use
- DHHS Referrals

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: INDIVIDUAL AND GROUP COUNSELING

Description of Program/Service:

This service includes professional assessment, counseling, and therapeutic services to adults, the purposes of which are to promote positive orientation, relief of excess stress, and growth toward more integrated and independent levels of functioning. Services utilize a variety of individual and group treatment modalities and are provided by trained, licensed professionals.

Evidence Based/Promising Practice Standards:

<https://www.google.com/url?q=http://www.campbellcollaboration.org/lib/download/2811/&sa=U&ei=n9vvUcvXH9SDqQGisYGIDw&ved=0CAcQFjAA&client=internal-uds-cse&usg=AFQjCNEvaYJ25LuDl1OdO-10pLojifhB0w>

This systematic review will evaluate the relationship between the therapeutic alliance and psychotherapy outcomes, using observational studies of young adults (ages 18-34) that include reliable and valid measures of the therapeutic alliance and evaluate psychotherapy outcomes. The strength of the alliance is expected to predict more positive outcomes.

Data: Do we collect data on this program?

APS Healthcare runs reports on “Adult Members Authorized for Outpatient Services”(includes MaineCare members and Courtesy Reviews done by APS). What This Report Measures: Year to date count of adults in each of these types of outpatient services: group therapy, individual therapy and medication management. This report counts people ages 18 and over authorized for adult mental health services.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: COMMUNITY REHABILITATION SERVICES (CRS)

Description of Program/Service:

Community Rehabilitation Services support the development of the necessary skills for living in the community and promote recovery and community inclusion. These services will be available 24/7, the consumer will have at least one face to face contact each day, staff will be at a work site 12 hours a day and on-call the other 12 hours. Services include individualized combinations of community integration, daily living support and skills development. The services are delivered by a team. Each consumer has a primary case manager. The eligibility criteria and service description are in the MaineCare Benefits Manual Chapter II Section 17.02 and 17.04-2.

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Evidence Based/Promising Practice Standards:

No Evidence Based Practice (Maine Program)

Data: Do we collect data on this program?

Performance Measures:

- Performance-Based Contract Measure Goal: This measure focuses on the reduction of psychiatric hospitalization use as an indicator to gauge the effectiveness of CRS Services.
- Performance-Based Contract Measure: 95% of CRS recipients who have been in service for 6 or more months will have no psychiatric hospitalizations during the past 6 months.
- Performance-Based Contract Measure Data Source: APS CareConnection

Other Performance Measures (Consent Decree):

Persons with MaineCare coverage who are also class members seeking services who are hospitalized in a psychiatric unit or psychiatric hospital will be assigned a community integration worker within two days of application. See definitions at Section 17.01-5, <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Persons with MaineCare coverage who are also class members seeking services who are not hospitalized in a psychiatric unit or psychiatric hospital will be assigned a community integration worker within three days of application.

Persons with MaineCare coverage who are not class members will be assigned a community integration worker within seven days of application.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: DAY SUPPORT SERVICES

Description of Program/Service:

Day Supports Services, formerly known as “day treatment,” focus on training designed to assist in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. Services are provided in accordance with MaineCare Provider Agreement, definitions and rules as specified in the MaineCare Benefits Manual, Chapter 101, Chapter 1 General Administrative Policies and Procedures and Chapters II & III Section 17, Community Support Services <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Evidence Based/Promising Practice Standards:

<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=189>

ICCD Clubhouse Model

The ICCD (International Center for Clubhouse Development) Clubhouse Model is a day treatment program for rehabilitating adults diagnosed with a mental health problem. The goal of the program is to contribute to the recovery of individuals through use of a therapeutic environment that includes responsibilities within the Clubhouse (e.g., clerical duties, reception, food service, transportation, financial services), as well as through outside employment, education, meaningful relationships, housing, and an overall improved quality of life. Individuals who participate in the Clubhouse are called "members." Fundamental elements of their participation include openness and choice in type of work activities, choice in staff, and a lifetime right of reentry and access to all Clubhouse services.

Each individual is welcomed, wanted, needed, and expected each day and is considered a critical part of a community engaged in important work. A core component of the program is the "work-ordered day," the structure around which daily activity is organized. The day-to-day operation of the Clubhouse is the responsibility of members and staff, who work side by side in a rehabilitative environment. Other core components include transitional, supported, and independent employment through which members can secure jobs at prevailing wages in the wider community; access to community support, such as housing and medical services; assistance in accessing educational resources; "reach-out" to maintain contact with all active members; participation in program decision making and governance; and evening, weekend, and holiday social programs.

Clubhouses are certified and coordinated internationally through the ICCD. Clubhouse staff, who function as generalists, maintain a caseload, including managing employment placements, housing issues, and access to community supports. They also are responsible for the ongoing work of the Clubhouse and help organize and participate in social activities. Staff have diverse life experiences and backgrounds in a variety of disciplines, including psychology, counseling, social work, and education. Clubhouse members do not pay dues or

membership fees. Their attendance is voluntary, and they can participate as little or as much as they choose.

Descriptive Information

Areas of Interest: Mental health treatment

Co-occurring disorders

Outcomes Review Date: August 2010

1. Employment
2. Quality of life
3. Perceived recovery from a mental health problem

Outcome Categories

Employment

Quality of life

Treatment/recovery

Ages

18-25 (Young adult)

26-55 (Adult)

55+ (Older adult)

Genders

Male

Female

Races/Ethnicities

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

White

Race/ethnicity unspecified

Settings

Other community settings

Geographic Locations

Urban

Suburban

Rural and/or frontier

Implementation History

The first Clubhouse, Fountain House in New York City, began in 1948 when former patients of a New York psychiatric hospital began to meet informally. The "club" they organized was intended to be a support system for people diagnosed with mental illness rather than a

treatment program. The ICCD Clubhouse Model has been implemented in urban, suburban, and rural areas with a wide variety of ethnic, cultural, and socioeconomic groups. Serving approximately 55,000 individuals annually, more than 300 Clubhouses operate in the United States and throughout the world, in countries such as Australia, Austria, Canada, China, Denmark, England, Estonia, Finland, Germany, Iceland, Ireland, Israel, Italy, Japan, Korea, Kosovo, the Netherlands, New Zealand, Norway, Poland, Russia, Scotland, South Africa, Sweden, and Uganda. (The International Clubhouse Directory can be accessed at http://iccd.org/search_form.php)

Clubhouses are supported and coordinated internationally through the ICCD, formed in 1994. The ICCD coordinates training and ongoing technical support on the model through 10 international training bases and maintains both an international certification process and international standards for Clubhouse programs.

NIH Funding/CER Studies

Partially/fully funded by National Institutes of Health: Yes

Evaluated in comparative effectiveness research studies: Yes

Adverse Effects: No adverse effects, concerns, or unintended consequences were identified by the developer.

Data: Do we collect data on this program?

Performance Measures

- Performance-Based Contract Measure Goal: To demonstrate that participating in Day Support Services has improved functioning and independence in the community.
- Performance-Based Contract Measure: 90% of individuals will have graduated from the program within 12 months.
- Performance-Based Contract Measure: 90% of participants will have a lower LOCUS score at one year intervals of participating in the program.

Performance- Based Contract Measure Data Source:

APS CareConnection

Mandate: Is there a legal mandate for this service

No

PROGRAM/SERVICE: SPECIALIZED GROUP SERVICES – DIALECTICAL BEHAVIOR THERAPY (DBT)

Description of Program/Service:

Dialectical Behavior Therapy (DBT) is a skills training group conducted in a psycho educational format. The group leader must be an independently licensed professional and have been formally trained in DBT. The co-facilitated group focuses on the acquisition and strengthening of skills. Skills Training consists of four (4) modules: mindfulness, distress tolerance, interpersonal effectiveness in conflict situations, and emotional regulation. Groups meet weekly for two (2) to two and a half (2 1/2) hour sessions for up to one (1) year, but may meet more frequently for a shorter duration. Format for the group is based upon “Skills Training Manual for Treating Border-Line Personality Disorder” authored by Marsha M. Linehan.

Evidence Based/Promising Practice Standards:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2963469/>

In summary, the patients for whom DBT has the strongest and most consistent empirical support include parasuicidal women with BPD. There also are some promising data on DBT for women with BPD who struggle with substance use problems. Preliminary data suggest that DBT may have promise in reducing binge-eating and other eating-disordered behaviors. On the one hand, the most conservative clinical choice would be to limit DBT to women with BPD. On the other hand, DBT is a comprehensive treatment that includes elements of several evidence-based, cognitive-behavioral interventions for other clinical problems. As such, DBT often is applied in clinical settings to multi-problematic patients in general, including those patients who have comorbid Axis I and II disorders, and/or who are suicidal or self-injurious; however, caution is important in applying a treatment beyond the patients with whom it has been evaluated in the research.

Data: Do we collect data on this program?

No

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: DETOXIFICATION: (MEASURED BY DAY) ASAM LEVEL III 7-D

Description of Program/Service:

These programs provide a planned regimen of 24 hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. They are appropriate for patients whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or medically managed inpatient treatment program.

Services include: biopsychosocial evaluation, medical observation, monitoring, and treatment, counseling (including group and/or family therapies, and withdrawal support), health education and follow-up referral.

Evidence Based/Promising Practice Standards:

<http://summaries.cochrane.org/CD006749/detoxification-treatments-for-opiate-dependent-adolescents>

Detoxification treatments for opiate dependent adolescents

Minozzi S, Amato L, Davoli M. Published Online:

October 7, 2009. Substance abuse among adolescents (13 to 18 years old) is a serious and growing problem. It is important to identify effective treatments for those who are opioid dependent. For adults, pharmacotherapy is a necessary and acceptable part of effective treatment. Detoxification agents are used to reduce withdrawal symptoms during managed withdrawal but the rate of completion of detoxification tends to be low, and rates of relapse are high. Withdrawal symptoms, particularly drug craving, may continue for weeks and even months after detoxification. The period of recovery from dependence is typically influenced by a range of psychological, social and treatment related factors. Detoxification treatments include methadone, buprenorphine, and alpha2-adrenergic agonists. Medications have been used less frequently in treating substance abuse disorders among adolescents. The review authors searched the literature for controlled clinical trials investigating pharmacological interventions with or without psychosocial intervention aimed at detoxification in adolescents. They found only two US trial, one compared 28-day treatment with buprenorphine, using tablets placed under the tongue, to wearing a clonidine patch in 36 opiate dependent adolescents who were treated as outpatients. The trial reported a trend in favor of buprenorphine in reducing the dropout rate but no difference between treatments in the duration and severity of withdrawal symptoms. More participants in the buprenorphine group went on to long-term naltrexone treatment. Side effects were not reported. The other trial compared maintenance treatment vs detoxification treatment: buprenorphine-naloxone maintenance vs. buprenorphine

DRAFT

detoxification. For drop out the results were in favor of maintenance treatment, as well as for results at follow up; no differences for use of opiate. Methadone is the most frequently used drug for the treatment of opioid withdrawal yet the review authors did not find any controlled trial using methadone. Conducting trials with young people may be difficult for both practical and ethical reasons.

Data: Do we collect data on this program?

Recommended is to see if the clients are referred onto treatment after they complete detox.

Reporting Note:

Most of the data for performance monitoring is taken directly from the Web Infrastructure for Treatment Services (WITS). Providers must complete and submit WITS Admission and Discharge data according to policy. For ambulatory services, Outpatient Service Delivery Forms (OSDF) must also be submitted.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: DAILY LIVING SUPPORT SERVICES

Description of Program/Service

Daily Living Support Services are designed to assist a person who satisfies the specific eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02-3, 17-04-05 to maintain the highest level of independence possible. Services are provided in accordance with MaineCare Provider Agreement, definitions and rules as specified in the MaineCare Benefits Manual, Chapter 101, Section 1 General Administrative Policies and Procedures and Chapters II & III, Section 17, Community Support Services.

<http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Daily Living Support Services are provided by an MHRT-1, which includes CRMA.

The provider shall review the member's ISP at least every ninety (90) days to determine whether the Daily Living Support Services should be continued.

Services are not confined to the traditional work schedule of 8 to 5.

If the consumer has a community integration worker or an ACT team, the treatment plan will be coordinated and directed by the CI worker or the ACT team.

Performance Standards/Strategies

- Daily Living Supports are designed to assist a member to maintain the highest level of independence possible.
- The services provide personal supervision and therapeutic support to assist members to develop and maintain the skills of daily living.
- The services help members remain oriented, healthy, and safe.
- Without these supportive services, members would not be able to retain community tenure and would require crisis intervention or hospitalization.
- These services are provided to members in or from their homes or temporary living quarters in accordance with an individual support plan.
- Support methods include modeling, cueing, and coaching.

Evidence Based/Promising Practice Standards:

No Evidence Based Practice

Data: Do we collect data on this program?

DRAFT

Performance Measures:

- Performance-Based Contract Measure Goal: To demonstrate that participating in Daily Living Support Services has improved functioning and independence in the community.
- Performance-Based Contract Measure: 90% of participants will have a lower LOCUS score at six month intervals after enrollment in the program.

Performance- Based Contract Measure Data Source: APS CareConnection

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: DRUG COURT CASE MANAGEMENT

Description of Program/Service:

The key goals of most drug courts are to reduce drug use and associated criminal behavior by engaging and retaining drug-involved offenders in programmatic and treatment services; to concentrate expertise about drug cases into a single courtroom; to address other defendant needs through clinical assessment and effective case management; and to free judicial, prosecutorial and public defense resources for adjudicating non-drug cases.

The drug court model usually entails:

- judicial supervision of structured community-based treatment;
- timely identification of defendants in need of treatment and referral to treatment as soon as possible after arrest;
- regular status hearings before the judicial officer to monitor treatment progress and program compliance;
- increasing defendant accountability through a series of graduated sanctions and rewards; and
- mandatory periodic drug testing

Evidence Based/Promising Practice Standards:

<http://www.ndci.org/sites/default/files/ndci/CASA.Bekenko.1998.pdf>

Columbia University's National Center on Addiction and Substance Abuse (CASA) has provided the first major academic review and analysis of drug court research to date. The author has reviewed 30 evaluations pertaining to 24 drug courts across the nation and concluded that "a number of consistent findings emerge from available drug court evaluations." Importantly, the CASA study is the first to specifically look at the effectiveness of the drug court model on offenders when they are participating in the drug court program, comparing the drug court model to other forms of community supervision. The study found that drug courts provide closer, more comprehensive supervision and much more frequent drug testing and monitoring during the program, than other forms of community supervision. More importantly, drug use and criminal behavior are substantially reduced while offenders are participating in drug court.

Data: Do we collect data on this program?

Client data are to be reported to DTxC (Drug Court MIS) on a weekly basis.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: DIFFERENTIAL SUBSTANCE ABUSE TREATMENT (“DSAT”)

Description of Program/Service:

DSAT is a treatment program designed to reduce substance abuse and related criminal behavior within the Maine offender population. This treatment is an evidenced based practice that addresses the different needs of men and women in substance abuse treatment, but also the individual level of substance use severity. This model can be used in institutional and/or community outpatient services.

Agencies contracting with the Maine Office of Substance Abuse and Mental Health Services (SAMHS) for provision of Differential Substance Abuse Treatment (DSAT) Services will implement programming as an ASAM Level I Outpatient Program. DSAT services will provide two (2) three hour group sessions per week. Exceptions to this schedule must be approved by SAMHS. Motivational Enhancement and Skill Building sessions will meet a minimum of once a week, or as need indicates.

The Maine Office of Substance Abuse (OSA), Maine Department of Corrections (MDOC), and the Judicial Branch worked in collaboration to target reductions in recidivism. This collaboration resulted in development of the Differential Substance Abuse Treatment (DSAT) model – based on Motivational Enhancement and Cognitive-Behavioral treatment - to provide a continuum of comprehensive substance abuse services to adults in all MDOC adult correctional institutions, as well as community settings across six counties in Maine. The personnel selected for program implementation undergo two main training sessions prior to their certification. The first training event is a 5 day Basic Training, the second is an annual 1 day “booster” event. These “hands-on” trainings teach participants how to deliver each of the sessions and further develop and refine skills, ensuring program integrity. Video feedback and role playing are introduced and utilized as a mechanism for supervision and certification as a program facilitator.

Evidence Based/Promising Practice Standards: cite source and then enumerate the standards

<http://www.samhsa.gov/scienceandservice/substanceRSS2008.aspx>

Process and outcome evaluations are used to assess the functioning of the programming. The results on the CEST (Client Evaluation Self-Test) indicate that clients who participated in the DSAT curriculum experienced a reduction in depression, hostility, and risk-taking behaviors, and an increase in social conformity, and therapeutic involvement. Equally important is that clients have the ability to identify personal progress, develop a good rapport with counselors, and recognize the competence of counselors - such offenders are more likely to make positive changes. DSAT can be effectively delivered through the mechanisms that are employed by OSA, as shown in the evaluation, to include training the counselors, using quality assurance mechanisms, and working with the drug courts on the

programming issues to support treatment engagement. The DSAT curriculum engages many of the offenders in the treatment process. They report good rapport with the counselors which is an important predictor of engaging offenders in treatment programming. Fewer drug court participants (17.5%) recidivated during a 12 month post-program follow-up than a comparison group of adult offenders traditionally adjudicated (33.1%).

Data: Do we collect data on this program? If yes, what are the data measures (cite source, i.e. NOM, Contract Performance, Consent Decree)?

Contracting agencies will:

1. Provide and maintain substance abuse credentialed DSAT trained facilitators for delivery of all DSAT services.
2. Input into the DSATWeb, keeping data current.
3. For agencies providing services to the Maine Adult Drug Treatment Courts (ADTC's) input into the DTxC system, keeping data current.
4. Quarterly DSAT Activity Reports
5. Agencies will submit quarterly DSAT Activity Report Forms by the 15th of the month following the end of the quarter using the attached form:

DSAT Quarterly Activity Report

Agency: _____ Program: Community Prison

Quarterly Report Dates: 1st 2nd 3rd 4th Date:

1) Number of Substance Use Screening Assessments (formerly CSAs) completed: _____

2) Number of Comprehensive Assessments completed: _____

3) Number of new admissions: _____

4) Total Number of current/active DSAT clients: _____

Drug Court _____ Community Corrections _____

MDOC Institutional Program _____ Other (DHHS, DEEP) _____

5) Number of DSAT groups:

Pre-Treatment _____ a.m. _____ p.m. _____

MET _____ a.m. _____ p.m. _____

Intensive _____ a.m. _____ p.m. _____

Maintenance _____ a.m. _____ p.m. _____

6) Number of active clients in DSAT groups and level:

Level 1 _____ male _____ female _____

Level 2 _____ male _____ female _____

Level 3 _____ male _____ female _____

Level 4/4+ _____ male _____ female _____

Level 5 Male Institutional Services

7) Total number discharged from DSAT treatment this quarter _____

____ completed motivational phase

____ completed intensive phase

____ completed maintenance phase

____ other (specify) _____

8) Community-based Services: Number of clients active in Aftercare _____

9) Number of clients expecting to apply DSAT toward completion of DEEP requirements _____

10) Prison-based Services: Number of clients referred to Community DSAT services:

Comments:

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: EXTENDED CARE ASAM LEVEL III.3 (MEASURED BY DAY)

Description of Program/Service:

Extended care is a service that provides a long-term supportive and structured environment for people who are substance use dependent with extensive substance use debilitation. These programs provide a supervised living experience within the program. Qualified staff teaches attitudes, skills and habits conducive to facilitating the member's transition back to the community. The extended care component requires sustained abstinence and provides medium intensity treatment and ongoing structured living experience within a facility/program or reentry into the treatment system. Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the world of work, education and family life. The treatment goals will vary from individual to individual and may be in the form of individual, group or family counseling. Outcome goals may range from custodial care to further treatment services and recovery.

7 hours per week or 1 hour per day of clinical individual or group counseling.

10 hours per week of rehabilitative groups designed to meet individual needs of clients.

Services include: Biopsychosocial assessment, group/individual/family treatment sessions (planned clinical program activities to stabilize and maintain stabilization of the residents substance dependence symptoms and to help him or her develop and apply recovery skills, this may include; relapse prevention, interpersonal choices and a development of a social network supportive of recovery) , living skills training, vocational assessment and preparation, transportation between programming or emergency care facilities, and care coordination.

Evidence Based/Promising Practice Standards:

Trans Theoretical Model (stages of change)

<http://www.uri.edu/research/cprc/TTM/detailedoverview.htm>

Motivational Interviewing

http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

Dialectical Behavior Therapy

<http://behavioraltech.org/resources/whatisdbt.cfm>

Cognitive Behavioral Therapy

<http://apt.rcpsych.org/content/8/4/307.full>

Relapse Prevention Therapy

Gorki's Center of Applied Sciences (CNAPS) Model.

http://www.tgorski.com/gorski_articles/developing_a_relapse_prevention_plan.htm

Eye Movement Desensitization and Reprocessing (as determined on an individual basis)

<http://www.emdr.com/general-information/what-is-emdr.html>

DRAFT

Developmental Recovery Process

http://www.tlctx.com/ar_pages/recovery_overview.htm

Addiction Focused Biopsychosocial Framework

http://www.tgorski.com/clin_mod/best_practices/Gorski%20Best%20Practice%20Standards%20010508.htm

Data: Do we collect data on this program?

Source – WITS

Standard

Total Program and SAMHS units are based on a 90% minimal standard occupancy rate. (Reference Form 001)

Required Effectiveness Indicators and Minimal Standards Indicator

Performance Measures: (minimum standards)

1. Reduced Morbidity: Abstinence/drug free prior to discharge = 85%
2. Reduced Morbidity: Reduction of use of primary substance abuse problem = 90%
3. Retention: Completion of Treatment = 50%
4. Referral in the continuum of care/next medically necessary service = 65%

Tracking Only

Average Time in Treatment for Completed Clients (Weeks)

GAF Improvement

Conduct follow-up contact (phone, text, email) with client 1x a week for the first 30 days, 2 x a month the following 60 days, 1 x a month for the remainder to the year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine effectiveness, as this may be requested by SAMHS.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: HALFWAY HOUSE ASAM LEVEL III.1 (MEASURED BY DAY)

Description of Program/Service:

Halfway house is a community-based, peer oriented residential program that provides low intensity clinical services to support recovery from substance use disorders. For this programming level, the effects of the substance related disorder on the individual's life are so significant, and the resulting level of impairment so great, that outpatient motivations and/or relapse prevention strategies are not feasible or effective. It is designed to improve the resident's ability to structure and organize the task of daily living and recovery, such as personal responsibility, personal appearance and are considered rehabilitative.

5 hours a week of low intensity treatment of substance related disorders.

12 hours per week of rehabilitative groups designed to meet individual needs of clients.

Services include: Biopsychosocial assessment, group/individual/family counseling, living skills, vocational assessment and preparation, transportation between programming or emergency care facilities and care coordination.

Evidence Based/Promising Practice Standards:

Motivational Interviewing

http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

Cognitive Behavioral therapy

<http://apt.rcpsych.org/content/8/4/307.full>

Stephanie Covington's Women in Recovery Series

<http://www.stephaniecovington.com/women-in-recovery-understanding-addiction.php>

Seeking Safety

<http://www.nrepp.samhsa.gov/viewintervention.aspx?id=139>

Differential Substance Abuse Treatment (DSAT)

<https://www1.maine.gov/dhhs/samhs/osa/pubs/correct/2004/dsatoverview.pdf>

Dialectical Behavior Therapy (chain of analysis and mindfulness)

<http://behavioraltech.org/resources/whatisdbt.cfm>

Sanctuary Model (certification as a trauma informed agency)

<http://www.sanctuaryweb.com/sanctuary-model.php>

Nurturing Parenting

<http://www.nurturingparenting.com/>

Data: Do we collect data on this program? If yes, what are the data measures (cite source, i.e. NOM, Contract Performance, Consent Decree)?

Source – WITS

DRAFT

Standard

Total Program and SAMHS Units are based on a 90% minimal standard occupancy rate. (Reference Form 001)

Required Effectiveness Indicators and Minimal Standards

Program performance must be at or above the minimal level on 3 of the following 4 performance indicators, monitored on a quarterly basis:

Performance Measures: (minimum standards)

1. Reduced Morbidity: Abstinence/drug free prior to discharge = 85%
2. Reduced Morbidity: Reduction of use of primary substance abuse problem = 90%
3. Retention: Completion of Treatment = 65%
4. Referral in the continuum of care/next medically necessary service = 75%

Tracking Only

Average Time in Treatment for Completed Clients (Weeks)

GAF Improvement

Conduct follow-up contact (phone, text, email) with client 1x a week for the first 30 days, 2 x a month the following 60 days, 1 x a month for the remainder to the year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine effectiveness, as this may be requested by SAMHS.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: INTENSIVE OUTPATIENT (“IOP”)

Description of Program/Service:

Intensive outpatient treatment is a component that provides an intensive and structured program of substance abuse evaluation, diagnosis, and treatment services in a setting that does not include an overnight stay.

1. This component shall include both community-based nonresidential rehabilitation and partial capitalization programs. It includes programs generally described as "day treatment" and "intensive outpatient services."
2. This component shall consist of a structured sequence of multi-hour clinical and educational sessions, scheduled for three or more days per week with a minimum of nine hours per week.

Evidence Based/Promising Practice Standards:

A set of core services is essential to all intensive outpatient treatment (IOT) efforts and should be a standard part of the treatment package for every client. Enhanced services often are added and delivered either on site or through functional and formal linkages with community-based agencies or individual providers.

<http://www.ncbi.nlm.nih.gov/books/NBK64094/>

Data: Do we collect data on this program?

Source – WITS

Performance Guidelines

The Office of Substance Abuse and Mental Health Services, in consultation with Provider representatives, has established standards and performance requirements relative to the quantity and quality of client service and care, and to administrative and fiscal management. The standards, as described below, represent the performance goals for client services. Administrative and fiscal management standards and requirements are listed in Rider B, C, D and E. Contracts will be on an expense basis. Allocation of resources for the contract year may be affected by agency performance in the previous year.

Reporting Note:

Most of the data for performance monitoring is taken directly from the Web Infrastructure for Treatment Services (WITS). Providers must complete and submit WITS Admission and Discharge data according to policy. For ambulatory services, Outpatient Service Delivery Forms (OSDF) must also be submitted.

Service Setting: **Intensive Outpatient
Intensive Outpatient Program ASAM Level Ii.1**

Required Effectiveness Indicators and Minimal Standards

Indicator

Number of units of service to be delivered.

Standard

Total Program and SAMHS Units are based on a 90% minimal annual delivery standard of the above units of service.

Agencies that exceed 100% of contracted units of service per quarter will receive an incentive payment of 5% of the quarterly payment. Agencies that do not meet 90% of the contracted service units for the quarter will receive a cut in reimbursement of 5% for that quarter.

Program performance must be at or above the minimal level on the following performance indicators, monitored on a quarterly basis:

<u>Indicator</u>	<u>Minimal Standard</u>
Access to treatment: median time to assessment	4 calendar days
Agencies that have median time of more than four days will have their payment reduced by 1%. Agencies that have a median time of two days or less will receive an incentive payment of 1%.	
Access to treatment: median time to treatment	7 calendar days
Agencies that have a median time between assessment and treatment of greater than seven calendar days will have their payment reduced by 1%. Agencies that have median time between assessment and treatment of less than three days will receive an incentive payment of 1%.	
Treatment Retention: stayed for four sessions	minimum standard 85%
Agencies that have less than 85% of their clients stay for four or more sessions will have their payment reduced by 1%. Agencies that have greater than 90% of their clients stay for four sessions will receive an incentive payment of 1%.	
Completed Treatment:	minimum standard 50%
Agencies that have less than 50% of clients complete treatment will have their payment reduced by 1%. Agencies that have more than 60% of clients complete treatment will receive an incentive payment of 1%.	

Tracking Only

The performance indicators below, contained in previous agreements, shall now be used for SAMHS tracking only through the Office of Substance Abuse and Mental Health Services Data Systems (formerly known as OSADS), Web Infrastructure for Treatment Services

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment
- Referral in the Continuum of Care
- Referral to Mental Health Services
- Average time in treatment for completed clients (weeks)

SERVICE SETTING: ADOLESCENT INTENSIVE OUTPATIENT INTENSIVE OUTPATIENT PROGRAM ASAM LEVEL II.1

Required Effectiveness Indicators and Minimal Standards

Indicator

Units of service to be delivered.

Standard

Total Program and SAMHS Units are based on a 90% minimal annual delivery standard.

Agencies that exceed 100% of contracted units of service per quarter will receive an incentive payment of 5% of the quarterly payment. Agencies that do not meet 90% of the contracted service units for the quarter will receive a cut in reimbursement of 5% for that quarter.

Program performance must be at or above the minimal level on the following performance indicators (primary clients only), monitored on a quarterly basis:

Indicator

Minimal Standard

Access to treatment: median time to assessment 4 calendar days
Agencies that have median time of more than four days will have their payment reduced by 1%. Agencies that have a median time of two days or less will receive an incentive payment of 1%.

Access to treatment: median time to treatment 7 calendar days
Agencies that have a median time between assessment and treatment of greater than seven calendar days will have their payment reduced by 1%. Agencies that have median time between assessment and treatment of less than three days will receive an incentive payment of 1%.

Treatment Retention: stayed for four sessions minimum standard 80%
Agencies that have less than 80% of their clients stay for four or more sessions will have their payment reduced by 1%. Agencies that have greater than 85% of their clients stay for four sessions will receive an incentive payment of 1%.

Completed Treatment: minimum standard 50%
Agencies that have less than 50% of clients complete treatment will have their payment reduced by 1%. Agencies that have more than 60% of clients complete treatment will receive an incentive payment of 1%.

Tracking Only

The performance indicators below, contained in previous agreements, shall now be used for SAMHS tracking only through the Office of Substance Abuse and Mental Health Services Data Systems (formerly known as OSADS), Web Infrastructure for Treatment Services.

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment
- Referral in the Continuum of Care
- Referral to Mental Health Services
- Average time in treatment for completed clients (weeks)

Performance-based contracting (PBC) reports are based on the data submitted within the specified time parameters. Late entry of data and/or form submittal may result in lower than expected results on the PBC reports.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: MEDICATION ASSISTED TREATMENT (MAT)

Description of Program/Service:

Service Description –Medication Assisted Treatment (MAT) for a Substance Use Disorder Medication Assisted Treatment (MAT) of Substance Use Disorders (e.g. Buprenorphine, naltrexone, acamprosate, Vivitrol, etc) is primarily and specifically intended to help stabilize addiction related symptoms. It can be combined with psychotropic medications to treat symptoms of a co-occurring condition if clinically indicated. Scheduled Medications may require different certificates or licensure for prescribers. In no way does this rider change that obligation. A physician, psychiatrist, advanced practice registered nurse, physician’s assistant, or psychiatric nurse within the scope of his/her license must provide these services.

Medication Assisted Treatment for Addiction:

Opioid Treatment Program (OTP) - Under medical supervision for maintenance or detoxification, OTP clinics administer opioid agonist medication (such as Methadone), monitor dosages, and provide counseling to people with a dependence on heroin or prescription opioid medications.

Other: Some other forms of Medication Assisted Treatment used for detoxification and/or long term treatment are medications including, but not limited to, Suboxone, Buprenorphine, Subutex, Vivitrol, and Antabuse which are prescribed medications by a physician in an inpatient or outpatient setting.

Evidence Based/Promising Practice Standards:

SAMHSA offers a “MedTEAM (Medication Treatment, Evaluation, and Management) Evidence-Based Practices (EBP) KIT” which equips treatment teams at mental health agencies with a systematic plan to ensure they tap the latest scientific evidence coupled with patient input in making medication management decisions for people with mental illnesses. Modules cover getting started through to program evaluation.

<http://store.samhsa.gov/product/SMA10-4549>

Data: Do we collect data on this program?

Data source is WITS for Substance Abuse providers.

Minimal Standards:

- 85% of clients are in independent living at time of discharge.
- 10% of clients obtain employment since admission to the program.

DRAFT

- 90% of clients are not arrested for any offense 30 days prior to discharge from treatment. (We typically measure this at update to see how clients' behavior has changed since admission).

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: PSYCHIATRIC MEDICATION SERVICES (MED MANAGEMENT)

Description of Program/Service:

Psychiatric Medication Services are those services that are directly related to the prescription, administration, education, and/or monitoring of medications intended for the treatment and management of the symptoms of mental illness. A psychiatrist, advanced practice registered nurse, physician's assistant, or psychiatric nurse within the scope of his/her license must provide these services.

In addition, some Substance Abuse Medication Assisted Treatment (MAT) may be prescribed under Psychiatric Med Management (see Substance Abuse MAT document).

Services are provided in accordance with MaineCare Provider Agreement, definitions and rules as specified in the MaineCare Benefits Manual, Chapter 101, Chapter 1 General Administrative Policies and Procedures and Chapters II & III, Section 65, Behavioral Health Services.

Evidence Based/Promising Practice Standards:

http://journals.lww.com/psychopharmacology/Abstract/2002/02000/Medication_Management_Ability_Assessment_Results.3.aspx

Patients with schizophrenia who adhere to physicians' recommended use of medications are less likely to relapse than those who do not. Self-report measures of adherence have been criticized on a number of grounds. Here we describe a performance-based measure of medication management, the Medication Management Ability Assessment (MMAA), which represents a modification of the Medication Management Test used in individuals with HIV infection. Subjects were 104 patients older than 45 years with diagnoses of schizophrenia or schizoaffective disorder, and 33 normal comparison subjects (NCs). Subjects participated in a role-play task (MMAA) that simulated a prescribed medication regimen similar in complexity to one that an older person is likely to be exposed to. The total number of pills over that prescribed, total number of pills under that prescribed and total number of correct responses were calculated. Self-report and prescription record data on adherence as well as data on measures of psychopathology, global cognitive status, and other clinical measures were also gathered. MMAA role-plays required 15 minutes, and its 1-week test-retest reliability was excellent (intraclass correlation coefficient, 0.96). Patients committed significantly more errors in medication management compared with NCs. Significantly more patients were classified as being nonadherent (i.e., taking $\pm 5\%$, 10%, 15%, or 20% of prescribed pills) compared with NCs. Patients with more severe cognitive deficits performed worse on the MMAA. MMAA performance was significantly related to prescription refill records, performance-based measures of everyday functioning, and self-reported quality of life. The MMAA is a useful instrument for observing ability to manage medications in patients with schizophrenia. The measure was

DRAFT

related to severity of cognitive impairment, suggesting that adherence may improve with psychotropic and psychosocial interventions that target these deficits.

Data: Do we collect data on this program?

APS Healthcare runs reports on “Adult Members Authorized for Outpatient Services” (includes MaineCare members and Courtesy Reviews done by APS). What This Report Measures: Year to date count of adults in medication management. This report counts people ages 18 and over authorized for adult mental health services.

Providers submit data on Service Encounters for Section 17 eligible individuals by Payer Type (i.e. MaineCare, Medicare, Dual Eligible, Uninsured, and Private Insurance).

Mandate: Is there a legal mandate for this service?

No

Pillar: Treatment

PROGRAM/SERVICE: METHADONE MAINTENANCE SERVICES (OPIATE AGONIST) – (MEASURED BY 1 DAY)

Description of Program/Service:

Methadone maintenance coverage will be limited to treatment:

1. Administered in accordance with federal and state laws and regulations that govern methadone administration, including the Maine Office of Substance Abuse and Mental Health Services of the Department of Health and Human Services, the Center for Substance Abuse Treatment (Division of the Substance Abuse and Mental Health Services Administration), the US Drug Enforcement Agency, and US Food and Drug Administration and the State Pharmacy Board, and Accreditation Bodies.
2. Provided as a part of a package of services including the cost of providing:
 - a. Methadone itself,
 - b. Necessary individual and group counseling, and
 - c. Case management services, which include referral for related medical, psychiatric or social services and follow up. Providers are required to maintain documentation of the client's relevant history, including regular checks of the Prescription Monitoring Program and to provide laboratory testing and monitoring associated with the administration of methadone.

Evidence Based/Promising Practice Standards:

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=19>

Interim Methadone Maintenance

Interim Methadone Maintenance, also known as Interim Maintenance or IM, is a simplified methadone treatment program for opioid-dependent adults who are on waiting lists for comprehensive methadone treatment. IM consists of a daily, individually determined methadone dose, administered by a nurse, plus emergency counseling for up to 120 days. U.S. Federal regulations permit methadone treatment programs (MTPs) to provide IM to adults who seek treatment but, due to limited program capacity, cannot be admitted within 14 days. The regulations specify that (1) only public or nonprofit MTPs can provide IM; (2) patients receive counseling with IM only for emergencies or during times of crisis (e.g., serious medical problem, relationship issues, temporary loss of housing), although this occurs on an infrequent basis; and (3) patients must undergo limited drug testing. IM aims to facilitate entry into MTPs and reduce heroin use and criminal behavior by capitalizing on the motivation of the individual seeking treatment and providing help at the time of the request.

Data: Do we collect data on this program?

Source – WITS

Mandate: Is there a legal mandate for this service? No

PROGRAM/SERVICE: NON-INTENSIVE OUTPATIENT (“OP”)

Description of Program/Service:

These services are located at an agency office and provide individual, group, and family sessions, usually for an hour or ninety minutes once a week.

Outpatient is a component that provides assessment, diagnosis, treatment, and after-care services in a non-residential setting. These services may also be provided to the families of substance abusers and other concerned persons, whether or not the abuser is receiving treatment. Components of outpatient services include:

Individual Counseling: A unit is defined as ¼-staff hour of contact between a therapist and a client involving counseling/treatment planning, guidance/support, problem solving assistance, providing relief/assistance in coping, promoting a positive re-orientation toward sobriety.

Family Counseling: A unit is defined as ¼-staff hour of contact between a therapist or therapists and a family involving any of the activities described under individual counseling, (above).

Group Counseling: A unit is defined as ¼-client hour of contact between a therapist or therapists and a group of clients.

Evaluation: All evaluation services to be reimbursed under this contract must have the prior written approval of the Office of Substance Abuse and Mental Health Services (SAMHS). Evaluation services may only be delivered to target populations as defined by SAMHS.

Evidence Based/Promising Practice Standards:

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=122>

One example of Evidence Based Practice for OP is Brief Marijuana Dependence Counseling (BMDC), which is a 12-week intervention designed to treat adults with a diagnosis of cannabis dependence. Using a client-centered approach, BMDC targets a reduction in the frequency of marijuana use, thereby reducing marijuana-related problems and symptoms. BMDC is based on the research protocol used by counselors in the Center for Substance Abuse Treatment’s Marijuana Treatment Project conducted in the late 1990s. A treatment manual provides guidelines for counselors, social workers, and psychologists in both public and private settings. BMDC is implemented as a 9-session multicomponent therapy that includes elements of motivational enhancement therapy (MET), cognitive behavioral therapy (CBT), and case management.

Data: Do we collect data on this program? Yes

PERFORMANCE GUIDELINES

The Office of Substance Abuse and Mental Health Services, in consultation with Provider representatives, has established standards and performance requirements relative to the quantity and quality of client service and care, and to administrative and fiscal management. The standards, as described below, represent the performance goals for client services. Administrative and fiscal management standards and requirements are listed in Rider B, C, D and E. Contracts will be on an expense basis. Allocation of resources for the contract year may be affected by agency performance in the previous year.

Reporting Note:

Most of the data for performance monitoring is taken directly from the Web Infrastructure for Treatment Services (WITS). Providers must complete and submit WITS Admission and Discharge data according to policy. For ambulatory services, Outpatient Service Delivery Forms (OSDF) must also be submitted.

Performance-based contracting (PBC) reports are based on the data submitted within the specified time parameters. Late entry of data and/or form submittal may result in lower than expected results on the PBC reports.

Standard:

Total Program and SAMHS Units are based on a 90% minimal annual delivery of units of service. (Reference Form 001)

The total units of service are further broken down into:

- Services to Primary Substance Abuse Clients: at least 70% of the total units
- Services to Co-Dependents/Affected Others: 30% maximum of the total units

REQUIRED EFFECTIVENESS Indicators AND Minimal Standards

Indicator

Minimal Standard

Program performance must be at or above the minimal level on 5 of the following 8 performance indicators (primary clients only), monitored on a quarterly basis:

- Abstinence/drug free 30 days prior to discharge..... 75%
- Reduction of use of primary substance abuse problem 60%
- Maintaining employment 90%
- Employability 3%
- Not arrested for any offense..... 95%
- Not arrested for an OUI offense during treatment 95%
- Participation in self-help during treatment 45%
- Completed Treatment..... 60%

Tracking Only

Average Time in Treatment for Completed clients (Weeks)

Completed Treatment - Affected Others

GAF Improvement

GAF Improvement - Affected Others

**SERVICE SETTING: OUTPATIENT
OUTPATIENT CARE ASAM LEVEL I**

Required Effectiveness Indicators and Minimal Standards

Indicator

Units of Service to be delivered.

Standard

Total Program and SAMHS Units are based on a 90% minimal annual delivery of units of service.

Agencies that exceed 100% of contracted units of service per quarter will receive an incentive payment of 5% of the quarterly payment. Agencies that do not meet 90% of the contracted service units for the quarter will receive a cut in reimbursement of 5% for that quarter.

Program performance must be at or above the minimal level on the following performance indicators (primary clients only), monitored on a quarterly basis:

Indicator **Minimal Standard**

Access to treatment: median time to assessment 5 calendar days
Agencies that have median time of more than five days will have their payment reduced by 1%. Agencies that have a median time of 2 days or less will receive an incentive payment of 1%.

Access to treatment: median time to treatment 14 calendar days
Agencies that have a median time between assessment and treatment of greater than 14 calendar days will have their payment reduced by 1%.
Agencies that have median time between assessment and treatment of less than seven days will receive an incentive payment of 1%.

Treatment Retention: stayed for four sessions minimum standard 50%
Agencies that have less than 50% of their clients stay for four or more sessions will have their payment reduced by 1%. Agencies that have greater than 65% of their clients stay for four sessions will receive an incentive payment of 1%.

Treatment Retention: stayed for 90 days..... minimum standard 30%
Agencies that have less than 30% of clients retained for 90 days will have their payment reduced by 1%. Agencies that exceed 40% retention of 90 days or more will receive an incentive payment of 1%.

Tracking Only

The performance indicators below, contained in previous agreements, shall now be used for SAMHS tracking only through the Office of Substance Abuse and Mental Health Services Data Systems (formerly known as OSADS), Web Infrastructure for Treatment Services.

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Maintaining employment
- Employability
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment
- Referral to Mental Health Services
- Average Time in Treatment for Completed clients (Weeks)

SERVICE SETTING: ADOLESCENT OUTPATIENT OUTPATIENT CARE ASAM LEVEL I

REQUIRED EFFECTIVENESS Indicators AND Minimal Standards

Indicator

Units of service to be delivered.

Standard

Total Program and SAMHS Units are based on a 90% minimal annual delivery standard.

Agencies that exceed 100% of contracted units of service per quarter will receive an incentive payment of 5% of the quarterly payment. Agencies that do not meet 90% of the contracted service units for the quarter will receive a cut in reimbursement of 5% for that quarter.

Program performance must be at or above the minimal level on the following performance indicators, monitored on a quarterly basis (primary clients only):

Indicator

Minimal Standard

Access to treatment: median time to assessment 5 calendar days
Agencies that have median time of more than five days will have their payment reduced by 1%. Agencies that have a median time of 2 days or less will receive an incentive payment of 1%.

Access to treatment: median time to treatment 14 calendar days
Agencies that have a median time between assessment and treatment of greater than 14 calendar days will have their payment reduced by 1%. Agencies that have median time between assessment and treatment of less than seven days will receive an incentive payment of 1%.

Treatment Retention: stayed for four sessions minimum standard 50%
Agencies that have less than 50% of their clients stay for four or more sessions will have their payment reduced by 1%. Agencies that have greater than 65% of their clients stay for four sessions will receive an incentive payment of 1%.

Treatment Retention: stayed for 90 days minimum standard 30%
Agencies that have less than 30% of clients retained for 90 days will have their payment reduced by 1%. Agencies that exceed 40% retention of 90 days or more will receive an incentive payment of 1%.

Tracking Only

The performance indicators below, contained in previous agreements, shall now be used for SAMHS tracking only through the Office of Substance Abuse and Mental Health Services Data Systems (formerly known as OSADS), Web Infrastructure for Treatment Services.

- Abstinence/drug free 30 days prior to discharge
- Reduction of use of primary substance abuse problem
- Not arrested for any offense
- Not arrested for an OUI offense during treatment
- Participation in self-help during treatment
- Completed Treatment
- Referral to Mental Health Services
- Average Time in Treatment for Completed clients (Weeks)

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: SPECIALIZED GROUP SERVICES - RECOVERY WORKBOOK GROUP

Description of Program/Service:

Recovery Workbook Group is a co-facilitated, curriculum-based recovery group designed to increase awareness and understanding of the recovery process. This service includes the development of coping and empowerment strategies, skills for rebuilding connections with self or others, and skills needed to strengthen and maintain the recovery process and to create opportunities for living fuller lives. The group meets for a maximum of thirty (30) consecutive sessions. The service is facilitated by individuals who have received a certificate for successful completion of the course "PDP 703-REC: Facilitating a Recovery Workshop" through the Boston University Center for Psychiatric Rehabilitation. The Recovery Workbook Group is co-facilitated and requires at least one peer facilitator. The second co-facilitator may be a peer, mental health professional or other qualified individual.

Evidence Based/Promising Practice Standards:

<http://journals.psychiatryonline.org/article.aspx?articleid=100333>

Objective: The study examined the effectiveness of the Recovery Workbook as a group intervention for facilitating recovery of persons with serious mental illness. **Methods:** The multicenter, prospective, single-blind, randomized controlled trial included 33 persons who were receiving assertive community treatment services. For 12 weeks, a control group (N=17) received treatment as usual and an intervention group (N=16) received Recovery Workbook training in addition to usual treatment. At study entry and within three days of completion of the intervention, participants' perceived level of hope, empowerment, recovery, and quality of life were measured with the Herth Hope Index, the Empowerment Scale, the Recovery Assessment Scale, and the Quality of Life Index, respectively. Repeated-measures analysis of variance was used to examine between-group differences. **Results:** Participation in the intervention group was associated with positive change in perceived level of hope, empowerment, and recovery but not in quality of life. The associations remained after analyses controlled for demographic variables. **Conclusions:** The study, which is one of the first randomized controlled trials of a recovery-based group intervention for persons with serious mental illness, showed that the Recovery Workbook group program was effective in increasing individuals' perceived sense of hope, empowerment, and recovery. In an era when recovery is the primary goal around which reformed mental health service delivery is organized, researchers should continue to study recovery-based interventions such as the Recovery Workbook to determine their potential as evidence-based treatment options. (Psychiatric Services 60:491-497, 2009)

Data: Do we collect data on this program? No

Mandate: Is there a legal mandate for this service? No

PROGRAM/SERVICE: RESIDENTIAL REHABILITATION - ADOLESCENT: (MEASURED BY DAY) ASAM LEVEL III.5

Description of Program/Service:

Residential rehabilitation services are designed to treat adolescents who have significant social and psychological problems. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect global change in a participant's lifestyles, attitudes, and values. For placement in this level of programming an individual would have multiple deficits, which may include substance related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values.

14 hours per week or 2 hours per day of clinical individual or group counseling

7 hours per week of rehabilitative groups designed to meet individual needs of clients

Services include: Biopsychosocial assessment, group/individual/family clinical treatment (planned clinical program activities to stabilize and maintain stabilization of the residents' substance dependence symptoms and to help him or her develop and apply recovery skills, this may include; relapse prevention, interpersonal choices and a development of a social network supportive of recovery), daily didactic/educational presentations, transportation between programming or emergency healthcare facilities, and care coordination.

Evidence Based/Promising Practice Standards:

The Seven Challenges

<http://sevenchallenges.com/>

Aggression Replacement Training

<http://aggressionreplacementtraining.com/>

Motivational Interviewing

http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

Cognitive Behavioral Therapy

<http://apt.rcpsych.org/content/8/4/307.full>

PRIME for Life

<http://www.primeforlife.org/>

Client-Directed Outcome-Informed Therapy

<http://www.goodtherapy.org/client-directed-outcome-informed-therapy.html>

Adolescent Community Reinforcement Approach

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=41>

Girls Circle

<https://onecirclefoundation.org/GC.aspx>

Trauma Informed Effective Reinforcement System for Girls

<https://www.nttac.org/index.cfm?event=trainingCenter.traininginfo&eventID=190>

DRAFT

Data: Do we collect data on this program? Yes

Standard

Total Program and SAMHS Units are based on an 80% minimal standard occupancy rate. (Reference Form 001)

Performance Measures: (minimum standards)

- Reduced Morbidity: Abstinence/drug free prior to discharge = 90%
- Reduced Morbidity: Reduction of use of primary substance abuse problem = 90%
- Retention: Completion of Treatment = 30%
- Referral in the continuum of care/next medically necessary service = 85%

Tracking Only

Average time in treatment for Completed Clients (Weeks)
Completed Treatment

Conduct follow-up contact (phone, text, email) with client 1x a week for the first 30 days, 2 x a month the following 60 days, 1 x a month for the remainder to the year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine effectiveness, as this may be requested by SAMHS.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: RESIDENTIAL REHABILITATION

Description of Program/Service:

Residential Rehabilitation 1: (measured by day) ASAM Level III.5

Residential rehabilitation services are designed to treat persons (specifically women and their children) who have significant social and psychological problems. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect global change in a participant's lifestyles, attitudes, and values. For placement in this level of programming an individual would have multiple deficits, which may include substance related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. In addition, the RH1 category provides care to the children of the clients in its facility.

14 hours per week or 2 hours per day of clinical individual or group counseling

7 hours per week of rehabilitative groups designed to meet individual needs of clients.

Residential Rehabilitation 2: (measured by day) ASAM Level III.5

Residential rehabilitation services are designed to treat persons who have significant social and psychological problems. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect global change in a participant's lifestyles, attitudes, and values. For placement in this level of programming an individual would have multiple deficits, which may include substance related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values.

14 hours per week or 2 hours per day of clinical individual or group counseling.

7 hours per week of rehabilitative groups designed to meet individual needs of clients

Services include: Biopsychosocial assessment, group/individual/family clinical treatment (planned clinical program activities to stabilize and maintain stabilization of the residents' substance dependence symptoms and to help him or her develop and apply recovery skills, this may include; relapse prevention, interpersonal choices and a development of a social network supportive of recovery), daily didactic/educational presentations, transportation between programming or emergency healthcare facilities, and care coordination.

Evidence Based/Promising Practice Standards:

Residential Rehabilitation 1

Gender specific programming based on the research of Stephanie Covington and the Stone Center Relational Model

<http://www.stephaniecovington.com/assets/files/8.pdf>

Relapse Prevention Therapy

http://www.tgorski.com/gorski_articles/developing_a_relapse_prevention_plan.htm

Motivational Interviewing

http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf

Cognitive Behavioral Therapy

<http://apt.rcpsych.org/content/8/4/307.full>

A Woman's way to the Twelve Steps

<http://www.cebc4cw.org/program/a-woman-s-way-through-the-twelve-steps/detailed>

The Incredible Years

<http://incredibleyears.com/>

Residential Rehabilitation 2

Seeking Safety

<http://www.bhrm.org/guidelines/PTSD.pdf>

The Therapeutic Community: Theory, Model, and Method – George De Leon PhD

<http://jod.sagepub.com/content/39/1/167.full.pdf>

Data: Do we collect data on this program?

Service Setting: Residential Rehabilitation RH1 and RH2 (ASAM III.5)

Standard:

Total Program and SAMHS Units are based on an 80% minimal standard occupancy rate. (Reference Form 001)

Required Effectiveness Indicators and Minimal Standards

Indicator

Performance Measures: (minimum standards)

- Reduced Morbidity: Abstinence/drug free prior to discharge = 90%
- Reduced Morbidity: Reduction of use of primary substance abuse problem = 90%
- Retention: Completion of Treatment = 75%
- Referral in the continuum of care/next medically necessary service = 85%

Tracking Only

DRAFT

- Average Time in Treatment for Completed Clients (Weeks)
- GAF Improvement
- Conduct follow-up contact (phone, text, email) with client 1x a week for the first 30 days, 2 x a month the following 60 days, 1 x a month for the remainder to the year post treatment episode to assess sustained progress. Maintain a log in client chart to track and determine effectiveness, as this may be requested by SAMHS.

Mandate: Is there a legal mandate for this service?

Yes

Not less than 5% of SAPT Block Grant funds must be allocated for pregnant women and women with dependent children per 45 CFR §96.124.

http://www.ecfr.gov/cgi-bin/text-idx?SID=7a98ea83af3b0b4e559f774af6b563d4&node=se45.1.96_1124&rgn=div8

PROGRAM/SERVICE: RESIDENTIAL TREATMENT (PNMI)

Description of Program/Service:

A Residential Treatment community residence [formerly Private Non-Medical Institution (PNMI)] is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, and treatment services to four or more residents in single or multiple facilities or scattered site facilities. A Residential Treatment (formerly PNMI) community residence for persons with mental illness must be licensed by the Department of Health and Human Services and follow the requirements of the MaineCare Manual Section 97 as well as the Office of Substance Abuse and Mental Health Services.

A Residential Treatment community residence for persons with mental illness is a Residential Treatment community residence with integral mental health treatment and rehabilitative services. Community residences for persons with mental illness also include residential services for the integrated treatment of persons with dual disorders, which provide mental health and substance abuse treatment services to individuals with coexisting disorders of mental illness and substance abuse.

Evidence Based/Promising Practice Standards:

SAMHSA offers a “Permanent Supportive Housing Evidence-Based Practices (EBP) KIT” which outlines the essential components of supportive housing services and programs for people with mental illness discusses how to develop new programs within mental health systems that are grounded in evidence-based practices. Kit includes eight booklets.

<http://store.samhsa.gov/product/SMA10-4510>

Data: Do we collect data on this program?

Performance-Based Contract Measure Goal:

- These measures focus on the reduction of inpatient hospitalizations and discharge to a home/community level of care.

Performance-Based Contract Measure:

- Measure 1: 75% of all residents who are discharged will not have a readmission to residential services within 12 months
- Measure 2: 80% of all current residents will not have a psychiatric hospitalization during the past quarter.

APS Healthcare also provides reporting on “Average Length of Stay in Adult Private Non-Medical Institutions,” which includes MaineCare members and Courtesy Reviews done by APS. What This Report Measures: Average length of stay and median length of stay of

DRAFT

members discharged from Adult Mental Health Residential Services (adult MH PNMI). Members may be discharged more than once.

APS Healthcare also provides reporting on “Bed Occupancy/Bed Capacity” which includes MaineCare members and Courtesy Reviews done by APS. What This Report Measures: Bed status shows the number of people in the various PNMI locations on the last day of the month. Monthly averages show the occupancy rate for the month by computing bed days used by possible bed days.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: EMERGENCY SHELTER (MEASURED BY DAY)

Description of Program/Service:

Shelter is a service which provides food, lodging and clothing for abusers of alcohol and other drugs, with the purpose of protecting and maintaining life and providing motivation for alcohol and drug treatment. Shelter shall be a pre –treatment service usually operated in connection with a detoxification component. At minimum, shelter shall be provided 12 hours per day.

Services include: food, lodging, clothing, personal hygiene, referrals for detoxification (if medically necessary), arrangements for needed health care services, encouragement of participation in self-help groups and transportation to the program and emergency healthcare facilities, and care coordination.

Evidence Based/Promising Practice Standards:

None

Data: Do we collect data on this program?

Standard

Total Program and SAMHS Units are based on a 90% minimal standard occupancy rate. (Reference Form 001)

REQUIRED EFFECTIVENESS Indicators AND Minimal Standards

Program performance must be at or above the minimal level on 2 of the following 2 performance indicators, monitored on a quarterly basis.

<u>Indicator</u>	<u>Minimal Standard</u>
Referral to self-help.....	90%
Referral in the Continuum of Care.....	40%

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: SKILLS DEVELOPMENT SERVICES

Description of Program/Service:

Skills Development Services are teaching-based services that assist people who satisfy the specific eligibility requirements of MaineCare Benefits Manual Chapter II Section 17.02 to increase their independence by learning the skills necessary to access community resources, including connecting with natural supports needed to achieve their particular goals. Services are provided in accordance with MaineCare Provider Agreement, definitions and rules as specified in the MaineCare Benefits Manual, Chapter 101, Chapter 1 General Administrative Policies and Procedures and Chapters II & III, Section 17, Community Support Services. <http://www.maine.gov/sos/cec/rules/10/ch101.htm>

Evidence Based/Promising Practice Standards:

No Evidence Based Practice

Data: Do we collect data on this program?

Performance Measures:

- Performance –Based Contract Measure Goal: To demonstrate that participating in Skills Development Services has improved functioning and independence in the community.
- Performance-Based Contract Measure: 90% of participants will have a lower LOCUS score at six month intervals after enrollment in the program.

Performance- Based Contract Measure Data Source: APS CareConnection

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: SPECIALIZED DIRECT SERVICES

1. Baxter Related, A Safer Place

Specialized professional mental health services, in the communication modality most readily understood by the consumer, will be provided to former students of the Maine School for the Deaf and/or the Governor Baxter School for the Deaf such that the consumer receives services at no out-of-pocket expense. Costs to be paid are for clinically authorized treatment services for the former students at Baxter School for the Deaf not covered by insurance or which have out of pocket costs for co-payments and/or deductibles up to the amount of the rate included in the Service Specific Demographic and Supplemental Document. Services include: individual and group counseling, medication management, and psychological services. Grant funds are to be the payer of last resort; the Provider agrees to bill all applicable sources (insurance, MaineCare, etc.).

2. Outpatient Services/Home-Based Treatment for Adults

Home-Based Treatment for Adults is a specialized outpatient service with a distinct rate within MaineCare and is limited to consumers who, due to a documented mental health or physical functioning limitation, are unable to travel to an outpatient mental health setting for their medically necessary mental health services. The treatment includes outpatient therapy and/or medication management. Services are provided in accordance with MaineCare definitions and rules as specified in the MaineCare Benefits Manual, Section 65.06-03 and Chapter 1, General Administrative Policies and Procedures.

There is a limit on Adult's Mental Health Outpatient Services of seventy-two (72) quarter-hour units of service per year. For a member to receive services beyond seventy-two (72) quarter-hour units of service in a service year for Adult's Mental Health Outpatient Services, the following conditions must be satisfied:

There must be documented evidence that continued outpatient treatment:

- Is reasonably expected to bring about significant improvement in symptoms and functioning; and
- is medically necessary to prevent the mental health condition from worsening, such that the member would likely need continued outpatient treatment; AND
- The member must be participating in treatment and making progress toward goals supporting his or her ongoing recovery, or, if the member is not making progress, there must be an active strategy in place to improve progress toward goals.

3. Diagnosis and Evaluation (Neuro-psych testing)

Services include clinical assessment of thinking, reasoning and judgment, meeting face-to-face with the member, time interpreting test results and preparing the report of test results. Services also may include testing for diagnostic purposes to determine the level of intellectual function, personality characteristics, and psychopathology, through the use of standardized test instruments or projective tests.

Psychological testing includes the administration of the test, the interpretation of the test, and the preparation of test reports.

Psychological testing is limited to no more than four (4) hours for each test except for the tests listed below. Providers must maintain documentation that clearly supports the hours billed for administration and associated paperwork.

Each Halstead-Reitan Battery or any other comparable neuropsychological battery is limited to no more than seven (7) hours (including testing and assessment). This is to be used only when there is a question of a neuropsychological and cognitive deficit.

Testing for intellectual level is limited to no more than two (2) hours for each test.

Each self-administered test is limited to thirty (30) minutes. Only the testing for the eligible member is reimbursable. This includes self-administered tests completed for the benefit of the member as indicated by the testing instrument. The following tests are considered self-administered, and include but are not limited to:

1. Achenbach Child Behavior Checklist;
2. Adult Adolescent Parenting Inventory;
3. Child Abuse Potential Survey;
4. Connor's Rating Scales;
5. Parenting Stress Index;
6. Piers-Harris Self Concept Scale;
7. Reynolds Children's Depression Scale;
8. Rotter Incomplete Sentences Blank;
9. Shipley Institutes of Living Scale; and
10. Fundamental Interpersonal Relations Orientation Scale-Behavior (FIROB).

Target Group:

Eligibility for this service is defined in Chapter II, Section 17 of the MaineCare Benefits Manual. Services are provided in accordance with MaineCare definitions and rules as specified in the MaineCare Provider Agreement and MaineCare Benefits Manual Section 17 and Chapter 1, General Administrative Policies and Procedures.

Evidence Based/Promising Practice Standards:

None

Data: Do we collect data on this program?

There are no Contract Performance Measures for these three specialized service areas. There are, however, reporting requirements:

- **Baxter Related, A Safer Place**

During this agreement the Provider will obtain authorizations through APS Healthcare and additionally bill for services through APS Healthcare. The Provider will utilize APS Healthcare designated processes for authorizations and submission of invoices for payment.

The Provider is authorized for payment for services provided in this agreement only to the contract maximum obligation.

Fee-for-Service Final Report will be due 60 days after the end on the contract.

The Provider further agrees to submit such other data and reports as may be requested by the Agreement Administrator.

Service Specific Demographic and Supplemental Document: The provider will complete and submit required Service Specific Demographic and Supplemental Document to the Agreement Administrator within 10 business days of the start date of the contract. If staff and/or locations are added or deleted, the Provider must notify the Department of these changes in writing within 5 business days.

- **Outpatient Services/Home-Based Treatment for Adults**

(http://www.qualitycareforme.com/MaineProvider_APSCareConnection.htm) to submit all authorization requests, client demographics, clinical assessment data and service delivery data.

Service Specific Demographic and Supplemental Document: The provider will complete and submit required Service Specific Demographic and Supplemental Document to the Agreement Administrator within 10 business days of the start date of the contract. If staff and/or locations are added or deleted, the Provider must notify the Department of these changes in writing within 5 business days.

The Provider further agrees to submit such other data and reports as may be requested by the Agreement Administrator. The Provider shall submit all data and reports to the Department in accordance with Section 6 of Rider B of this Agreement.

- **Diagnosis and Evaluation (Neuro-psych testing)**

The Provider shall submit quarterly financial and performance reports in accordance with the specifications of the Department, according to the following schedule:

APS Healthcare Reporting: The Provider will use APS CareConnection

(http://www.qualitycareforme.com/MaineProvider_APSCareConnection.htm) to submit all authorization requests, client demographics, clinical assessment data and service delivery data.

The Provider understands that the reports are due within the timeframes established and that the Department will not make subsequent payment installments under this Agreement until such reports are received, reviewed and accepted.

The Provider further agrees to submit such other data and reports as may be requested by the Agreement Administrator. The Provider shall submit all data and reports to the Department in accordance with 34-B M.R.S.A. §1207 and in accordance with Section 6 of Rider B of this Agreement.

Mandate: Is there a legal mandate for this service?

There is a mandate for Baxter Related, A Safer Place, pursuant to P&S Law, Chapter 12, May 2, 2001.

PROGRAM/SERVICE: SPECIALIZED GROUP SERVICES - TRAUMA RECOVERY AND EMPOWERMENT GROUP (“TREM”)

Description of Program/Service:

Trauma Recovery and Empowerment Group (TREM) utilizes a skills-based group treatment approach to address issues of sexual, physical, and emotional abuse. The co-facilitated group meets for a maximum of thirty-three (33) consecutive weeks. Thirty (30) sessions focus on empowerment, trauma recovery, and advanced trauma recovery issues. The remaining three (3) sessions serve as the conclusion, or termination, for the group. Each session is seventy-five (75) minutes long and includes a combination of discussion and experiential exercises. Format for the group is based upon “Trauma Recovery and Empowerment – A Clinician’s Guide for Working with Women in Groups” authored by Maxine Harris, Ph.D. and The Community Connections Trauma Work Group and may include utilization of the workbook entitled “Healing the Trauma of Abuse” co-authored by Mary Ellen Copeland, M.A., M.S., and Maxine Harris, Ph.D.

Evidence Based/Promising Practice Standards:

<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=158>

The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24- to 29-session group emphasizes the development of coping skills and social support. It addresses both short-term and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.

Data: Do we collect data on this program?

No

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: WOMEN'S RESIDENTIAL TREATMENT SERVICES

Description of Program/Service:

In accordance with its mission to provide integrated services, SAMHS is soliciting proposals for residential treatment services for women assessed as having a Substance Use Disorder defined by the Diagnostic and Statistical Manual (DSM- IV TR: Dependence) and meeting the criteria for ASAM Level III.5 care. In addition, the grantee must be co-occurring competent and must assess for, and concurrently treat, mental health issues. The selected provider(s) will demonstrate competency in implementing evidenced based practices for women including, but not limited to, the following elements: gender specific programming, trauma informed treatment, cognitive behavioral therapy, motivational interviewing, 12-step or other social support participation, couples' & family therapy and parenting skills. The provider must demonstrate competency in treating co-occurring disorders and in working with special populations. In addition, priority placement must be given to pregnant injecting drug users and pregnant substance abusers in compliance with 45 CFR 96.131 .

(<http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=3a5d052dc67da4dccb3df52d18c66aec&rgn=div8&view=text&node=45:1.0.1.1.53.12.27.12&idno=45>)

Applicants must demonstrate the ability to accommodate children, from infancy to five years, living with their mothers in the facility, have beds set aside for other parenting women and provide case management and referral services (e.g., arranging childcare, transportation to medical appointments, etc.).

Women are an underserved population in regard to substance abuse treatment as they often face barriers that prevent them from seeking help for themselves. These barriers include stigma, childcare, transportation, economic issues and family obligations. The Department seeks to provide low-barrier treatment to pregnant and parenting women, to enhance their treatment outcomes and to reduce the number of drug affected babies (DAB) and babies born with fetal alcohol spectrum disorder (FASD) in Maine. This is consistent with the goal of the Department to "protect and enhance the health and well-being"

- The selected agency(s) will provide residential treatment services 24 hours per day, 7 days per week for females, 18 years and older, assessed as having substance abuse or substance abuse and co-occurring mental health disorders and meeting the criteria for American Society of Addiction Medicine (ASAM) Level III.5 care (<http://paulearley.net/ASAM-PPC-Articles/asam-textbook-chapter-4-5/Levels-of-Care.html>). To be eligible for services, a woman must be:
 - pregnant and substance using;
 - parenting and substance using, with a child(ren) ages birth through five; or
 - substance using and attempting to regain legal custody of her child(ren).

The order of priority for accepting program participants is:

1. pregnant injection drug users;
2. pregnant substance users;
3. parenting injection drug users; and
4. parenting substance users.
 - a. As a result of this RFP, a total of 15 treatment beds will be funded serving a maximum of 180 women. The length of stay will be limited to 30 days. Extensions will be considered on a case by case basis and must be requested through the funding source.
 - b. In addition to the 15 treatment beds, 10 beds will be available to accommodate infants and children of program participants. Bids will be accepted which propose residential treatment services offering up to 15 treatment beds. Bidders may submit bids proposing less than 15 if they so choose, in which case two or more providers may be selected to reach the total of 15 beds.
 - c. Programs must provide case management and ensure that women and their children have access to primary medical and pediatric care and other needed services.
 - d. The treatment program shall also include, but not be limited to, the following components:
 - Individual counseling
 - Group counseling
 - Family counseling (as appropriate)
 - Crisis intervention
 - Skill development, including those which will increase resiliency, self-reliance, self-advocacy)
 - Relapse prevention
 - Discharge planning
 - Recreational activities
 - Referral to ancillary services, including naturally occurring resources in the client's community
 - Drug testing
 - Medication administration (as appropriate)
 - Milieu activities such as meal preparation; household chores; and laundry
 - Parenting education, including child development
 - HIV/TB testing and counseling

Evidence Based/Promising Practice Standards:

Programs shall implement evidence based practices selected from the Substance Abuse and Mental Health Administration's (SAMSHA) National Registry of Evidence-based Programs and Practices (NREPP (<http://www.nrepp.samhsa.gov/ViewAll.aspx>)). Programming must include gender specific and other therapeutic interventions for women including trauma informed, relational, sexual and physical abuse and parenting.

Data: Do we collect data on this program?

The intent is to focus on the improvement of outcomes (results) for the persons who use the services rather than upon outputs (level of effort) by the service providers. The Department has developed the following goal and performance-based contract measure(s) for the program that is the subject of this RFP. Proposals will be evaluated for the degree of responsiveness in meeting these desired outcomes.

Goals:

Empower women to achieve and maintain recovery from substance abuse and to lead healthy and productive lives.

Reduce the number of Drug Affected Babies (DAB) and babies with Fetal Alcohol Spectrum Disorder (FASD).

Reduce the risk of developmental, behavioral, cognitive, and emotional problems for children of women with Substance Use and/or co-occurring disorders.

Performance Standard(s):

1. Provide residential treatment services to up to 180 pregnant and/or parenting women with substance abuse or substance abuse and co-occurring mental health disorders and accommodate up to 10 children with their mothers in the facility any given time.
2. Provide therapeutic child care to up to 50 children (per year) ages 6 weeks through 5 years.
3. Demonstrate 80% minimal standard occupancy, measured in bed-days.

Performance Based Contract Measure:

1. Reduced Morbidity - abstinence/drug free prior to discharge = 90%
2. Reduction of use of primary substance abuse problem = 90%;
3. Retention - completion of treatment = 75%;
4. Referral in the continuum of care/next medically necessary service = 85%.
5. Service plan developed for 90% of children attending therapeutic day care.

Individual Client Data Collection Method of PBC Measure:

The performance measures listed above will be captured by client data entered by providers into the Web Infrastructure for Treatment Services (WITS) per contract instructions. This data will include admission and discharge information.

Performance data is submitted in narrative form to the Office of Substance Abuse and Mental Health Services on a Quarterly basis. This report relating the progress for the applicable quarter is due October 30th, January 30th, April 30th and July 30th.

DRAFT

Other Performance Measurements:

The Client Satisfaction Survey assists treatment providers in evaluating the effectiveness of their services. The survey collects demographic data, satisfaction with present treatment services, satisfaction with present treatment staff, and results of present treatment.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: SPECIALIZED GROUP SERVICES - WELLNESS RECOVERY ACTION PLANNING (“WRAP”)

Description of Program/Service:

Wellness Recovery Action Planning (WRAP) Wellness Recovery Action Planning is a curriculum-based self-management and recovery system developed, trademarked, and maintained by the Copeland Center for Wellness and Recovery. WRAP explores the foundational concepts of recovery and wellness, including hope, personal responsibility, and education; increases the understanding of personal experiences; encourages the use of natural supports; and helps individuals develop a personal plan that promotes an improved quality of life focusing on relapse prevention, personal growth and recovery. The group meets for a maximum of twelve (12) sessions of two (2) hours each. WRAP services are co-facilitated by peers, who must have successfully completed the Copeland Center's "Mental Health Recovery WRAP: Facilitator Certification" program or any equivalent successor Copeland Center program for certifying WRAP facilitators.

Evidence Based/Promising Practice Standards:

<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=208>

Wellness Recovery Action Plan (WRAP) is a manualized group intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness. WRAP has the following goals:

- Teach participants how to implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day-to-day lives;
- Help participants organize a list of their wellness tools--activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising;
- Assist each participant in creating an advance directive that guides the involvement of family members or supporters when he or she can no longer take appropriate actions on his or her own behalf; and
- Help each participant develop an individualized post crisis plan for use as the mental health difficulty subsides, to promote a return to wellness.

WRAP groups typically range in size from 8 to 12 participants and are led by two trained co-facilitators. Information is imparted through lectures, discussions, and individual and group exercises, and key WRAP concepts are illustrated through examples from the lives of the co-facilitators and participants. The intervention is typically delivered over eight weekly 2-hour sessions, but it can be adapted for shorter or longer times to more effectively meet the needs of participants. Participants often choose to continue meeting

after the formal 8-week period to support each other in using and continually revising their WRAP plans.

Although a sponsoring agency or organization may have its own criteria for an individual's entry into WRAP, the intervention's only formal criterion is that the person must want to participate. WRAP is generally offered in mental health outpatient programs, residential facilities, and peer-run programs. Referrals to WRAP are usually made by mental health care providers, self-help organizations, and other WRAP participants. Although the intervention is used primarily by and for people with mental illnesses of varying severity, WRAP also has been used with people coping with other health issues (e.g., arthritis, diabetes) and life issues (e.g., decision making, interpersonal relationships) as well as with military personnel and veterans.

Data: Do we collect data on this program?

A report is sent to SAMHS quarterly regarding which consumer received the funds and why they received them. SAMHS receives a report regarding the amount of funds that were spent that quarter.

Mandate: Is there a legal mandate for this service?

No

Chapter 10

Recovery Services

A journey of healing and transformation that enables a person to live a meaningful, satisfying and contributing life in a community of his or her choice. Recovery is an individual process, a way of life, an attitude, and a way of approaching life's challenges. The need is to meet the challenges of one's life and find purpose within and beyond the limits of the illness while holding a positive sense of identity.

PROGRAM/SERVICE: CIT TRAINING

Description of Program/Service:

CIT (Crisis Intervention Team) programs are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness.

Evidence Based/Promising Practice Standards:

Crisis Intervention Team Core Elements –

The University of Memphis School of Urban Affairs and Public Policy Department of Criminology and Criminal Justice CIT Center, September, 2007, Randolph Dupont, PhD
University of Memphis Major Sam Cochran, MS Memphis Police Services Sarah Pillsbury, MA

Evaluation and research can help measure the impact, continuous outcomes, and efficiency of a community's CIT program. More specifically, it may help to identify whether the program is achieving its objectives and should be an ongoing part of CIT. Outcome research has shown CIT to be effective in developing positive perceptions and increased confidence among police officers; providing very efficient crisis response times; increasing jail diversion among those with a mental illness; improving the likelihood of treatment continuity with community-based providers; and impacting psychiatric symptomatology for those suffering from a serious mental illness, as well as substance abuse disorders. This was all accomplished while significantly decreasing police officer injury rates. The following components are being studied within CIT, some currently and others in the planning stages of evaluation.

Research and Evaluation Issues:

1. Development of Community Consensus
2. Improved Law Enforcement Perception of Individuals with Mental Illness
3. Increased Confidence in Interacting with Individuals with Mental Illness
4. Decreased Crisis Response Times
5. Decreased Law Enforcement Injury Rates
6. Decreased Citizen Injury Rates
7. Improved Health Care Referrals
8. Decreased Arrest Rates
9. Jail Diversion Impact
10. Increased Treatment Continuity
11. Improved Treatment Outcomes
12. Decreased Psychiatric Symptomatology
13. Impact on Recidivism Rate
14. Improved Community Perception of Law Enforcement

The "Memphis Model"

CIT Coordinator:
Major Robert Vaughn

Program Benefits

Since the CIT program began in Memphis, the citizens and the criminal justice system of Memphis have experienced significant benefits of the program. Some of the benefits of the program are listed below.

- Crisis response is immediate
- Arrests and use of force has decreased
- Underserved consumers are identified by officers and provided with care
- Patient violence and use of restraints in the ER has decreased
- Officers are better trained and educated in verbal de-escalation techniques
- Officer's injuries during crisis events have declined
- Officer recognition and appreciation by the community has increased
- Less "victimless" crime arrests
- Decrease in liability for health care issues in the jail
- Cost savings
- Crisis Intervention Team

Evaluation of Chicago Police Department's Crisis Intervention Team for Youth training

Methodology

Three research methods were used in this evaluation project, including course evaluation surveys, pre- and post-tests, and focus groups. These methods were used to determine the extent to which:

- Officers were satisfied with the training.
- Officer knowledge of youth mental health increased.
- Officers utilized crisis intervention techniques in the field during the six months following course completion.
- Officers' intentions of applying the crisis intervention techniques coincided with actual use during the six months following course completion.
- Officers retained knowledge of youth mental health six months after course completion.

Course Evaluation Surveys

Anonymous course evaluation surveys were used to measure officer satisfaction with course content and delivery and obtain other feedback. The surveys were developed by Chicago Police Department's Crisis Intervention Team for Youth (CIT-Y) training staff.

Surveys were distributed at the start of each day of the course. Participants were instructed to fill out the surveys periodically, as the day's training modules were presented.

At the end of the last day of the course, evaluators collected the surveys from CIT-Y staff and entered the responses into a computerized database. A total of 583 surveys (88 percent) were collected across Year 1 CIT-Y trainings. Had all 133 training participants completed each day's survey, a total of 665 course evaluation surveys would have been collected.

Pre- and Post-Course Tests

Pre- and post-tests were used before the course started and just after it ended to measure whether officer knowledge of youth mental health increased with the training. Unique numeric codes were assigned to match each participant's pre- and post-test responses without the officers having to identify themselves.

The pre- and post-tests were developed by NAMI-GC staff with consultation from a social science professor, and modified by the evaluators. Modifications included five additional questions to gauge officers' intentions of applying what they learned during the course. Evaluators entered pre-and post-test responses into a computerized database.

Focus Group and Survey

A focus group is an open-ended discussion between participants on a particular topic, guided by a moderator. Focus groups are a practical way to collect input from a number of individuals in a relatively short period of time. Law enforcement officers who attended the first and third CIT-Y training sessions were asked to volunteer to participate in a focus group to be held every six months after their course ended. Objectives of the focus group and survey were to gauge officer retention of the training and implementation of techniques presented during the course. While 32 CIT-Y officers volunteered to take part in the focus group, only seven actually participated.

Once focus group participants gave informed consent, they were instructed to complete a brief survey, which was linked numerically to their pre- and post-training tests. This survey included five pre- and post-test questions to learn officer retention of youth mental health knowledge and five pre- and post-test statements about implementation of training material. Officer responses to these 10 questions were compared to those answered six months previously upon completion of the course.

Evaluation project staff held the focus groups at CPD headquarters in a private conference room. Focus group sessions lasted about 60 minutes and were audio-recorded. Evaluation project staff moderated the focus group and asked officers the following questions to generate discussion:

- To what degree did you use what you learned in the CIT-Y training?
- What were the most helpful and least helpful parts of the CIT-Y training?

- To what extent were you prepared to implement the CIT-Y material?
- To what extent did you face barriers when implementing the CIT-Y material?
- What information, if any, was not addressed in the CIT-Y training that would have been beneficial?

A total of 583 course evaluation surveys were collected and revealed that officers found the training to be extremely relevant to police work and knowledge enhancing. The course evaluation survey also allowed for feedback. Officers suggested many ways the training curriculum could be improved.

Course evaluation surveys will be modified for the Year Two evaluation to measure the extent to which the curriculum conveys its training objectives to participants. Course evaluation surveys will still include questions to learn officer satisfaction with training accommodations, curriculum materials, and presentation delivery.

The pre- and post-course tests were created by NAMI-GC staff, who consulted a social science professor. Findings revealed the test questions had answers that were common knowledge and were not related to the course curriculum, as pre-course test scores averaged a high of 85.5 percent and the post-course test scores remained nearly the same at 86.8 percent. The pre- and post-tests will be revised by the evaluators for the Year Two evaluation, as an attempt to measure officer knowledge of training information.

Seven CIT-Y officers served as focus group participants. A focus group survey was completed before the moderator initiated discussion. Findings revealed focus group participants' intentions to use the training information were higher than actual use in the field. The moderator asked the focus group participants five questions to generate information about how the course enhanced their ability to respond to youth crises. The focus group discussion revealed ways in which officers applied the crisis intervention skills and the barriers they encountered when attempting to apply techniques learned.

Several recommendations for training and evaluation improvement were shared with CIT-Y training staff. After evaluators shared preliminary findings, training staff initiated changes to improve the training.

Data: Do we collect data on this program?

They did an evaluation when they had a grant but are not currently doing evaluations.

Mandate: Is there a legal mandate for this service?

No. This training is offered according to the contract with DHHS/SAMHS.

PROGRAM/SERVICE: EMPLOYMENT SPECIALIST

Description of Program/Service:

The Employment Specialist within each CSN will perform multiple types of activities directed at helping consumers obtain employment, maintain employment, and improve their employment-related skills. They will develop employment opportunities both in a consumer-specific and in a generic fashion, i.e., not always in relation to a specific person. Their employment support services to consumers will utilize the most effective evidence-based practices in supported employment for people with psychiatric disabilities.

Evidence Based/Promising Practice Standards:

The Review of Vocational Rehabilitation for People with Severe Mental Illness, a Comparison of Supported Employment and prevocational Training (Crowther et al., 2001).

Vocational outcomes, competitive employment, working for 40 or more hours in a single month and monthly earnings. Follow up was conducted after 24 months.

Supported Employment. Gale Alexander Kament, PhD, <http://abilitymagazine.com>

Supported employment is responsible for greater numbers of consumers getting and maintaining jobs than any other approach.

Supported Employment/Individual Placement and Support.
<http://www.centerforebp.case.edu/practices/se>

58 percent of the people receiving these services are employed in competitive jobs in their local communities. SE Increases: Employment in competitive jobs, number of hours worked and amount of income earned in competitive jobs

Supported Employment: An Evidence-Based Practice. Gary R. Bond, PhD and Kikuko Campbell, MPH, MA

Competitive Employment, Consumer Choice, Rapid job search, Integration with mental health treatment, Attention to consumer preferences, Benefits counseling & Time-unlimited and individualized support.

Data: Do we collect data on this program?

Yes, evidence-based data. Maine Medical Center/Department of Vocational Services- The first will be tracked through DHHS SAMHS, while items 2-9 will be tracked through Social Solutions and follow up contacts by the Employment Specialists. The last two will be tracked through annual consumer surveys and focus groups.

1. Of those consumers with a vocational goal established which require training or services prior to employment, 80 percent will initiate such training or services with the CSN ES within six months.
2. Of those consumers engaged with the CSN ES, 75 percent will make progress toward their employment and/or education goals within six months.
3. Of those consumers engaged with the CSN ES for job search assistance, 50 percent will have a job interview during the first six months.
4. Of those consumers with job interviews, at least 25 percent will initiate full- or part-time employment within three months of the first interview.
5. Of those consumers initiating employment, at least 25 percent will be employed (not necessarily in same position) six months later.
6. One hundred consumers receiving employment support services from the seven MMC Employment Specialists covered by this contract will become employed part-time or full-time during the contract period.
7. At least 75 percent of consumers who express interest in work or school and have received services from the Employment Specialist will be satisfied with the vocational support they received.
8. At least 50 percent of the consumers who received services from the Employment Specialist will experience improved quality of life as a result of pursuing vocational goals.

Mandate: Is there a legal mandate for this service?

Yes, it is a consent decree requirement as employment is a core service.

PROGRAM/SERVICE: PORTLAND RECOVERY COMMUNITY CENTER

Description of Program/Service:

The center supports those who are recovering from alcohol and drug related problems, from every recovery pathway; and family members and friends of people struggling with addiction. All recovery activities are offered free of charge by trained volunteers with a passion for recovery. The center receives its funding from the Block Grants for Prevention and Treatment of Substance Abuse.

Evidence Based/Promising Practice Standards:

There is no evidence based practice or promising practice standards.

Data: Do we collect data on this program?

Yes. The contract requires a Quarterly Narrative and Quarterly Expense report is due 30 days after the end of each quarter. The Quarterly Narrative Reports documenting progress relating to program performance during the applicable quarter due October 30th, January 30th, April 30th and July 30th. Payment installments will not be made until such reports are received and reviewed. This is not a performance measure.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: SELF-HELP/PEER SUPPORT

Description of Program/Service:

- Peer Support Emergency Department Program- Peer Support Specialist work collaboratively with the hospital staff to enhance the services provided in the Emergency Department. The Peer Recovery Specialist's role in the Emergency Department is to support the individual who is experiencing mental health crisis to resolve the crisis situation; to assist the individual to view the crisis as an opportunity for growth, change, and transformation to consider proactive ways for the individual to manage future crises ideally within the community rather than in a hospital or crisis setting, to offer support and comfort during the individual's experience in the ED; and to provide education about community and peer resources.
- Learning Recovery Center- Services include Peer Crisis Respite, Interactive Interviews/Proactive Conversations, educational and social activities, and recovery group.
- Peer Crisis Respite Program- Support is provided in one of three beds at the Peer Crisis Respite. Peer Support Specialists and Relief Peer Support Specialist will utilize the principles of Recovery and Intentional Peer Support to support the guest who is experiencing a mental health crisis to resolve the crisis situation; to assist the individual to view the crisis as an opportunity for growth, change, and transformation; to consider proactive ways for the individual to manage future crises.

Evidence Based/Promising Practice Standards:

No evidence based practice but research towards that end.

Discovering the Fidelity Standards of Peer Support in an Ethnographic Evaluation- Cheryl MacNeil, Ph.D. and Shery Mead, MSW December 2003- Interviews were done at a peer support program and came up with seven Standards: Critical Learning, Community, Flexibility, Instructive, Mutual Responsibility, Safety and Setting Limits

Emerging Research Base of Peer-Run Support Programs- compiled by Jean Campbell, PhD, 5/05

- Holter, M., Mowbra, C., Bellamy, C., MacFarlane P. & Dukarski, J. 2004-Fidelity criteria for consumer-operated drop-in centers. Results: value of consumerism, consumer control, choices and opportunities for decision-making, voluntary participation and respect for members by program staff.
- Dumont, J. & Jones, K. 2002- Evaluation of a Crisis Hostel 5 beds. Results: better healing outcomes, greater levels of empowerment, shorter hospital stays and less hospital admissions.

- Trainor, J., Shepherd, M., Boydell, K., Leff, A. & Crawford, E. 2002- Consumer/Survivor Development Initiative surveyed 600 individuals of their cooperative businesses. Results: CSDI members used fewer mental health services, noted an increase in community involvement and contacts, found consumer/survivor organizations to be more helpful than traditional mental health services and found other consumer survivors as individuals to be more helpful professionals with mental health issues.
- Forquer, S. & Knight, E. 2001 - Managed care company and mental health centers that integrated recovery and self-help. Results: suicide rate and substance abuse decreased significantly, as did hospitalization; social contacts and participants' ability to carry out ADLs increased significantly.
- There are many more similar compilations which are too many to list.

International Association of Peer Supporters (iNAPS)

DRAFT JUNE 8, 2013

NATIONAL ETHICAL GUIDELINES AND STANDARDS OF PRACTICE FOR PEER RECOVERY SUPPORTERS

A consortium of stakeholder organizations, led by the International Association of Peer Supporters, is currently developing a draft of practice standards for peer recovery supporters. The standards are designed to honor the diverse settings in which peer recovery supporters are working, the tasks peers are asked to perform, and to create guidelines for an emerging peer recovery support workforce that is built upon the strengths and recovery principles peer recovery supporters embody.

In addition to the SAMHSA Working Definition and Guiding Principles of Recovery, the following core values have been ratified by peer recovery supporters across the country as the core ethical guidelines for peer support practice:

1. Peer Recovery Support Is Voluntary
2. Peer Recovery Supporters Are Hopeful
3. Peer Recovery Supports Are Open Minded
4. Peer Recovery Supporters Are Empathetic
5. Peer Recovery Supports Are Respectful
6. Peer Recovery Supporters Facilitate Change
7. Peer Recovery Supporters Are Honest and Direct
8. Peer Recovery Support Is Mutual and Reciprocal
9. Peer Recovery Support Is Equally Shared Power
10. Peer Recovery Support Is Strengths-Focused
11. Peer Recovery Support Is Transparent
12. Peer Recovery Support Is Person-Driven

STANDARDS OF PRACTICE

1. Support Choice

DRAFT

2. Share Hope
3. Withhold Judgment
4. Listen With Emotional Sensitivity
5. Be Curious and Embrace Diversity
6. Educate and Advocate
7. Address Difficult Issues With Caring and Compassion
8. Encourage Peers To Give and Receive
9. Embody Equality
10. See What's Strong Not What's Wrong
11. Set Clear Expectations and Use Plain Language
12. Focus On The Person, Not The Problems

Data: Do we collect data on this program?

Yes. All are required by the contract but are not performance measures.

- Peer Support Emergency Department Program- Monthly Report will be submitted the 15th of the month following the last activity associated with that month to be reported.
- Learning and Recovery Center Program- A quarterly report, completed by the end of the following month regarding participation.
- Peer Crisis Respite Program- A quarterly report, completed by the end of the following month-bed nights, individuals will report increased skills and knowledge & individuals will report an increased ability to manage a crisis episode.

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: LONG-TERM EMPLOYMENT SUPPORTS

Description of Program/Service:

Long Term Employment Supports (LTES) is a goal-oriented service with specific individualized plans that identify the type, level, and duration of supports. LTES are services provided to a person who is working in a competitive employment setting, and who requires support to keep that job. LTES services are individualized follow-along supports that are provided to the employer and client as needed. Employer supports may include education and guidance and client facilitation of natural supports (friends, family, co-workers). LTES is expected to decrease over time as a natural supports develop.

Evidence Based/Promising Practice Standards:

The Review of Vocational Rehabilitation for People with Severe Mental Illness, a Comparison of Supported Employment and prevocational Training (Crowther et al., 2001

Vocational outcomes, competitive employment, working for 40 or more hours in a single month and monthly earnings. Follow up was conducted after 24 months.

Supported Employment. Gale Alexander Kament, PhD, <http://abilitymagazine.com>

Supported employment is responsible for greater numbers of consumers getting and maintaining jobs than any other approach.

Supported Employment/Individual Placement and Support.
<http://www.centerforebp.case.edu/practices/se>

58 percent of the people receiving these services are employed in competitive jobs in their local communities. SE Increases: Employment in competitive jobs, number of hours worked and amount of income earned in competitive jobs.

Supported Employment: An Evidence-Based Practice. Gary R. Bond, PhD and Kikuko Campbell, MPH, MA

Competitive Employment, Consumer Choice, Rapid job search, Integration with mental health treatment, Attention to consumer preferences, Benefits counseling & Time-unlimited and individualized support.

Data: Do we collect data on this program?

Yes. **APS Healthcare.** We also collect percentage of LTSE clients working at least 10 hours a week, percentage of those that worked 30 or more hours a week and the percentage of LTSE Providers who do not have anyone working 30 or more hours a week. We collect the average wage, the median wage, percentage who earned more than

DRAFT

minimum wage. We collect new admission information from provider. We can obtain detailed information on clients with a ratio of hours of LTSE service hours to work hours above 25% and above 50%. **Contract Performance Goal**-90% of individuals receiving LTSE will have a ratio of LTSE service hours to hours worked of 25% or less during the reported quarter.

Mandate: Is there a legal mandate for this service?

Yes. The Consent Decree required the Department to create a community mental health system. Employment is one of the core essential services listed in the Consent Decree.

PROGRAM/SERVICE: WARM LINE

Description of Program/Service:

A peer support telephone warm line is staffed by paid peer supporters trained in Intentional Peer Support. This service is distinct from a crisis service and may be consumer or agency operated. It is designed for the purpose of engaging with adult mental health consumers and developing mutual relationships and connections that lead to growth, change and development of natural supports in one's own community.

The Intentional Warm Line which offers statewide low barrier access to adults across Maine ages 18 and up and live with serious mental illness. Intentional Peer Support and other recovery resources shall be provided through a statewide, toll-free phone service available 24 hours a day. The Intentional Warm Line service will be available to offer support during challenging times and during the times when peers are more emotionally present and able to engage in mutual conversations focused on moving towards what they want as part of a full, rich life. The Intentional Warm Line services is about redefining help, and transforming lives through mutuality. The major intent of the program going forward is to build mutual relationships that move the caller towards the healthy life they desire. The goal is not reliance on the Intentional Warm Line, but mutual sharing that encourages the building of a life that is lived integrated into the community. Care will be taken to explain the shifting focus from a "listening" line to a mutual conversation focused on moving forward in recovery.

Information will be sent, in multiple mediums, to provider organizations, offering traditional mental health and co-occurring disorder treatment such as crisis response and case management that can direct peers to the Intentional Warm Line service. Peer centers, social clubs, self-help groups, shelters, and drop-in centers statewide will receive informational and educational material. Municipal services, such as law enforcement and social welfare, will receive informational material as will hospitals and primary care physicians. This information will include hours of operation and contact numbers.

The Intentional Warm Line (IWL) will meet the following operational criteria:

- Individuals who call the IWL during operational hours will always get a live response, opportunity to be placed in queue, or opportunity to leave a message and receive a call back within thirty minutes.
- The IWL will have immediate rollover capacity to statewide crisis providers and established collaborative relationships and protocols
- The IWL shall coordinate with local consumer/ peer programs.
- IWL staff shall be familiar with the caller's local community resources for behavioral and non-behavioral health services and natural community resources for information and referral.

- The IWL will provide opportunities for education about recovery, building connections, mutual responsibility, divergent worldviews, and come from a strength-based perspective that supports people to engage in their plans for the future.
- The IWL will function as a bridge to facilitate the caller's development of connections and relationships in their own natural community including local self-help, peer support and natural community supports and activities.
- Caller and Warm Line staff will demonstrate a commitment to recovery and growth by demonstrating willingness to challenge self, others and the relationship.
- IWL activities will enhance consumer participants' sense of competency, independence, self-worth and a regained sense of control over one's life by measurable and specific means.
- IWL staff will engage with callers to redefine the experience of help as a co-learning and growing experience.
- IWL staff will engage with individuals who utilize Warm Line services an average of twice a week for a six month period or greater frequency to explore how the Warm Line can support the individual in the development of natural supports.

Evidence Based/Promising Practice Standards:

National Empowerment Center - Articles
Warm Lines: An alternative to hospitalization
By Daniel Fisher, M.D., Ph.D.

Psychiatric Rehabilitation Journal

Issue: Volume 35, Number 1 / Summer 2011
Pages: 65 - 68
URL: Linking Options

DOI: 10.2975/35.1.2011.65.68

Sustaining Recovery through the Night:

Impact of a Peer-Run Warm Line

Rebecca Spirito Dalgin A1, Simonne Maline A2, Peter Driscoll A3
A1 University of Scranton
A2 Sweetser, Brunswick, ME
A3 Amistad Peer Support and Recovery Center, Portland, ME

Abstract:

Objective: This exploratory study describes the impact of a peer-run warm line on the lives of individuals with psychiatric disabilities. Methods: Phone surveys were completed with 480 warm line callers over four years. Results: Warm line callers reported a reduction in

the use of crisis services and a reduction of feelings of isolation. Conclusions and Implications for Practice: The results indicate that peer-run warm lines can fill an important void in the lives of individuals living with mental illnesses. Although warm lines at any time of day are helpful, keeping warm lines running after 5pm and throughout the night provides support services not typically available after office hours and can assist with loneliness, symptom management, and the process of recovery.

Warm lines staffed with appropriately trained, clinically supervised, compensated peer specialists can help round out mental health services in rural and urban communities. Future research should focus on the various implementation and funding options of this unique peer support service.

They suggest soft, fuzzy images, but do not be deceived: warm lines are proving a powerful approach to reducing hospitalization. Warm lines are a form of social support and a complement to hot lines whose time has come. In this age of social isolation, the phone is proving itself a lifeline for people with mental illness who are either too afraid or alone to connect with family or friend.

In New Hampshire, a survey¹ was conducted with Emergency Services (ES) phone call answering services staff about their experiences before and after a consumer-run warm line in the region was established in the region.

The survey results indicated that non-emergency calls by consumers to the ES phone line were reduced by sixty percent with the establishment of a local warm line.

Warm lines run by people in recovery from mental illness hold a special appeal for callers with the same label. Many people with mental illness refuse to call a crisis team because they are afraid they will again be committed. Indeed a survey of previously hospitalized consumers by the Well Being Project in 1987 found that 47% of them refused to even contact a clinic due to the trauma of hospitalization. This means that consumers would rather wait until their crisis reaches the point where they could no longer be calmed by respite or other alternatives to hospitalization.

I interviewed the director of a typical consumer-run warm line in New Hampshire. He stated that they grew out of the expressed need of club members to have support available after the club closed. These members felt unsafe calling the crisis team. The warm line operates with a different person receiving calls each day. They are given training and supervision by the director of the club. He stated that an unexpected benefit has been the preparation and motivation the job has provided to the workers. Several of them have gotten full-time jobs and have gotten off disability.

Data: Do we collect data on this program?

Goals and Indicators

Sweetser will report to OAMHS on the following Goals and Indicators.

Goal 1: IWL activities will enhance consumer participant's sense of competency, independence, self-worth and a regained sense of self control over one's life by measurable and specific means.

Measurement tool used: the Mental Health Recovery Measure¹⁰ and the Recovery Assessment Scale¹¹ are two tools to be reviewed with evaluation consultant, Dr. Rebecca Spirito-Dalgin in consultation with OCA.

Gathered Through: Focus Groups every six months, done in rotating cities within the state open to all peers who can join us. Data will also be gathered using call back calls throughout the year.

Performance Indicator: Within a year through focus groups and call backs (100 unique callers randomly chosen), the following measures will be reached or surpassed:

- 35% of the callers contacted, will report increased activities in the Salzer's 10 domains of community integration.
- 35% of the callers contacted, will report increased social connectedness as shown through data gathered using the Recovery Assessment Scale measurement tool.
- 35% of the callers contacted, will report increased self-determination and a sense of hope as shown through data gathered using the Recovery Assessment Scale measurement tool.

Goal 2: To increase participation of callers in utilizing natural supports within the communities of their choice.

Measurement tools used: Modified "proactive conversation" to be developed with IWL program management and OCA.

- Follow up survey to be created with the Evaluator, IWL program management and OCA.

Gathered Through: 100 follow up calls to be done throughout the contract year.

Performance Measure:

- A minimum of 100 callers will have a modified "proactive conversation" on file with the Intentional Warm Line.
- 25% of the callers contacted, will report decreased use of traditional crisis services (hotline, ED use, hospitalization and use of law enforcement).
- 35% of the callers contacted, will report increased natural community involvement as shown through data gathered using the Mental Health Recovery Measure measurement tool.

Goal 3: Establish process for individuals who call frequently

Performance Indicator:

- In first 6 months individuals who call frequently (callers who call 2 times a week for a period of 6 months) will be identified and a process will be developed to reduce use and move towards natural supports of their choice.
- Ongoing analysis will happen around the definition of frequent callers with IWL program management and OCA. We will work towards development of guidelines and best practices for engaging in healthy relationships with callers.

Goal 4: The Intentional Warm Line program will outline specific strategies to educate staff about regional and local resources throughout the state (informal and formal). This will be useful information to help callers to connect with people/resources in their own communities of choice.

Performance Indicator: Staff will develop and have access to a current resource manual of both formal and informal supports and activities for each Community Service Network (CSN).

Goal 5: Identify the nature of calls and trends over time.

Performance Indicator: The Intentional Warm Line program will identify the nature of calls to the Intentional Warm Line and trends over time. This will be reported to OAMHS through trending reports that include:

- Theme/ Reason for call
- Information and/or referral
- A specific problem or concern
- Feeling lonely/isolated
- As part of a maintenance plan/to check in
- Recovery Planning
- Crisis
- Feeling distressed
- Other

The Intentional Warm Line will maintain clear monthly data which will include:

- Number of calls
- Number of new callers
- Average length of calls
- Number of referrals to crisis providers
- Origin or county of calls
- Number of unduplicated callers by origin or county of calls

Mandate: Is there a legal mandate for this service?

No

PROGRAM/SERVICE: CERTIFIED INTENTIONAL PEER SUPPORT

Description of Program/Service:

<http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/ipps-requirements.html>

This ten-day training is a requirement for Peer Support Specialists working on the Maine Warmline, in Emergency Departments, in state hospitals and on some ACT teams. Topics covered include; Creating Learning Environments, First Contact, Language, Listening Differently, Challenging Situations and Working in the System.

1. Intentional Peer Support Specialists Training
 - a. Peer Support 101
 - b. Application Process
 - c. Reviewed by consumers
 - d. Web Training
 - e. Includes learning styles assessment
 - f. 10-days classroom training
 - g. Must not miss more than five hours of classroom time
 - h. Completion of final test
 - i. If test is not completed – entire training must be repeated
2. Quarterly Co-Supervision
 - a. Co-Supervision 1 time per quarter - may attend more frequently
3. Continuing Education
 - a. Two continuing Education Classes Per Year
 - b. Continuing Ed options will also be offered at the Recovery Conference
4. 75-hours of Peer Support per year
 - a. Documented quarterly
5. Certification is issued upon completion of all requirements.
 - a. Requirements must be met within one year of completion of Peer Support Specialists Training
 - b. Co Supervision, Continuing Education and 75-hours Peer Support requirements must be met each year to maintain yearly certification

See Core Competences below.

Evidence Based/Promising Practice Standards:

The curriculum uses Promising Practice Standards.

Intentional Peer Support (IPS), is a revolutionary, peer-driven, dialogic, community building approach to mental health wellness, recovery, growth and development that was conceived, developed and pioneered by Shery Mead. Intentional Peer Support serves as the gold-standard for peer-driven alternatives to traditional mental health treatment paradigms grounded in the medical model. In IPS, peers come together as responsible

adults who are seeking to learn, grow, heal and change through mutual, collaborative relationships that create new ways of seeing, thinking, and doing. IPS teaches us to harness the power of our peer relationships in purposeful ways that foster connection, mutuality, learning and growth. Instead of seeing each other as sick or ill, we look for how each of us has come to make sense of our experiences in the ways we have. We help each other re-examine old beliefs that have kept us stuck, look at things from new angles, and create new possibilities for being and acting in the world. IPS teaches us to do all of this through the power of our peer relationships!

Data: Do we collect data on this program?

Roadmap for Fidelity Reviews

Why do a Fidelity Review?

The intent of the Fidelity Review Process is to evaluate participants' proficiency in IPS skills and to support those needing to raise their proficiency in order to maintain certification.

The Fidelity Review also informs content in training and continuing education.

Who determines the content of the Review?

The review content is created by a collaborative effort involving the IPS trainers, the Maine Office of Substance Abuse and Mental Health Services, and Shery Mead's IPS organization in Vermont.

Who administers the Review?

One SAMHS CIPSS Trainer and a non-state employee member of IPSAC will administer the reviews.

How do we know that the Review is fair and accurate?

SAMHS believes it is fair to expect that after completing the Core CIPSS training and a year of co-reflections, continuing education and the required contact hours of IPS, Peer Support Specialists in Maine should be able to demonstrate their knowledge of the three principles and their skills in the four tasks of IPS, and self-reflect on their individual work in the practice of IPS.

The same numeric scale is used to score each answer of the Fidelity Review. For those whose initial scores fall below the minimum required to maintain certification, the review will be scored again independently by the remaining individual members of the committee and a recommendation will be made following a compilation of those scores. The higher score, whether the original average or the average from the rest of the committee, will determine the necessity of retaking the review.

IPSAC and SAMHS are committed to ensuring the Fidelity Reviews for IPS are fair, ethical, and transparent.

How are Reviews administered?

Reviews will be held at selected DHHS offices, and will be done orally and in person. Participants will be required to attend independently.

How often is the Review administered?

The first Review is the year after you've taken your Core training. For example, if you complete the training in the summer of 2014, you will take your first Fidelity Review in the fall of 2015.

After the initial Fidelity Review, it will be repeated biennially (every two years).

What if I'm not current with my certification requirements?

You must be up to date in attending Co-Reflections and Continuing Education when reviews are scheduled, or have a plan in place with the Recovery Training Coordinator, Kelly Staples, to get up to date by December 31.

Process and Timeline

Reviews will take place in the fall, September-November. Participants will receive their scores within 6 weeks. Those requesting follow-up feedback can schedule time with an IPSAC committee member to discuss their review.

For participants whose scores fall below the minimum required in order to maintain certification, feedback will be provided prior to retaking the review. The second review will be administered 6 months after the initial Fidelity Review.

What if I need an accommodation?

Requests for accommodations based on disability will be discussed with the IPSAC, and a decision will be made by a representative of SAMHS Human Resources within 2 weeks.

How will Reviews be scheduled?

Participants due for Review this year will be notified by the SAMHS Recovery Training Coordinator of available dates in their area at least 30 days in advance. Participants must respond with their top three preferences within 2 weeks after receiving the email, and the Coordinator will notify participants of the final schedule within 2 weeks.

What do I do if I need an extension to complete the Fidelity Review?

Contact the IPSAC chairperson, Katharine Storer, in writing prior to your scheduled time. Contact information is at the end of this section. IPSAC will respond within two weeks of receiving your request.

What are the possible results of the Fidelity Review?

- If you score at or above the minimum required to demonstrate proficiency in your IPS skills your certification will continue.
- If you score below the minimum required to demonstrate proficiency in your IPS skills you will have the opportunity to retake the Review in 6 months, and will receive recommendations for further study in the interim with the opportunity to discuss your initial Review with a member of IPSAC.
- If you are unable to retake the Review or raise your score to or above the minimum required to demonstrate proficiency, you will no longer be certified in IPS, and you are welcome to reapply to the Core training after 6 months.

When will I receive my certificate?

Certificates will be issued by February 15th of the certification year. Certificates will be valid January 1 through December 31.

If you are required to retake your Fidelity Review and you are able to raise your score to the minimum or above, your certificate will be issued within 60 days, and will be valid through December 31 of that year.

How long is my certificate good for?

CIPSS Certificates will be re-issued every January as long as you have maintained the certification requirements of Co- Reflection, Continuing Education and Contact Hours and a Biennial Fidelity Review.

DRAFT

Appendix I

Contract Agreements

APS Healthcare

APS Healthcare was awarded the contract with the State of Maine's Department of Health and Human Services to provide a Behavioral Health Utilization Management System for services currently purchased through the State's Office of Maine Care Services and administered by the Adult Mental Health Services, Children's Behavioral Health Services, and the Office of Substance Abuse. The following document is the Business Associate Agreement with the Department of Health and Human Services in order to protect Personal Health Information.



Department of Health and Human Services

Business Associate Agreement

This Business Associate Agreement is made this 1st day of July , 2012 by and between the State of Maine, Department of Health and Human Services and Innovative Resource Group, LLC dba APS Healthcare Midwest ("Business Associate") with an address at 44 South Broadway Suite 1200, White Plains, New York 10601.

WHEREAS, the parties intend to protect the privacy and security of all individually identifiable health information and protected health information in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-91, codified at 42 U.S.C. §§ 1320 (d)(1)-(d)(8), and all regulations adopted pursuant thereto. Although this agreement is executed to comply with the provisions of HIPAA, the parties agree that certain state laws imposing confidentiality restrictions also apply to govern this business relationship. These may include all or some of the following state laws; this list is for informational purposes only, to illustrate the potential scope of state confidentiality provisions, and is not intended to be an all-inclusive list of the applicable statutes: 5 MRSA §19203; 5 MRSA §20047; 22 MRSA §§42, 261,815,824, 833, 1494, 1596, 1828, 3173, 3292, 4008, 5328,7250, 7703, 8754; 34-B MRSA §1207.

DRAFT

NOW THEREFORE, the parties agree as follows:

Definitions:

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191.

"Protected Health Information" shall have the same meaning as the term "protected health information ("PHI") in 45 C.F.R.§1604.103, limited to information created or received by the Business Associate from or on behalf of the Department.

"Required by law" shall have the same meaning as the term "required by law" in 45 C.F.R.§164.103.

"Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services, or his or her designee.

1. Term of Agreement

This Agreement shall be effective 7/1/12 and shall continue to 6/30/13. This Agreement shall automatically renew itself for an additional twelve-month period unless otherwise terminated by either party. In the event that this Agreement is automatically renewed, the Business Associate agrees to be bound by the Terms and Conditions currently in effect. The confidentiality provisions of this Agreement shall **survive indefinitely**, even beyond the termination of this Agreement, or as defined under provisions of law.

2. Termination of Agreement

Upon termination of this agreement the Business Associate is required, if feasible, to return or destroy all PHI received from or created or received by the Business Associate on behalf of the Department and retain no copies. If returning or destroying PHI is not feasible, Business Associate agrees to protect the confidentiality of the PHI to the extent required by HIPM and any regulations promulgated there under, and limit any further use or disclosure to those purposes that make the return or destruction of the information infeasible. Either party may terminate the Agreement by 30 day written notice to the other party.

3. Termination for Cause

Upon the Department's knowledge of a material breach by the Business Associate, the Department shall either, at its sole discretion:

- (a) Provide the Business Associate an opportunity to cure the breach or end the violation within a time frame and upon such conditions as established by the Department;
- (b) Immediately terminate this Agreement in the event the Business Associate has breached a material term of this Agreement and cure is not possible; or
- (c) In the event neither termination nor cure is feasible, the Department shall report the violation to the Secretary.

4. Permitted Uses and Disclosures

The only permitted uses and disclosure of PHI in this agreement are stated in attachment A. Except as otherwise limited by this agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities or services for, or on behalf of, the Department provided that such use and disclosure would not violate HIPM, the regulations promulgated there under, or the HIPM minimum necessary policy. The Business Associate will disclose protected health information only as permitted, or required by this Agreement, or as required by law.

5. Documentation and Availability

Business Associate is required to maintain and make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528. Documentation will be made available as necessary for an accounting of disclosures of PHI to the individual and or the Department as permitted by 45 C.F.R. 164.528.

The Business Associate will make PHI available to an individual to access and or copy his/her PHI as permitted by 45 C.F.R. 164.524, within 30 days from the time of request. The Business Associate will make available PHI for amendment as permitted by 45 C.F.R. 164.526, within 60 days from the time of request.

The Business Associate will make its internal practices, books and records relating to the use or disclosure of PHI received from the Department or created or received by the Business Associate on behalf of the Department, available to either the Department or the HHS Secretary for the purposes of determining the compliance of either the Department or the Business Associate with the Medicaid Act and HIPM Privacy Rule. 45 C.F.R. 164.504

In the event Business Associate has PHI in a designated record set, the Business Associate agrees to make any amendments to the Designated Record Set as the Department directs or agrees to in accordance with 45 C.F.R. §164.526 in such time-period and in such manner as the Department may direct.

6. Inappropriate Use and Disclosure

The Business Associate is required to report to the Department any inappropriate use or disclosure of the PHI of which it becomes aware, i.e. use or disclosure not permitted in this agreement or permitted by law. Business Associate will make such report to the Department Privacy Officer or designee by the end of the following business day.

The Business Associate shall exhaust, at its sole expense, all reasonable efforts to mitigate any harmful effect known to the Business Associate arising from the use or disclosure of PHI by Business Associate in violation of the terms of this Agreement.

7. Appropriate Safeguards

The Business Associate will implement, to the Department's satisfaction, all reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI. Safeguards will be implemented for paper as well as electronic versions of PHI. Business Associate will ensure that any agent or subcontractor

to whom it provides PHI received from, created or received by Business Associate on behalf of the Department agrees to the same restrictions and conditions which apply through this Agreement to the Business Associate with respect to such information.

8. Obligations of the Office of MaineCare Services

The Department shall notify Business Associate of any limitation in its Notice of Privacy Practices that would affect the use or disclosure of PHI by the Business Associate.

The Department shall notify the Business Associate of any changes, revocations, restrictions or permissions by an individual to the use and disclosure of his/her PHI.

The Department shall notify the Business Associate of any restriction to the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR §164.522, to the extent such restriction may affect the use or disclosure of PHI by the Business Associate. The HIPAA Privacy Rule allows covered entities, at their discretion, to accommodate requests for confidentiality by the subject of the PHI. If the Department has agreed to accommodate a confidentiality request, it has a duty to disclose such to its trading partners in order to allow the trading partner to honor the confidentiality agreement.

9. Agents

The Business Associate agrees to ensure that any agent, including a subcontractor to whom it provides or entrusts PHI as defined in this Agreement, will agree to the same restrictions and conditions governing PHI which apply to the Business Associate with respect to such information under the terms and conditions of this Agreement.

10. Hold Harmless

Business Associate agrees to indemnify and hold harmless the Department, its directors, officers, agents, shareholders, and employees against any and all claims, demands, expenses, liabilities or causes of action which arise from any use or disclosure of PHI not specifically permitted by this agreement or applicable state and federal laws.

11. Miscellaneous

- (a) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Department to comply with the requirements of the Privacy Rule and HIPAA.

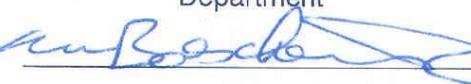
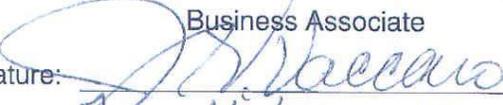
- (b) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Department to comply with the Privacy Rule and HIPAA.

12. Priority of Agreement

If any portion of this Agreement is inconsistent with the confidentiality terms of any of the agreements listed in Attachment A, the terms of the agreements listed in Attachment A shall prevail.

DRAFT

IN WITNESS WHEREOF, the parties have executed this BUSINESS ASSOCIATE AGREEMENT the day and year first written above.

Department		Business Associate	
Signature:		Signature:	
Name:	<u>William W. Boeschstein, Jr.,</u>	Name:	<u>Jerome V. Vaccaro, MD</u>
Title:	<u>Chief Operating Officer</u>	Title:	<u>President</u>
Date:	<u>3/15/13</u>	Date:	<u>2-28-2013</u>

Memorandum of Understanding with the Maine State Homeless Management Information System

This Memorandum of Understanding ("Memorandum") is entered into by and between Maine State Housing Authority ("MaineHousing"), 353 Water Street, Augusta, Maine 04330 and the State of Maine Department of Health and Human Services Office of Adult Mental Health Services ("DHHS") which administers the Projects For Assistance in Transition from Homelessness ("PATH") program.

This Memorandum sets forth the general agreements between DHHS and MaineHousing regarding the Homeless Management Information System ("HMIS") for the State of Maine ("Maine State HMIS") and administration of the PATH program. DHHS uses organizations ("Participants") to administer PATH under the terms of a user policy. The Participants input information on Maine State HMIS.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, MaineHousing and DHHS hereby agree as follows:

1. USE OF COMPUTER SYSTEM SOFTWARE. DHHS and MaineHousing shall have the following responsibilities with respect to the use by of Maine State HMIS in connection with the PATH program:
 - a. MaineHousing has the responsibility and authority to establish, support and manage the Maine State HMIS and establish procedures in a manner that will meet applicable HUD standards for data quality, privacy, security, and other related requirements as defined in the latest available HUD standards.
 - b. MaineHousing will designate and contract with a software vendor to provide HIPAA Compliant software for Maine State HMIS (the "Maine State HMIS Software".)
 - c. At least yearly, MaineHousing will review the relationship with the chosen software vendor to assure that the vendor's system is operated and maintained in compliance with HUD's HMIS standards, HIPAA compliance, and the needs of DHHS and will make the results of this review available to DHHS.
 - a. HIPAA compliance is a requirement for many agencies using HMIS. The following five methods ensure that the current vendor (ServicePoint) is fully compliant with HIPAA data center standards:
 - i. Network Security includes -firewalls, certification servers, VPN access, and Operating System authentication.
 - ii. Encryption (optional) is a database level security which encrypts confidential information located in database tables

- iii. Audit Trails log and report on users who have viewed, updated, or deleted client records
 - iv. Client Record Privacy Options allow or restrict access to all or part of a client file, including individual fields (data level).
 - v. Automatic Timeout logs a user out of the system after a specified period of idle time, thereby decreasing the potential viewing or manipulation of client data by unauthorized individuals.
-
- b. Subject to the terms and conditions of any licensing agreement by which MaineHousing is bound, as said licensing agreement may be amended or otherwise modified from time to time, and to the provisions of this Memorandum, MaineHousing will permit DHHS and its Participants to use the Maine State HMIS Software.
 - c. MaineHousing will provide appropriate staffing for administering the Maine State HMIS system.
 - d. MaineHousing will put in place policies and procedures regarding the use and security of the Maine State HMIS Software and its data.
 - e. MaineHousing HMIS database administration staff shall have necessary and appropriate access to data submitted by Participants to administer the Maine State HMIS Software, resolve data issues, and assure data security and integrity.
 - f. DHHS agrees to cause its Participants to comply with applicable Maine State HMIS policies and procedures as set forth in the *Maine Homeless Management Information System Procedures Manual*, as may be amended, and the *Maine HMIS Privacy Practices Notice*, as may be amended, including data entry, quality, and privacy standards
 - g. DHHS agrees to cause its Participants to enter complete and timely information including protected personal information regarding clients served into the Maine State HMIS Software as necessary to comply with HUD standards and provide for accurate unduplicated accounting.
 - h. DHHS State Contact shall have access to all data submitted by Participants, including protected personal information regarding clients served by DHHS. DHHS's access shall be in the form of the existing customizable reporting tools.
 - i. DHHS and its Participants shall not provide access to or permit any person to use the Maine State HMIS Software unless that person has had training on the use of the software, MaineHousing has received a User Authorization

DHHS State Contact: Sheldon Wheeler
PATH- State Contact
Director, Housing Resource Development
State of Maine
Department of Health and Human Services
Office of Adult Mental Health
11 State House Station
Augusta, ME 04333-0011

Either party may designate from time to time other or different addresses to which its notices hereunder shall be sent by providing written notice of such address as provided above.

6. ENTIRE AGREEMENT AND SEVERABILITY. This Memorandum constitutes the entire agreement between MaineHousing and DHHS and neither party shall be bound by any statement or representation not contained herein. This Memorandum supersedes any prior contract, agreement or understanding, written or otherwise, which previously may have been entered into by and between DHHS and MaineHousing. If any court determines that any provision of this Memorandum is unenforceable, invalid or void, all other provisions of this Memorandum not included in the court's determination shall remain in full force and effect and both DHHS and MaineHousing shall continue to be bound by them.
7. ASSIGNMENT. Neither DHHS nor MaineHousing may assign, sell, transfer or otherwise dispose of this Memorandum or any portion of its rights or obligations hereunder without the prior written consent of the other party hereto. Any such action taken without such prior written consent shall be null and void and will not release the parties from their respective obligations hereunder. Nothing herein shall require any prior written consent for either party to hire employees or agents in the normal course of business.
8. WAIVER. Neither MaineHousing's nor DHHS's failure to enforce any provision of this Memorandum or to exercise any right or seek any remedy against the other party hereto for breach of this Memorandum, or MaineHousing's or DHHS's acceptance of any performance by the other party under this Memorandum during any such breach shall not be deemed to constitute a waiver of any rights, causes of action, or remedies available at law or in equity to MaineHousing or DHHS, as the case may be, under this Memorandum.
9. AMENDMENTS. The provisions of this Memorandum may be amended at any time, but only by mutual agreement of the parties hereto and only in writing.
10. GOVERNING LAW. This Memorandum shall be governed in all respects by the laws of the United States and the State of Maine. In fulfilling its duties and obligations hereunder, DHHS and MaineHousing shall comply fully with the

DRAFT

applicable laws and regulations, as amended from time to time, governing the PATH program.

11. AUTHORIZED SIGNATURE. The undersigned officer or representative of MaineHousing and DHHS, hereby warrants that he/she has the authority to execute this Memorandum on behalf of MaineHousing and DHHS, that MaineHousing and DHHS shall be bound by his/her action and that MaineHousing and DHHS has all necessary power and authority under federal, state and local law to undertake the duties and responsibilities set forth herein.

IN WITNESS WHEREOF, MaineHousing and DHHS hereby execute this Memorandum effective

Date:

ITS Director

State of Maine

Department of Health and Human Services, PATH program

Confidentiality Clause in Rider B
CONFIDENTIALITY

1. All materials and information given to the Provider by the Department, or acquired by the Provider on behalf of the Department, whether in verbal, written, electronic, or any other format, shall be regarded as confidential information.
2. In conformance with applicable Federal and State statutes, regulations, and ethical standards, the Provider and the Department shall take all necessary steps to protect confidential information regarding all persons served by the Department, including the proper care, custody, use, and preservation of records, papers, files, communications, and any such items that may reveal confidential information about persons served by the Department, or whose information is utilized in order to accomplish the purposes of this Agreement.
3. In the event of a breach of this confidentiality provision, the Provider shall notify the Agreement Administrator immediately.
4. The Provider shall comply with Maine Public Law 10 MRSA §1347 (Notice of Risk to Personal Data Act).

DRAFT

APPENDIX II

Data Systems

DATA SYSTEMS

Knowledge Based Information Technology (KIT)

What is KIT? KIT stands for Knowledge-Based Information Technology. It's an online data management system that allows grantees to enter in their information/data that allows project officers to monitor their work in relation to contract deliverables.

What does KIT collect? It collects data on the activities and strategies performed by prevention grantees. It can also collect narrative progress notes by grantees. This includes number of strategies, number of times a strategy is implemented, number of participants, and in one part it collects demographic information of participants.

How do grantees access KIT? They enter through a web based portal, logging in with name and password.

What kinds of reports are available on KIT? There are two sides in the KIT system, one is the side (screens) that Health Maine Partnership (HMP) coalitions have access to and report all their HMP work in, these are environmental based strategies (aka Universal interventions); the other side is for organizations funded just by the office of Substance Abuse and Mental Health Services (SAMHS) to do substance abuse prevention selective or indicated strategies and programs.

HMP side of KIT

Reports and Plans available to grantees upon log-in:

1. Organization Work plan;
2. Work plan status report (each milestone for each strategy shows its status: "in process on-time", "in process behind schedule", "not started", "complete". This report also includes the quarter each milestone is expected to be completed);
3. Additional Contracts report - shows leveraged funds and funders;
4. Objective and Strategy report – shows list of their selected objectives and strategies; and
5. Status Report gives the counts (how many interventions implemented; how many people attended in aggregate by quarter and annually).

Project officers can pull all these same reports as can the KIT Administrator (Cheryl Cichowski). The KIT vendor is building a report so that the KIT Administrator can pull aggregate counts for all HMP's without contacting the vendor this data is used to report the Prevention National Outcome Measures in the annual Substance Abuse Prevention and Treatment Block Grant report to SAMHSA (currently the Administrator has to contact the vendor to create this each year).

Grantees are supposed to update the information in KIT monthly.

SAMHS Prevention side of KIT

KIT (for Indicated, Selective programs ie SIRP) – grantees enter number participants, birthdate, gender, race; dosage (number sessions); number activities; then their quarterly report will pull the information they put in during that quarter into a report.

Reports available to KIT administrator not grantee – In aggregate:

1. events by program;
2. participant demographic by group;
3. service record by activity; and
4. number persons served by strategy by type of intervention.

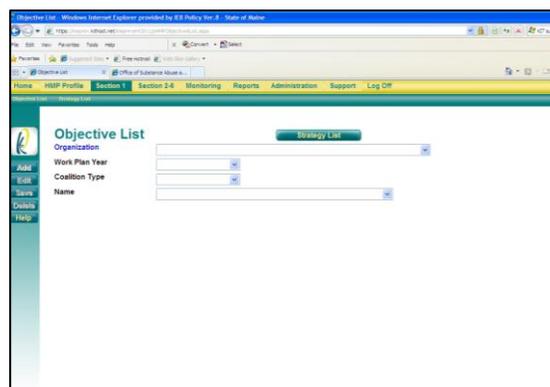
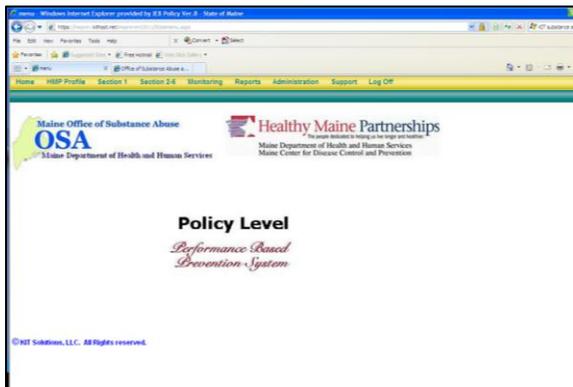
Definitions:

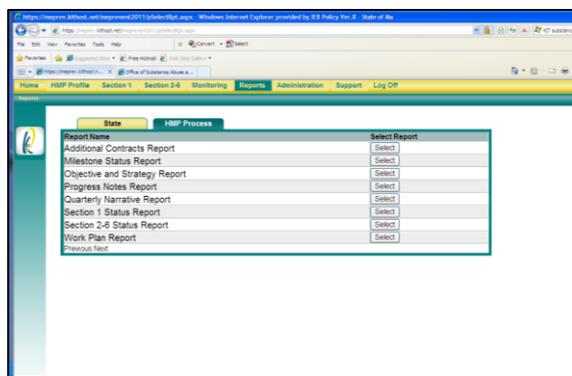
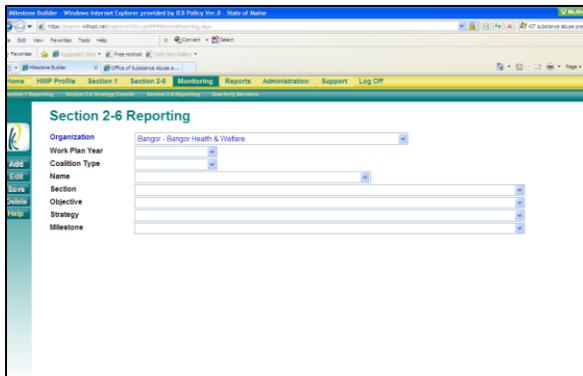
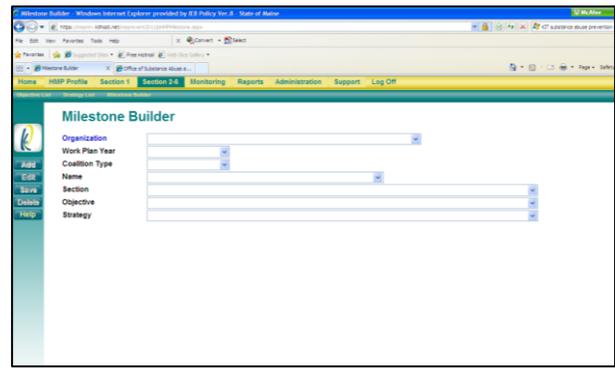
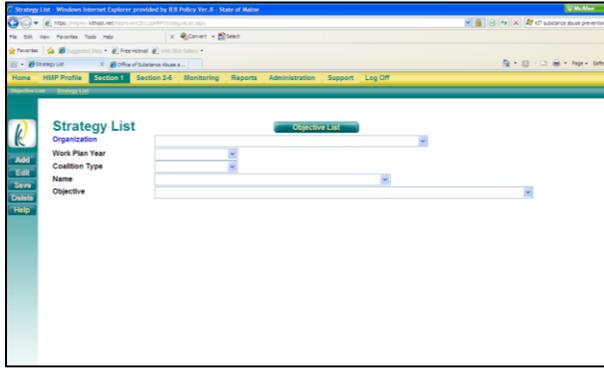
Universal Interventions - broad approach that targets an entire population, the general public, or a school, whole communities, or workplaces. Work to change norms, access/availability, and policies which ultimately change behaviors.

Selective Interventions – target sub populations or individuals who have a higher than normal risk of abusing substances, but may not have begun using. Risk is usually due to biological, psychological, or social factors (such as growing up in a home with substance abusers).

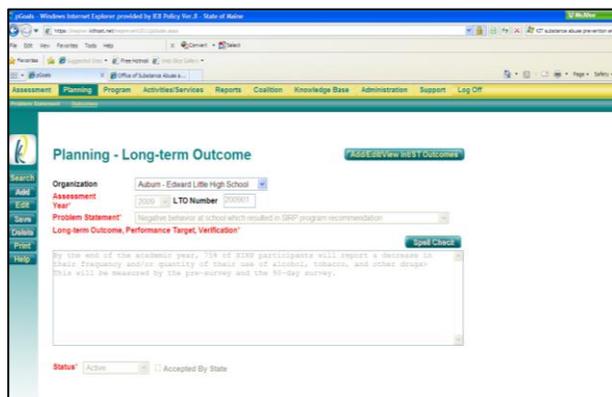
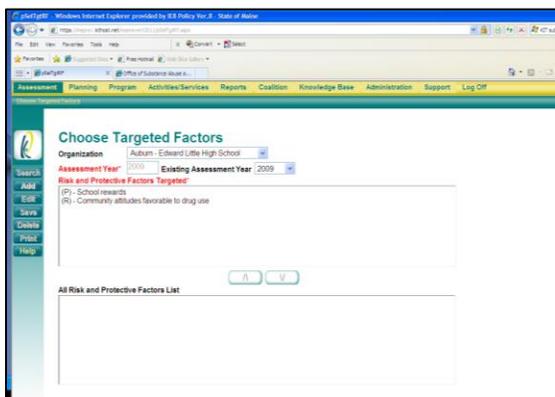
Indicated Interventions – targets individuals who have already begun using or have tried a substance and are at high risk of abusing substances. Usually these individuals have shown some signs already.

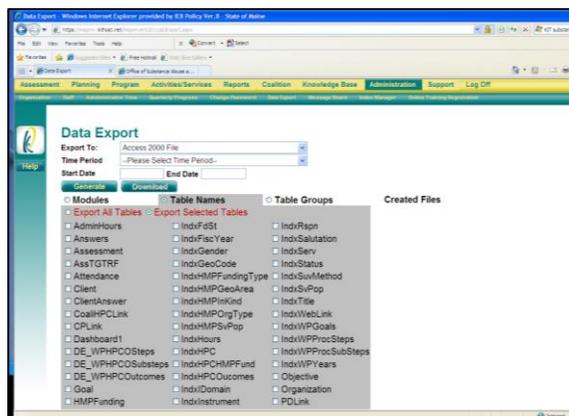
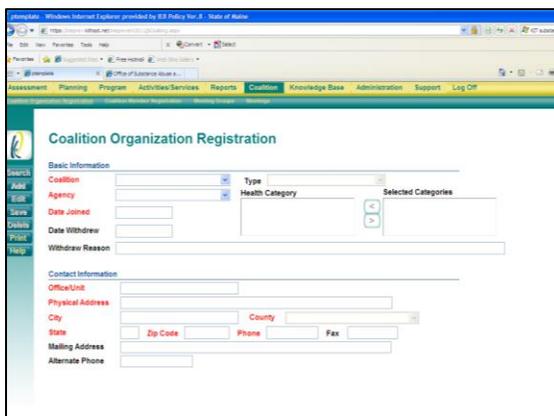
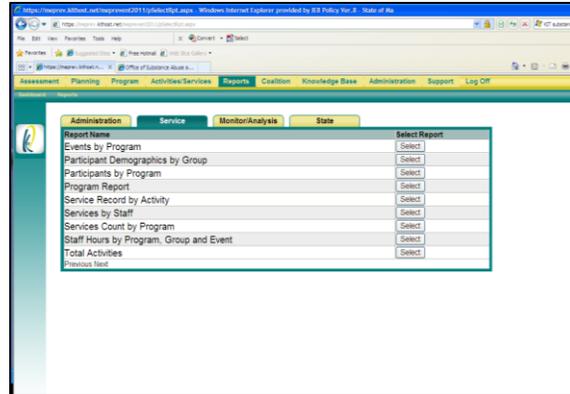
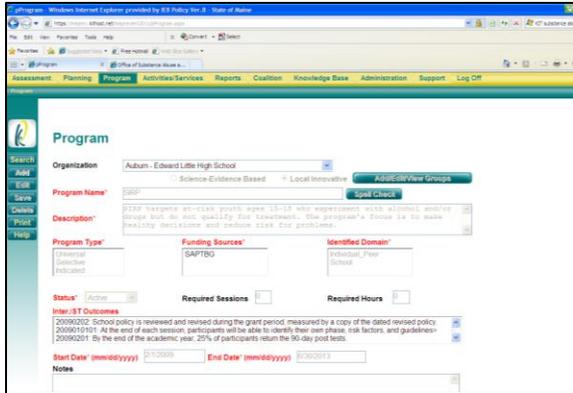
Screenshots, HMP side:





Screen Shots – Indicated/Selective Program Side:





Prescription Monitoring Program (PMP)

What is PMP? The Prescription Monitoring Program is a web-based system that aids in the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substance prescriptions.

What does PMP collect? Dispensers are required to upload Schedule II, III, and IV controlled substance data not later than the close of business on the next business day of the controlled substance after it has been dispensed (both filled and delivered).

What kinds of reports are available on the PMP? PMP reports are available for all approved registrants that are granted access: (See the PMP rules for more specifics)

- Prescribers, their assistants - in regards to their patients
- Dispensers – as it pertains to a specific patient script
- Licensing boards – in regards to investigations
- Individuals – in regards to any prescription dispensed to them
- PMP Vendor (HID) – in regards to program operation
- Law Enforcement – for bona fide specific investigations
- Medical Examiner/Coroner – cause of death determination
- Office of Maine Care services - for the purposes of managing members
- Also, De-identified information may be provided for research and education

Maine Prescription Monitoring Program

Home Access System Help Quick Links

Maine Data Requesters' Query Site

The Maine Prescription Monitoring Program (ME PMP) is Maine's solution for monitoring Schedule II-IV controlled substances dispensed in the State of Maine. The ME PMP was created to prevent and detect prescription drug misuse and diversion. The PMP maintains a database of all transactions for controlled substances dispensed in the State of Maine. This database is available online to prescribers and dispensers. The PMP is a free service of the Office of Substance Abuse in the Maine Department of Health and Human Services.

The Maine Department of Health and Human Services grants system access accounts to practitioners and pharmacists so that they may look up, view, and print controlled substance dispensing information on their specific patients directly via user name and password.

RxSENTRY
Copyright © 2013 Health Information Designs, LLC
If you need further assistance, please contact the PDMP Help Desk

Maine Office of Substance Abuse and Mental Health Services
41 Anthony Avenue, SHS #111
Augusta, Maine 04333-0111
Phone: (207) 287-2559 Fax: (207) 287-6910
E-mail: osamhs@maine.gov

DRAFT

Data Reports:

A recipient query – which is a query on a patient

Maine Prescription Monitoring Program

Home Query Report Queue User Management Help Quick Links Log Out

Recipient Query

Prescriber History Query
Prescriber DEA Query
Multiple State Query

*Last Name
*First Name
Search Method: Fastest: Last name equals; first name begins
*Date of Birth
Within: Exact Match
Gender: Select Gender
County: Select County
ZIP Code
Primary Address
City
Other Address 1
City
Other Address 2
City
*Dispense Start Date
*Dispense End Date
Next Clear

RESENTRY
Copyright © 2013 Health Information Design, LLC
If you need further assistance, please contact the PDMP Help Desk

Maine Office of Substance Abuse and Mental Health Services
41 Anthony Avenue, 5003 #11
Augusta, Maine 04333-0111
Phone: (207) 287-2666 Fax: (207) 287-4910
E-mail: osamhs@maine.gov

This is a report query run on patients that receive schedule II, III, and IV drugs. The image below is an example of the information the report provides.

Generate Report

Recipient Report
Dispensed From 06/01/2010 to 08/22/2013
2 out of 2 Recipients Selected
DATA, DUMMY - DOB: 01/01/1980 - 41 Anthony Ave
DATA, DUMMY G - DOB: 01/01/1980 - 41 Anthony Ave
Map Results

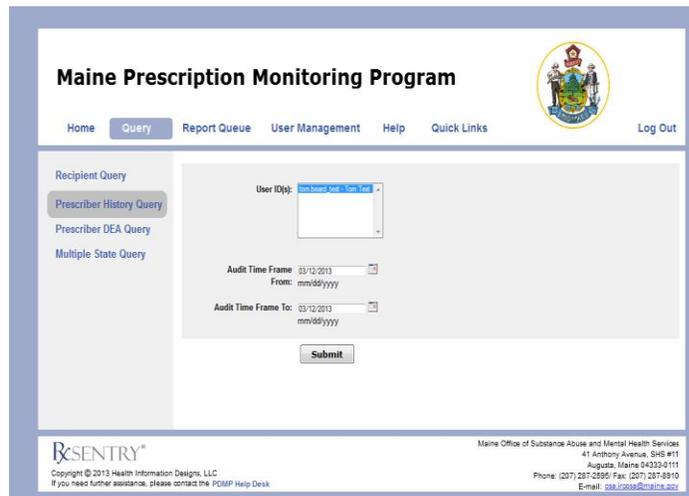
Date Dispensed	Date Prescribed	Quantity Dispensed	Days of Supply	Authorized Refills	NDC	Drug Name	Prescriber	Prescription Number	Dispenser	Dispenser City	Recipient Last Name	Recipient First Name	Date of Birth	Recipient Street Address	Recipient City
06/01/13	06/18/13	90	30	1	00228202910	ALPRAZOLAM 0.5 MG TABLET	TEST MD	4001907	TEST PHARMACY	PORTLAND	DATA	DUMMY	01/01/80	41 Anthony Ave Augusta	Augusta
06/01/13	06/01/13	30	15	1	64376063101	ALPRAZOLAM 0.5 MG TABLET	TEST MD	4002048	TEST PHARMACY	PORTLAND	DATA	DUMMY A	01/01/80	41 Anthony Ave Augusta	Augusta
04/14/13	05/16/13	30	30	2	10702002701	PHENTERMINE 30 MG CAPSULE	TEST MD	4001990	TEST PHARMACY	PORTLAND	DATA	DUMMY G	01/01/80	41 Anthony Ave Augusta	Augusta

Information on the report includes:

- Date Dispensed
- Date Prescribed
- Quantity Dispensed
- Days of Supply
- Authorized Refills

- NDC Code
- Drug Name
- Prescriber
- Prescriber Number
- Dispenser
- Dispenser City
- Recipient Last Name
- Recipient First Name
- Date of Birth
- Recipient Street Address
- Recipient City

Prescriber history query – which shows the PMP report use history



By choosing a user ID, a prescriber can search a PMP utilization history report of their delegates and can generate a report showing one's own PMP use history. This feature is important for providers. By signing a sub-account registration form that allows access to the PMP on their behalf to others, they are accepting responsibility of access. This report provides them with some oversight of that use. Also, with the consent of the provider, the report is used by hospitals and offices that are interested in measuring PMP utilization of staff.

Prescriber DEA query – shows the personal prescribing record of the provider.

The screenshot shows the 'Maine Prescription Monitoring Program' web application. The 'Query' tab is selected in the top navigation bar. On the left sidebar, 'Prescriber DEA Query' is highlighted. The main form area contains the following fields: 'User ID' (text input with 'test_user'), 'DEA' (text input with '12345'), '*Dispense Start Date' (calendar icon with '03/15/2013'), and '*Dispense End Date' (calendar icon with '03/15/2013'). A 'Submit' button is located below these fields. The footer includes the 'RESENTRY' logo, copyright information for Health Information Design, LLC, and contact details for the Maine Office of Substance Abuse and Mental Health Services.

This is a personal prescribing report that lists all of the scheduled drugs prescribed by doctor. The report can also be used to screen for any illegitimate prescribing that may have occurred under a prescribers DEA number. (Lost or stolen script pads etc.). Sometimes when performing a recipient query on a patient, it is difficult find a report, especially for patients with names often misspelled, i.e. O’Leary. This report is another way to search for those patients in the system and is a good backup method to verify PMP information about those patients. If after searching both methods the prescription in question still doesn’t appear, there is a chance that an error in omission or some other error may have occurred. In those cases the PMP recommends that providers call the pharmacy that the patient uses to have a conversation with them about the prescription in question.

Multiple state query – which shows the PMP reports that were run for information about their patients that were dispensed in other states that Maine shares data with.

The screenshot shows the 'Maine Prescription Monitoring Program' web application with the 'Multiple State Query' form selected. The 'Request Information' section has '*Disclosing State(s)' set to 'Alabama' and 'Requestor Role' set to 'Prescriber'. The 'Recipient Information' section includes fields for '*Last Name', '*First Name', 'Identifier', '*Date of Birth', 'Gender' (dropdown), 'Street Address', 'City', 'State' (dropdown set to 'All states'), and 'ZIP Code'. The 'Dispensing Time Frame' section has '*Dispense Start Date' and '*Dispense End Date' (calendar icons), 'OR', and 'Preset Date Ranges' set to 'Past Month'. The 'Sorting Options' section has 'Sort' set to 'By recipient by date' and 'Grouping' set to 'Group results by state'. A 'Submit' button is at the bottom. The footer contains the same contact information as the previous screenshot.

From a box at the top of this query screen a user can choose other states Maine shares data with and run a report for the patient that shows dispensing of prescription drugs in those states.

Web Infrastructure for Treatment Services

What is WITS? WITS is the Web Infrastructure for Treatment Services. The Web Infrastructure for Treatment Services was legislatively mandated by the State Legislature in P.L. 1983 c. 464. It is also required by the U.S. SAMHSA that the Maine Office of Substance Abuse and Mental Health Services (SAMHS) submit substance abuse treatment data to their Treatment Episode Data Set (TEDS) on a monthly basis. WITS is the vehicle used to comply with that reporting.

SAMHS uses the information from WITS for a variety of purposes in addition to the requirements noted above. WITS data are used to populate portions of the SAPTBG (Substance Abuse Prevention and Treatment Block Grant). WITS aggregate data are used to monitor and track trends in substance use for new or changing patterns. The system allows the Office to monitor contracted agencies for utilization and effectiveness. In addition, WITS is used for needs assessment planning and workforce development.

What does WITS collect? WITS collects de-identified admission and discharge data on clients in substance abuse treatment. Data elements include but are not limited to demographics, payer source, dependent children, primary referral to treatment, substances leading to admission, living arrangements, employment, IVDU history, etc.

WITS also collects electronic wait list (EWL) data as required by the SAPTBG from licensed and contracted substance abuse providers. The EWL collects capacity, census data as well as client level data for clients waiting to enter treatment for each service that an agency is licensed to provide.

How do grantees access WITS? WITS is a secure system requiring a user ID and password to log on.

What kinds of reports are available on WITS? Providers can pull up client lists based on the agency's federal ID number, Client ID, admission date, or service setting. They can also run an Agency Monitoring report to show how many admissions and discharges have been entered by their staff within the filtered time frame of the report.

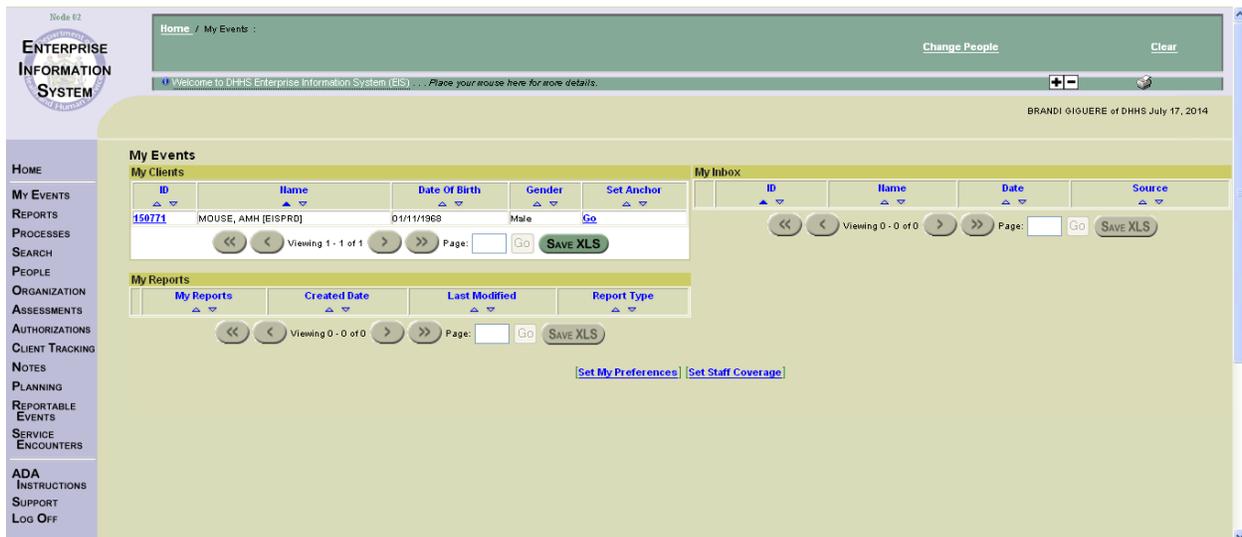
WITS data are also fed into an online querying tool called the WITS Web-based Reporting System (WITSR). The WITSR has a public facing side where anyone who wishes can run frequency, crosstab or trend reports based on admission or discharge data. WITSR has secure side where providers can log in with their WITS account credentials to run agency specific data.

Enterprise Information System

What is EIS? EIS (Enterprise Information System) is a web based mental health client level data collection tool. EIS collects data from not only state staff but agency provider information is received and fed into EIS.

What does EIS collect? EIS collects mental health case management data, progress notes, critical incident reports, assessments, psychiatric hospitalizations, and service encounter data.

What kinds of reports are available on EIS? EIS data is loaded into a reporting/query tool called Cognos. This tool is used to collect Consent Decree reporting requirements, trending reports and agency monitoring reports. Cognos reports also are uploaded into EIS giving end users the ability to run reports as needed.



Service Encounter Database

The Service Encounter Database or SED was designed to provide contract management a way to validate and confirm grant payment invoices that they receive from Mental Health Agencies. Until the SED was built contract management had no way to track, confirm or verify the grant payment invoices they were authorizing.

Mental Health Agencies are allocated grant funds by contract management to use for those clients who either do not have insurance or whose insurance doesn't cover all services. These agencies periodically have invoices for those unpaid services and send them to purchasing services for payment. The invoices do not give line by line changes for client services rendered but simply state the total owed them for the services they provided. Purchasing services then sends the invoice to contract management to get the authorization to pay in grant funds for those services.

The SE database came into being as a way to provide line by line verification of the invoices being sent by the agencies. Agencies capture line by line the detail of the services they render to grant funded clients and then submit that detail by text file to the SED. There is a report in the Enterprise Information System (EIS) that contract management can run to verify the grant fund invoices they receive. Once they have verified an invoice they then notify contract management that they are authorizing payment.

Driver Education Evaluation Programs (DEEP) Data System

What is DEEP? The Driver Education and Evaluation Programs (DEEP) are the Legislatively mandated (5 MRSA c.521, Sub-c. V) Operating Under the Influence (OUI) countermeasures programs in the state of Maine. The goal of the programs is to lessen the incidence of injury, disability and fatality that results from alcohol and other drug related motor vehicle crashes, and to reduce the risk of re-offense for OUI.

What does DEEP Data system collect?

Client demographics, Number of alcohol moving violations, Client Status ,Client Program history, Client payment history, Client case history, Client correspondence, DEEP certified Providers.

Who can access DEEP system: DEEP is a secure system for DEEP staff only requiring a user name and password.

What kind of reports are available on the DEEP system?

Bureau of Motor Vehicle Summary report, Class roster's, Class schedules, Closed cases, Repeat offenders, Second opinions, Daily money, Recent activity, Open cases, Evaluation history, Treatment history, Provider by location with client, Provider listing for clients, Provider Summary.

DRAFT

APPENDIX III

Surveys

SURVEYS

What is MIYHS?

In 2009, the Maine Department of Education (MDOE), the Maine Office of Substance Abuse (OSA), and the Maine Center for Disease Control and Prevention (MCDC) implemented the Maine Integrated Youth Health Survey, with the intent of repeating the survey every two years.

The Maine Integrated Youth Health Survey (MIYHS) is designed to:

- Ensure the State's ability to provide federal and State level data while still providing localized reports to schools and counties to assist in efforts to reduce health risks and improve health protective factors and youth assets;
- Maximize the use of State resources in conducting, analyzing and reporting student health data;
- Provide a single survey framework encompassing topics of risk and asset (protective) influences on student behavior for a comprehensive look at youth well-being for elementary, middle and high school students;
- Obtain a sufficient response rate to ensure representative data for state program purposes;
- Ensure voluntary and anonymous participation for students and parents;
- Allow any local education agencies (school administrative units or regional school units) wishing to take part in the survey to do so;
- Meet the sample for weighted data that will allow for comparison to the National Youth Risk Behavior Survey which is administered in grades 7-12;
- Track progress in achieving the Healthy People/Healthy Maine 2010 and Healthy People/Healthy Maine 2020 objectives, National Outcome Measures (NOMS), and objectives and performance measures for federal grants, and Maine's Marks;
- Assist local education agencies and communities in leveraging State and federal funding to improve the health and education of Maine students;
- Increase accuracy in data gathered and reported on; and
- Reduce the burden to schools and students from over-surveying by State agencies, including providing for fewer surveys sponsored by State agencies and for shorter survey instruments.

What is SAMHS role in MIYHS?

SAMHS, DOE, MCDC, and an external contractor have various responsibilities for the MIYHS as described in a MOU. SAMHS responsibilities include:

- Working with the MCDC-OIT team to create and maintain a statewide MIYHS website for dissemination of school, school district, county, Public Health District, and State level.
- Reviewing and testing the data as they arrive for accuracy and errors.
- Revising data release policies as needed to comply with HIPAA, FERPA, CDC IRB regulations.
- Fulfilling and tracking data request.
- Creating a MIYHS user guide.

In addition, to the responsibilities listed in the MOU, SAMHS assists in the review of the MIYHS questionnaire, logic edits, and answers of interest. During school recruitment, SAMHS helps implement recruitment strategies targeting reluctant schools in order to obtain the participation necessary for various reporting goals for funding sources like the U.S. CDC Youth Risk Behavior Survey and other federal and state grants. SAMHS also has representatives on the MIYHS Steering Committee. The SAMHS Data and Research Program Specialist is a co-chair on this committee with the MDOE HIV Prevention Coordinator and MCDC Population and Family Health Division Deputy Director or that position's appointed representative.

What does MIYHS collect?

The MIYHS include the following data collection:

- Grades K and 3 parent surveys.
- Grades K, 3 and 5 data collection by school nurse or designated representative of height/weight measurement and oral health screening for Grades K and 3. The collection of this data will be overseen by the MDOE's School Nurse Consultant, using school nurses and other school personnel trained in the measurement protocols.
- Grade 5 and 6 student survey. There will be a single version of this survey.
- Grades 7 and 8 – middle school student survey. There will be four versions of this survey. One of these versions will conform to national YRBS standards, and will be called the "MS YRBS version." This will be a "split census" survey, with all schools recruited for the survey, each school randomly assigned two of the four versions of the survey, and students assigned by class one of two versions within each school.
- Grades 9-12 – high school student survey. There will be four versions of this survey. One of these versions will conform to national YRBS standards, and will be called the "HS YRBS version." This will be a "split census" survey, with all schools recruited for the survey, each school randomly assigned two of the four versions of the survey, and students assigned by class one of two versions within each school.

The types of age appropriate variables collected on the survey include:

- Alcohol
- Marijuana
- Prescription Drugs
- Other drugs
- Smoking
- Preventing sunburn
- Disabilities
- Violence and bullying
- Unintended Injury
- Sex
- Depression and suicide
- Gambling
- Risk and Protective Factors and Assets Asthma
- Nutrition
- Body Weight
- Physical activity

How do people access MIYHS data?

State, Public Health District, and County Level data reports are available on <https://data.mainepublichealth.gov/miyhs/>. Confidential reports for schools and school districts will also be available on the website through a secure login feature in Fall 2013. For now, confidential reports, disaggregated data files and requests are available to qualified users according the MIYHS Data Policy by contacting SAMHS Data and Research Program Specialist.

What kinds of reports are available on the MIYHS website?

State, Public Health District, and County Level **Detailed Reports** contain answer of interest prevalence and 95% CI for the total population as well as by sex, race/ethnicity, and grade level for each survey year. State, Public Health District, County, school district, and school level **Comparison Reports** contain overall answer of interest prevalence and compares the specified unit to its value in the previous survey year and to the state of Maine, highlighting statistically significant differences in the comparisons.

Substance Abuse Client Satisfaction Survey

What is the SA Client Satisfaction Survey?

The Substance Abuse Client Satisfaction Survey evaluates the satisfaction of clients from substance treatment facilities. SAMHS is required to provide this survey as a part of the Substance Abuse Prevention and Treatment Block Grant.

Who participates?

Agencies that have SAMHS substance abuse treatment funding are required to participate in the survey. In addition, agencies that provide Opioid Treatment Programs or Medication Assisted Treatment, ones treating co-occurring disorders, and ones receiving MaineCare funding are invited to participate. One month is selected to conduct this survey. During this month, participating agencies notify the clients with whom they have contact about the opportunity to participate in the survey.

What is the methodology (or process of implementing/analyzing)? What questions are on it?

To minimize the cost and time involved in distributing paper forms, both for SAMHS and for agencies with multiple facilities, we offer agencies the option of distributing survey on-line as well as through the mail; offering separate surveys for adults and adolescents. Agencies were initially notified by email and phone three months before the survey of the upcoming survey and were asked to choose which format they would like to offer to their clients. Follow-up contact with agencies who had not responded occurred through 2 months before the survey. Most agencies chose to offer the survey to their clients using the paper format only, because many of the agencies were not set up to allow client access to computers in a secure location at their facility and many noted their clients lacked access at home to computers. Instructions, paper surveys, client letters, and prepaid envelopes addressed to SAMHS are sent to agencies a couple weeks before the survey month. During the survey month, agencies with low returns are contacted to see if there are any difficulties

Since it is difficult to know how representative the responding clients are to the population of all substance abuse clients in Maine, the results can only be considered the opinions of the survey participants and cannot be generalized to the client population as a whole. A statewide report is generated for the adult survey that reports one-way proportional tabulations of categorical responses to questions about demographic characteristics, satisfaction with services, satisfaction with staff, results of treatment and overall satisfaction. We also look at average overall satisfaction scores by demographic characteristics.

For individual agencies, we provide reports on results from their clients. In order to protect client confidentiality, only agencies and individual facilities whose clients returned 20 or more useable surveys received a full report; an abbreviated report with collapsed response

DRAFT

categories was made available when 17-19 surveys were received, and all facilities received an overall satisfaction score if 6 or more clients responded.

We could also provide a statewide report of adolescent agencies. However, often over 2/3 of all adolescent responses come from one agency. As a result, we considered a state report on the results from adolescents both redundant and a breach of that facility's privacy.

Mental Health Well-Being Survey

What is the MH Client Satisfaction Survey?

Agencies that have SAMHS Mental Health contracts are required to participate in the survey. One month is selected to conduct this survey. During this month, participating agencies notify the clients with whom they have contact about the opportunity to participate in the survey.

What is the methodology (process of implementing/analyzing)? What questions are on it?

Surveys are distributed in paper form to the agencies in bulk. Agencies are initially notified by email and phone three months before the survey of the clients. There is follow-up contact with agencies who had not responded. Instructions, surveys, client letters, and prepaid envelopes addressed to SAMHS are sent to agencies a couple of weeks before the survey month. During the survey month, agencies with low returns are contacted to see if there are any difficulties.

Since it is difficult to know how representative the responding clients are to the population of all mental health clients in Maine, the results can only be considered the opinions of the survey participants and cannot be generalized to the client population as a whole. A statewide report is generated that reports on-way proportional tabulations of categorical responses to questions about demographic characteristics, satisfaction with services, satisfaction with staff, results of treatment and overall satisfaction. We also look at average overall satisfaction scores by demographic characteristics.

For individual agencies, we provide reports on results on the clients from the quality module, consent decree employment and demographic questions. In order to protect client confidentiality, only agencies whose clients returned 20 or more useable surveys receive a full report. The Office of Continuous Quality Improvement will be reporting on questions 1-24.

APPENDIX IV

Quality Management Review Forms

Quality Management Review Forms

Substance Abuse on-site visit/contract monitoring

Process: During the course of the agreement period, Substance Abuse and Mental Health Services reviews information submitted by the Provider to identify issues that need addressing. SAMHS and Purchased Services meet with the Provider at least annually to discuss compliance with the agreement as well as any areas of non-compliance. The Checklist below is a guide for the annual meeting as well as a tool for gathering information during the agreement period by SAMHS and will be located in the contract file.

Agency	
Site Visit Date	
Agency Staff	
DHHS Staff	

Agreement Number	Service Type	Funding Source (eg SAPT, SGF, MC)

Please indicate Y, N or NA for each item below.

Prior to Visit

	Optional to do onsite visit annual calendar; and/or send out a letter to Agency introducing visit.
	Check MACWIS to see if agency is, 1) licensed, and for what; 2) if there are any recent reviews, complaint investigations, etc.
	Look for and gather data/waitlist info/WITS completion/incentivized contracts on target, etc
	Review client satisfaction surveys for specific provider
	Print out contract between DHHS (SAMHS) and Agency
	Coordinate visit with Division of Licensing and Regulatory Services licenser if possible.
	Coordinate visit with Agency.
	Check and gather critical incident reports as applicable.

	Print out client interview form.
	Review quarterly reports

Service/Program Policies – review of Agency’s policy/procedures manual, and include:

	Nondiscrimination in providing services
	Confidentiality: 42 CFR, Part 2 reflected in records. http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:1.0.1.1.2&idno=42
	Demonstrates HIPAA compliance
	Drug-free workplace policy – includes establishment of a drug-free awareness program (see contract specifics)
	Client record organization/maintenance/disposal
	Client access to records
	Clients' rights
	Client grievance/appeal procedures (posted)
	Program rules
	Has written tobacco policy which complies with state tobacco laws (MSRA 22 §1580 A and §1541-1550). (Please see detailed information at the bottom of this form.)
	Admission criteria
	Urinalysis
	Treatment/Follow-up/Aftercare
	Priority Treatment address substance abusers in the following order: 1) pregnant injecting drug abusers; 2) pregnant substance abusers; 3) injecting drug abusers; 4) self-disclosing HIV/AIDS; 5) all others (Women' 3 and 4 must be: 3) parenting injection drug users; and 4) parenting substance users.)
	Quality assurance
	NIATx compliance is evidenced by:
	Complies with Charitable Choice statute.
	Supervision is Conducted:

How
By Whom _____

Comments:

Treatment/Service Requirements

	Each referral is provided an initial assessment. Assessment tool used:
	An individual treatment plan is developed for each client (with client signature).
	Services provided meet individual treatment needs.
	Individual counseling offered.
	Group counseling offered.
	Psycho-education curriculum is appropriate for population served.
	Collateral services provided as needed.
	Case management services provided.
	Counselors providing services participate in ongoing case management meetings.
	Continuing education available to staff .
	Demonstrates cultural competence in providing services (staff training required)..
	Program has access to interpreter services.
	Agency is trauma informed and/or implements trauma informed EBPs. (Please check which one below.) <input type="checkbox"/> Trauma informed
	Treatment services are provided in accordance with evidence/research evidenced-based best practices as discussed in SAMHSA’s TIP and TAP series.
	Routinely makes TB services available for each SA treatment client. (May be through referral.)
	Complies with opioid treatment standards. (Opioid replacement programs only.)

Comments:

General Service Standards

	Services provided in accordance with contract goals and objectives.
	Maintains value/respect for inherent dignity of each individual presenting for services

Program Documentation

	Client treatment records kept in accordance with industry standards
	Access to records controlled/recorded.
	Waiting list/referral procedures required by SAPTBG
	Waiting list form reviewed/maintained monthly
	Interim Services offered to those on waiting list (within 48 hours if pregnant substance abuser.)
	Interim Services include HIV counseling/testing services

Comments:

Tobacco Policy: "All agencies providing Mental Health and/or Substance Abuse Services under this agreement shall have a current written tobacco policy addressing:

- Inclusion of tobacco assessment and need for treatment in all plans of care.
- Annual screening of individuals receiving MH/SA services for tobacco use and dependence using best practice assessment protocols, tools, and procedures.
- Referral of individuals receiving MH/SA services to evidence-based tobacco cessation treatment
- Use of tobacco in agency facilities, on agency property, and at all locations in which services are delivered. At minimum, these policies shall comply with state tobacco laws (MSRA 22 §1580 A and §1541-1550).

These policies shall be reviewed annually with all staff and updated as necessary. Updates shall be submitted to the DHHS program administrator upon update.

Resources regarding tobacco screening, treatment and policies may be found at <http://www.maine.gov/dhhs/mecdc/population-health/hmp/ptm/> and <http://www.project-integrate.org/tobaccofreepolicies.html> "

Chart Review - Verify that the following items are documented in client charts.

Client ID: _____

	Client Rights
	Confidentiality/Restriction of Rights
	Program Rules
	Grievance process
	Releases of information meet 42 CFR requirements
	Date of Assessment (within 3 sessions) _____
	Assessment tool used _____
	Date of treatment plan (completed within 30 days of first session)
	Client signature on treatment plan
	Group Treatment provided
	Individual Treatment provided
	Collateral contact (as needed)
	Case management (as needed)
	Services provided meet individual treatment needs.
	Case notes refer back to goals and objectives in treatment plan.
	If CADC, treatment plan signed by supervisor
	If CADC, notes signed by supervisor

Comments:

Client ID: _____

	Client Rights
	Confidentiality/Restriction of Rights
	Program Rules
	Grievance process
	Releases of information meet 42 CFR requirements
	Date of Assessment (within 3 sessions) _____
	Assessment tool used _____

	Date of treatment plan (completed within 30 days of first session)
	Client signature on treatment plan
	Group Treatment provided
	Individual Treatment provided
	Collateral contact (as needed)
	Case management (as needed)
	Services provided meet individual treatment needs.
	Case notes refer back to goals and objectives in treatment plan.
	If CADC, treatment plan signed by supervisor
	If CADC, notes signed by supervisor

Comments:

Client ID: _____

	Client Rights
	Confidentiality/Restriction of Rights
	Program Rules
	Grievance process
	Releases of information meet 42 CFR requirements
	Date of Assessment (within 3 sessions) _____
	Assessment tool used _____
	Date of treatment plan (completed within 30 days of first session)
	Client signature on treatment plan
	Group Treatment provided
	Individual Treatment provided
	Collateral contact (as needed)
	Case management (as needed)

	Services provided meet individual treatment needs.
	Case notes refer back to goals and objectives in treatment plan.
	If CADC, treatment plan signed by supervisor
	If CADC, notes signed by supervisor

Comments:

Client ID: _____

	Client Rights
	Confidentiality/Restriction of Rights
	Program Rules
	Grievance process
	Releases of information meet 42 CFR requirements
	Date of Assessment (within 3 sessions) _____
	Assessment tool used _____
	Date of treatment plan (completed within 30 days of first session)
	Client signature on treatment plan
	Group Treatment provided
	Individual Treatment provided
	Collateral contact (as needed)
	Case management (as needed)
	Services provided meet individual treatment needs.
	Case notes refer back to goals and objectives in treatment plan.
	If CADC, treatment plan signed by supervisor
	If CADC, notes signed by supervisor

Comments:

Client ID: _____

	Client Rights
	Confidentiality/Restriction of Rights
	Program Rules
	Grievance process
	Releases of information meet 42 CFR requirements
	Date of Assessment (within 3 sessions) _____
	Assessment tool used _____
	Date of treatment plan (completed within 30 days of first session)
	Client signature on treatment plan
	Group Treatment provided
	Individual Treatment provided
	Collateral contact (as needed)
	Case management (as needed)
	Services provided meet individual treatment needs.
	Case notes refer back to goals and objectives in treatment plan.
	If CADC, treatment plan signed by supervisor
	If CADC, notes signed by supervisor

Report:

Class Member Treatment Planning Review

Review Date: _____ Region: 1 2 3 CSN: 1 2 3 4 5
 6 7

Time Spent: _____

Reviewer: Last Name: _____ First Name: _____

Client: Last Name: _____ First Name: _____ MI: _____

DOB: _____ SS# _____ AMHI Class? Yes ___ No ___

Case Manager: Last Name: _____ First Name: _____

Agency: _____ Site: _____

Program Type: CI ICM ICI ACT

Date(s) of Treatment Planning Review: From _____ To _____

I. Releases:

a. Does the record document that the agency has planned with and educated the consumer regarding releases of information at Intake/Initial treatment planning process?

Yes No Evidence Found N/A, intake/initial treatment plan more than 1 year old

EVIDENCE: _____

Notes: _____

b. Does the record document that the agency has planned with and educated the consumer regarding releases of information during each Treatment Plan review?

Yes No Evidence Found Initial Plan/90 day review not yet due

EVIDENCE: _____

Notes: _____

c. Does the record document that the consumer has a Primary Care Physician (PCP)?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

d. If 'c' is Yes, has there been an attempt to obtain a release signed by the consumer for the sharing of information with the PCP?

Yes No Evidence Found N/A ('c' is no)

EVIDENCE: _____

Other (specify) _____

Notes: _____

II. Treatment Plan:

a. Does the record document that the domains of housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional/psychological and psychiatric were assessed with the consumer in treatment planning?

Yes No Evidence Found

Note: If 'no evidence found', plan of correction is required - complete Section VI a.1.

EVIDENCE: _____

Notes: _____

b. Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

c. Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

d. Does the record document that the individual's potential need for crisis intervention and resolution services was considered with the consumer during treatment planning?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

e. Does the record document that the consumer has a crisis plan?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

- f. If 'e' is No, is the reason why documented?
 Yes No Evidence Found N/A ('e' is yes)
EVIDENCE: _____
 Other (specify) _____
 Notes: _____

- g. If 'e' is Yes, has the crisis plan been reviewed as required every 3 months?
 Yes No Evidence Found Initial Plan/90 day review not yet due N/A ('e' is no)
EVIDENCE: _____
 Notes: _____

- h. If 'e' is Yes, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?
 Yes No Evidence Found No psychiatric crisis during review period N/A ('e' is no)
EVIDENCE: _____
 Notes: _____

- i. Does the record document that the consumer has a mental health Advance Directive?
 Yes No Evidence Found
EVIDENCE: _____
 Notes: _____

- j. If 'i' is Yes, has the advance directive been reviewed at least annually by the CSW and consumer?
 Yes No Evidence Found A year has not passed since initiation N/A ('i' is no)
EVIDENCE: _____
 Other (specify) _____
 Notes: _____

- k. If 'i' is No, is the reason why documented?
 Yes No Evidence Found N/A ('i' is yes)
EVIDENCE: _____
 Other (specify) _____
 Notes: _____

III. Needed Resources:

a. Does the record document that natural supports (family/friends) are being accessed as a resource?

Yes No Evidence Found

EVIDENCE: _____

Other (specify) _____

Notes: _____

b. If 'a' is No, has the worker discussed with the consumer the consideration of natural supports as a resource?

Yes No Evidence Found N/A ('a' is yes)

EVIDENCE: _____

Other (specify) _____

Notes: _____

c. Does the record document that generic resources (those resources that anyone can access) are being accessed?

Yes No Evidence Found

EVIDENCE: _____

Other (specify) _____

Notes: _____

d. If 'c' is No, has the worker discussed with the consumer the consideration of generic resources as a resource?

Yes No Evidence Found N/A ('c' is yes)

EVIDENCE: _____

Other (specify) _____

Notes: _____

e. Does the record document a resource need that has not been provided according to/within the expected response time? (Expected response times are defined in column 2 of the attached Unmet Need Standards)

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

f. If 'e' is Yes, does the treatment plan reflect interim planning?

Yes No Evidence Found N/A ('e' is no)

EVIDENCE: _____

Notes: _____

g. If 'e' is Yes, does the record document that the treatment team reconvened after the unmet need was identified?

Yes No Evidence Found N/A ('e' is no)

EVIDENCE: _____

Other (specify) _____

Notes: _____

IV. Service Agreements:

a. Does the record document that Service Agreements are required for this plan? (See Paragraph 69 Protocol for Definitions)

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

b. If 'a' is Yes, have the service agreements been acquired?

Yes No Evidence Found N/A ('a' is no)

EVIDENCE: _____

Notes: _____

c. If 'a' is Yes, are the service agreements current?

Yes No Evidence Found N/A ('a' is no)

EVIDENCE: _____

Notes: _____

V. Vocational Services:

a. Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

b. Does the record document that the vocational domain is being addressed with the consumer at each 90-day treatment plan review?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

SUBRECIPIENT MONITORING WORKSHEET

Name of Subrecipient/Agency:		Federal Funding Source:	
Program Name:		State Funding Source:	
Address:		Federal Awarding Agency:	
City/State/Zip:		State Awarding Agency:	
Telephone & Fax:		Number of years Administering Program:	
Date of Last Site Visit:		Name of Front-line Manager:	
Date of Site Visit:		Name of Supervisor:	
Contact Person and Telephone #:		Person Responsible For Billing:	

Materials & Items on hand	Compliance? Yes / No / NA	Comments (attach additional sheets if necessary)	On previous report?	Corrective action necessary?	Date of Corrective Action
Copy of current DHHS contract on hand					
Copies of material correspondence with Department					

Audit:

Copy of most recent audit during grant/funding term, documenting receipt of specific grant/funding dollars					
Does subrecipient/agency's audit reflect any findings directly or indirectly pertaining to grant/funding?					
Does it appear the subrecipient/agency has begun to address these findings, if any?					

Materials & Items on hand	Compliance? Yes / No / NA	Comments (attach additional sheets if necessary)	On previous report?	Corrective action necessary?	Date of Corrective Action
Does the subrecipient/agencies audits necessitate adjustment of the pass-through entity's own records?					
Has subrecipient/agency permitted the pass-through entity to have access to all program and fiscal records and statements?					
Can subrecipient/agency document Federal award(s) by:					
Award name and number					
Name of Federal agency					
Code of Federal Regulation (CFR#)					
Code of Federal Domestic Assistance (CFDA# MHBG 93.958; PATH 93.150)					
Award year					
Has subrecipient/agency been advised and have copy of requirements imposed on them by:					
Federal laws (MHBG: Title 19 Public Health Service Act Subparts I, III, B; PATH: PHS 521)					
Provisions of contracts, MOU's, or Grant/Funding Agreements					
Provisions of supplemental requirements imposed by the pass-through entity					

Materials & Items on hand	Compliance? Yes / No / NA	Comments (attach additional sheets if necessary)	On previous report?	Corrective action necessary?	Date of Corrective Action
Does the subrecipient/agency have a written disaster plan?					
If yes, is the Agency Representative familiar with it?					
If no, is the subrecipient/agency developing a disaster plan?					
How many unduplicated individuals are receiving MH Block Grant funded services within the following categories:					
Have MaineCare					
Have Private Insurance					
Have No Insurance					
How many Unduplicated individuals have you served by category using MH Block Grant funds--define the services in each category:					
Case Management					
Medication Clinic					
Private Vendors					
Unknown					
Residential Treatment					
Mobile Outreach					
Transportation					

Materials & Items on hand	Compliance? Yes / No / NA	Comments (attach additional sheets if necessary)	On previous report?	Corrective action necessary?	Date of Corrective Action
Waitlist: do you keep a waitlist for Block Grant funded services? If so, how many persons are on it and what are the waitlist protocols					

Appendix V

Assessment Tools

Adult Needs and Strengths Assessment Tool

Who owns ANSA

The Praed Foundation is a public charitable foundation committed to improving the well-being of children and families. The Praed Foundation maintains the copyrights on the Child & Adolescent Needs and Strengths (CANS), the Family Advocacy and Support Tool, the Crisis Assessment Tool, and the Adult Needs and Strengths Assessment (ANSA) to ensure that they remain free for anyone to use who shares this commitment

What is ANSA

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA is currently used in a number of states and Canada in applications hospitals, emergency departments, psychosocial rehabilitation programs, and ACT programs.

The ANSA was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The original version, the Severity of Psychiatric Illness (SPI), was created in the 1990's to study decision-making in psychiatric emergency systems. The ANSA expands on the concepts of the SPI to include a broader description of functioning and include strengths with a recovery focus.

How Does ANSA Work

The ANSA is easy to learn and is well liked by recipients, family members, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to an individual and his/her family. The way the ANSA works is that each item suggests different pathways for service planning. There are four levels of each item with anchored definitions; however, these definitions are designed to translate into the following action levels (separate for needs and strengths):

For needs:

- a. No evidence
- b. Watchful waiting/prevention
- c. Action
- d. Immediate/Intensive Action

For strengths:

- a. Centerpiece strength

- b. Strength that you can use in planning
- c. Strength has been identified-must be built
- d. No strength identified

Decision support applications include the development of specific algorithms for levels of care including psychiatric hospitalization and intensive community services, and traditional outpatient care. Algorithms can be localized for sensitivity to varying service delivery systems and cultures.

In terms of quality improvement activities, a number of settings have utilized a fidelity model approach to look at service/treatment/action planning based on the ANSA assessment. A rating of '2' or '3' on a CANS needs suggests that this area must be addressed in the plan. A rating of a '0' or '1' identifies a strength that can be used for strength-based planning and a '2' or '3' a strength that should be the focus on strength-building activities.

Finally, the ANSA can be used to monitor outcomes. This can be accomplished in two ways. First, items that are initially rated a '2' or '3' are monitored over time to determine the percent of youth who move to a rating of '0' or '1' (resolved need, built strength). Or, dimension scores can be generated by summing items within each of the dimensions (Problems, Risk Behaviors, Functioning, etc). These scores can be compared over the course of treatment. ANSA dimension scores have been shown to be valid outcome measures in hospital, partial hospital, psychosocial rehabilitation, and intensive community services.

The ANSA has demonstrated reliability and validity. With training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications require a higher degree. The average reliability of the ANSA is 0.75 with vignettes, 0.86 with case records, and can be above 0.90 with live cases. The ANSA is auditable and audit reliabilities demonstrate that the ANSA is reliable at the item level. Validity is demonstrated with the ANSA relationship to level of care decisions and other similar measures of symptoms, risk behaviors, and functioning.

The ANSA is an open domain tool that is free for anyone to use. There is a community of people who use the ANSA and share experiences and additional items and supplementary tools.

What Service in Maine is the ANSA used

Currently Residential Services is the only service where ANSA data is being collected. It is done at admission either by the hospital (if the Consumer is in the hospital) or by the agency where the Consumer is being admitted and then completed once a year after that.

What Next

None of the data collected is being used to determine level of service required by an individual. The Office of Quality Improvement has done a Cluster/Factor Analysis and plan to do an update in August. They are using 3 different levels of severity. Indiana has done some work on severity scales. (Carlton)

The Office of Child and Family Services is going to start using the Child and Adolescent Needs and Strengths.

Other States

Indiana uses the ANSA across all services. They have developed an Algorithm through a contracted service in conjunction with Betty Walton. All their providers submit their ANSAs through a portal and then the Algorithm is applied and the provider gets information regarding which level of service the client needs.

Allegany County in Pennsylvania is using the ANSA for Community Integration. Orange County in California, San Francisco, and Virginia are also using ANSA.

Level of Care Utilization System (LOCUS) Implementation: Summary and Procedures

Brief Purpose:

The American Association of Community Psychiatrists (AACCP) developed the Level of Care Utilization System (LOCUS) as a tool to provide mental health clinicians and service providers with a systematic approach to the assessment and determination of the service and support needs of individuals with mental health challenges.

The LOCUS tool is used in Maine for the following purposes:

1. Guide and support clinical decisions on the appropriate level and intensity of consumer supports and services;
2. Support and inform the development of Individualized Support Plans (ISPs);
3. Inform and guide program and system planning and development activities;
4. Act as a component of eligibility criteria for specific MaineCare Services

It is important to note that the LOCUS is not to be used in place of clinical judgment, but as a tool to support and guide clinical and support decisions.

Description of the LOCUS

This instrument is used to derive level of service intensity appropriate to an individual's needs. It includes two primary components; 1) an assessment of the individual along six dimensions (i.e. Risk of Harm; Functional Status; Medical, Addictive and Psychiatric Co-Morbidity; Recovery Environment–Stressors and Supports; Treatment and Recovery History and Attitude and Engagement; and 2) a structured decision making guide that uses assessment results to determine an appropriate Level of Care for Services. The LOCUS specifies six Service Levels. Each assessment dimension is rated from least to most acute using a five-point scale. The rater, based on knowledge of the consumer, completes the assessment. Summing the individual dimension ratings generates the composite score.

Who is assessed?

The LOCUS is intended for use with Adults 18 years and older experiencing mental health challenges in the following service areas:

1. All services (including Community Integration Services, Community Rehabilitation Services, Assertive Community Treatment, Daily Living Support Services, Skills Development Services, Day Supports Services and Specialized Group Services) provided through MaineCare Chapter II, Section 17;
2. Residential Treatment, provided through MaineCare Section 97, Adult Mental Health Private Non-Medical Institution Services (PNMIs); and

3. Psychiatric Nursing/Psychotropic Medication Services provided through MaineCare Chapter II, Section 40 Home Health Services

Who Completes The LOCUS?

It is expected that service providers will use existing intake/assessment tools and procedures to gather the information necessary to complete the LOCUS. The LOCUS is completed by a Mental Health Professional (see MaineCare Benefits Manual, Chapter II, Section 17.09), Community Integration/ACT Worker or MHRT-C. Individuals shall only use the LOCUS after they have received training and met the reliability criteria. Some of the licenses and qualifications of those who can use the LOCUS include; CRC, LCPC, LCSW as well as APR-N or an RNC within Psychiatric Nursing.

When is the LOCUS Completed?

The LOCUS is completed as part of the service enrollment process. After the initial assessment the consumer is reassessed on an annual basis and upon exit from services. As of 7/1/13, consumers receiving Daily Living Support Services must be reassessed at six month intervals. To maximize the usefulness of this tool, service providers are strongly encouraged to reassess an individual's status whenever major transitions or life changes warrant reassessment (i.e., crisis, major life change, etc.).

Training Process:

Training is essential to ensure the appropriate use of these tools. The training has two components;

1. a three to four hour training session that includes instruction on the content and administration of the LOCUS and hands on practice using the tools, and
2. a reliability check in which each trainee will be required to score four vignettes using the LOCUS. Individuals' scores are then checked against pre-determined "gold standard" scores and criteria for each of the vignettes.

Agency trainers are required to train within their sites and at times within their regions. The Department's Office of Adult Mental Health Services is responsible for performing reliability checks and providing corrective feedback to individuals and site trainers.

ADULT LOCUS SCORING SHEET

Adult Level of Care Utilization System

Consumer Name: _____ Assessment Date: _____

Client ID Number: _____ DOB: _____

LOCUS Administration: Baseline or Entry into Service Annual

Exit from Service Other (Specify): _____

						Score
1. Calculation of LOCUS Composite Score						
Dimension	Dimension Ratings (circle score)					Rating
I. Risk of Harm	1	2	3	4*	5	
II. Functional Status	1	2	3	4*	5	
III. Medical, Addictive and Psychiatric Co-Morbidity	1	2	3	4*	5	
IV. Recovery Environment						
A. Level of Stress	1	2	3	4	5	
B. Level of Support	1	2	3	4	5	
V. Treatment and Recovery History	1	2	3	4	5	
VI. Attitude and Engagement	1	2	3	4	5	
Composite LOCUS Score (Add numbers in right column)						
2. LOCUS - Derived Level of Care Recommendation: (consult Determination Grid)						

Notes:

- Bolded Dimension Ratings indicate Independent Criteria (IC). When IC is met, admission to the designated level is required regardless of the Composite Score.
- ***Risk of Harm:** Assign to **Level V** if scale score is 4; Assign to **Level VI** if scale score is 5).
- ***Functional Status and *Co-Occurring Conditions (Co-Morbidity):** Assign to **Level V** if scale score is a 4 and the sum of IVA (Level of Stress) and IVB (Level of Support) is greater than 2; Assign to **Level VI** if scale score is 5
- **Exception:** If the functional Status and/or the Co-Occurring Score is 4 and the sum of IVA and IVB is 2, the Composite Score determines level of care.

Rater Signature & Credentials

Rater ID Number

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁵ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

⁷⁶ <http://www.samhsa.gov/trauma-violence/types>

⁷⁷ <http://store.samhsa.gov/product/SMA14-4884>

⁷⁸ *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

Footnotes:

Since 2002, Maine has implemented and continues to support a Trauma Informed System of Care.

Overview of Maine's Systems of Care:

Maine has a historical commitment to system of care development, and has brought forward key components to integrate in statewide expansion. Maine was one of the first states to receive a Child and Adolescent Service System Program Grant (CASSP) in 1984, yielding a comprehensive mental health system for children, adoption of the original system of care principles by the Bureau of Children with Special Needs, and wraparound training for mental health providers and schools. Family involvement and strength-based practices were enhanced as well. Flexible funding and respite services became standard parts aspects of the service array. In 1993, four rural counties were awarded one of the first "System of Care" grants: Wings for Children and Families included family members as 50 percent of the board of directors, as advocates and professional care managers. Another component was Kmihqitahasultipon ("We Remember") a Maine Native American initiative developed by the Passamaquoddy Tribe, including case managers and in-home services staffed by Native Americans, resulting in a 90 percent reduction in the number of children treated outside the tribal area with no hospitalizations in the last three years of the grant. From 1993 through 1998, Maine's Infrastructure Grant through the Center for Mental Health Services supported the development of Local Case Resolution Committees statewide, with parents financially supported to participate. By 1999, the Division of Juvenile Services partnered with CBHS to secure funding for the co-location of mental health services in Juvenile Development Centers and district offices. Then, in 2006, Maine received the Trauma-Informed System of Care grant, called the THRIVE Initiative, which served as the model for Expand ME, a System of Care Expansion Planning grant awarded to Maine in 2011. Maine was one of 24 planning grant recipients; this award was instrumental in the development of a Systems of Care Implementation. The hallmarks of the THRIVE Initiative are as follows:

1. Inclusion in all CBHS contracts the requirements to adopt system of care principles in policies, procedures, and public documents;
2. Provision of recorded training materials and agency specific trainings about systems of care principles and trauma-informed care.
3. Inclusion of trauma-informed system of care in MaineCare (Maine's Medicaid) services policy language.

4. Inclusion of youth and family members in advisory and governing groups for statewide initiatives including Wraparound Maine, CBHS Continuous Quality Improvement Program, Youth Outcome Questionnaire, Maine Managed Care Initiative, Evidence Based Practices Committee, and APS Healthcare Administrative Services Member Advisory Council.
5. Learning Collaborative on Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy
6. Delivery of trauma-informed training to Child Welfare staff.
7. Joining together seven state family organizations in one entirety: The Maine Alliance of Family Organizations (MAFO) with monthly Office of Child and Family Services meetings.
8. Creation of Maine's first statewide youth organization for youth with behavioral health challenges: Youth MOVE Maine.

The focus of the implementation grant is to take the trauma-informed work of the seven years prior to its implementation, and scale them up with a particular focus on the Department of Corrections' Division of Juvenile Services. The purpose of this project is to further expand the trauma-informed system of care practices developed by THRIVE from three western Maine counties to the entire state, encompassing not only the 142 agencies who deliver mental health services but also to youth, providers, and staff of Juvenile Services. The service population for direct intervention is youth ages 12-20, diagnosed with a serious emotional disturbance, whose offenses have placed them on informal adjustment, probation, or community reintegration from one of Maine's correctional facilities located in Regions 1 and 3. Expansion of trauma-informed work includes: modifying the trauma-informed assessment for Juvenile Justice; assisting in the development of trauma screening; supporting the delivery of trauma-informed wraparound; and funding family and youth support partners.

The objectives of the implementation grant are:

1. Create an infrastructure within Juvenile Services for providing trauma-informed system of care services by: a) assessing Juvenile Service policies, practices, and tolls to assure they follow trauma-informed system of care principles; b) assisting Juvenile Services with modifying its practices to be trauma-informed at the state/policy level, the provider agency level, and at the direct contact service delivery level as perceived by youth and families; c) enhancing the national Performance Based Standards (PbS) system to include trauma-informed elements in both assessment and continuous quality improvement; d) administering the modified PbS tool to the juvenile justice community and correctional staff statewide and piloting the national PbS family tool; e) reviewing service array with the Office of Child and Family Services to include:

TARGET, Collaborative Problem Solving, Multisystemic Therapy, Multidimensional Foster Care and Trauma Focused Cognitive Behavioral Therapy, and Restorative Circles.

2. Ensure that youth involved with juvenile justice are screened, assessed, and referred to effective services in a way that promotes family-driven and youth-guided principles and is culturally responsive to minority youth by: a) implementing screening and assessment tools including the YLS_CMI at first point of contact to better determine appropriate services with the demonstration project focusing on Northern and Southern Maine (Regions 1 and 3); b) Utilizing trauma-informed Wraparound with fidelity as a portal for the system of care for youth in Northern and Southern Maine who qualify through a diagnosis of serious emotional disturbance; c) developing a youth module to Wraparound to better meet the needs of youth; and, d) assigning a Community Partner (either Family Support, Youth Support or Cultural Broker) to work with juvenile services staff and youth prior to discharge from a facility and in subsequent years on informal adjustment or probation.

3. Enroll 50 youth in Year 1 and 100 each year thereafter in the evaluation to assess trauma exposures; benefits of partnering with family and youth at referral and reintegration; improved screening and assessment including trauma elements; and use of trauma-informed services.

4. Reinforce trauma-informed system of care practices statewide to all 142 mental health agencies serving Maine and military partners through continued assessment, training/technical assistance, CQI and social marketing activities by: a) re-administering the trauma-informed agency assessment to all mental health agencies; b) supporting Continuous Quality Improvement activities based on each agency's own trauma-informed assessment; c) providing training and technical assistance to mental health agencies and outreach to pediatric practices and special health care providers working with military families; d) developing statewide Learning Collaborative and train the trainer opportunities to support trauma-informed practices; e) reviewing Maine Medicaid policy and regulations and exploring Medicaid, State General Funds, and Block Grant Dollars for sustainability; f) providing community education and social marketing, including digital stories and tip sheets to mental and physical health providers and military families to raise awareness about the impact of traumatic events on mental health; and, g) disseminate trauma-informed SOC practices nationally through partnership with the juvenile corrections standards setting group, PbS Learning Institute, Inc.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

Footnote:

Maine has several programs in supporting care coordination to promote pre-sentencing diversion activities and special courts set up for co-occurring disorders. The Maine Co-Occurring Disorders Court (MCOCD) was initiated in June 2005. A federal grant from the Bureau of Justice Assistance supported the expansion of the Court. Due to the successful experience of the Court, additional federal funding was sought and received from SAMHSA to serve more clients in Kennebec County and to expand into Somerset County in the winter of 2008. Additionally, case management and treatment services have been enhanced to address criminogenic risks and needs in the target population. MCOCD graduates report that the Court has helped them turn their lives around and that they are now sober, law-abiding, and productive citizens of Maine. This Court provides judicial oversight, strict monitoring, rapid access to specialized treatment, and case management services in lieu of jail. Decisions are made by a multi-disciplinary team including the judge, prosecutor, clinician, and a case manager, among others. The MCOCD preserves public safety by establishing close monitoring of the participant in the community, required compliance with the program to remain in the community, and consequently breaks the cycle of repeat offending rooted in untreated mental illness and substance abuse.

Maine Pretrial Services (MPS) is a non-profit agency providing pretrial bail supervision of defendants who are charged with crimes or probation violations and might otherwise have to wait in jail until trial. MPS currently provides pre-arraignment screening and risk assessment, release and supervision, Title 30-A home release programming, case management for all of Maine's Adult Drug Treatment Courts, Co-occurring Disorders Court, Hancock County Deferred Sentencing Project, deferred disposition and administrative release supervision.

As discussed in the previous section (Trauma) the focus of the implementation grant received by Maine in 2011, was to take the trauma-informed work of the seven years prior to its implementation, and scale them up with a particular focus on the Department of Corrections' Division of Juvenile Services. The purpose of this project was to further expand the trauma-informed system of care practices developed by THRIVE from three western Maine counties to the entire state, encompassing not only the 142 agencies who deliver mental health services but also to youth, providers, and staff of Juvenile Services. The service population for direct intervention is youth ages 12-20, diagnosed with a serious emotional disturbance, whose offenses have placed them on informal adjustment, probation, or community reintegration from one of Maine's correctional facilities located in Regions 1 and 3. Expansion of trauma-

informed work includes: modifying the trauma-informed assessment for Juvenile Justice; assisting in the development of trauma screening; supporting the delivery of trauma-informed wraparound; and funding family and youth support partners.

The objectives of the implementation grant were:

1. Create an infrastructure within Juvenile Services for providing trauma-informed system of care services by: a) assessing Juvenile Service policies, practices, and tolls to assure they follow trauma-informed system of care principles; b) assisting Juvenile Services with modifying its practices to be trauma-informed at the state/policy level, the provider agency level, and at the direct contact service delivery level as perceived by youth and families; c) enhancing the national Performance Based Standards (PbS) system to include trauma-informed elements in both assessment and continuous quality improvement; d) administering the modified PbS tool to the juvenile justice community and correctional staff statewide and piloting the national PbS family tool; e) reviewing service array with the Office of Child and Family Services to include: TARGET, Collaborative Problem Solving, Multisystemic Therapy, Multidimensional Foster Care and Trauma Focused Cognitive Behavioral Therapy, and Restorative Circles.

2. Ensure that youth involved with juvenile justice are screened, assessed, and referred to effective services in a way that promotes family-driven and youth-guided principles and is culturally responsive to minority youth by: a) implementing screening and assessment tools including the YLS_CMI at first point of contact to better determine appropriate services with the demonstration project focusing on Northern and Southern Maine (Regions 1 and 3); b) Utilizing trauma-informed Wraparound with fidelity as a portal for the system of care for youth in Northern and Southern Maine who qualify through a diagnosis of serious emotional disturbance; c) developing a youth module to Wraparound to better meet the needs of youth; and, d) assigning a Community Partner (either Family Support, Youth Support or Cultural Broker) to work with juvenile services staff and youth prior to discharge from a facility and in subsequent years on informal adjustment or probation.

3. Enroll 50 youth in Year 1 and 100 each year thereafter in the evaluation to assess trauma exposures; benefits of partnering with family and youth at referral and reintegration; improved screening and assessment including trauma elements; and use of trauma-informed services.

4. Reinforce trauma-informed system of care practices statewide to all 142 mental health agencies serving Maine and military partners through continued assessment, training/technical assistance, CQI and social marketing activities by: a) re-administering the trauma-informed agency assessment to all mental health agencies; b) supporting Continuous Quality Improvement activities based on each agency's own trauma-informed assessment; c) providing training and technical assistance to mental health agencies and outreach to pediatric practices

and special health care providers working with military families; d) developing statewide Learning Collaborative and train the trainer opportunities to support trauma-informed practices; e) reviewing Maine Medicaid policy and regulations and exploring Medicaid, State General Funds, and Block Grant Dollars for sustainability; f) providing community education and social marketing, including digital stories and tip sheets to mental and physical health providers and military families to raise awareness about the impact of traumatic events on mental health; and, g) disseminate trauma-informed SOC practices nationally through partnership with the juvenile corrections standards setting group, PbS Learning Institute, Inc.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

Footnote:

In 2002, Maine was one of the first states in the nation to formally introduce and pass legislation regarding Mental Health insurance parity. In effect, the Maine Mental Health Parity law mandates offering coverage for all individuals and group plans for serious mental illness and for them to be paid at a rate equal to physical health. There are a few exceptions to this law, such as employers with fewer than 20 employees. In 2013, the Obama administration issued clarity on how the parity law should be implemented. While Maine has had a parity law in place for quite a while, there is still much effort being put forth to address the shortage of psychiatrists in the state that are needed to provide services for mental health and substance abuse treatment. In the past, payment rates to psychiatrists have been so low, that they have effectively minimized coverage. There is still a shortage of psychiatrists in Maine for both children and adults.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Footnote:

Maine's current system consists of Crisis Intervention Telephone Response, Mobile Response, and Crisis Stabilization-Residential Service.

Crisis intervention services has a statewide toll free crisis hotline number as the telephone response component. This is the client's first point of entry with crisis services where they are connected to needed resources upon the time of the call. If the caller's needs cannot be resolved over the phone, then they are connected to Crisis Mobile response.

Crisis Intervention-Mobile Response services are immediate, crisis-oriented, on-scene services positioned toward stabilization of an acute emotional disturbance to ensure the safety of a consumer, and the community, in the least restrictive setting with an emphasis that emergency rooms are to be used as a last resort for crisis response.

The goal of Mobil Response is to provide on-scene interventions, de-escalation, stabilization, recovery, and follow-up services within a short-term treatment modality. Mobil Response workers have access to psychiatric consultation during the initial assessment 24 hours a day, 7 days a week.

Crisis Stabilization/Residential services are short term, highly supportive, supervised residential settings for individuals experiencing psychiatric crisis. These facilities are utilized for clients experiencing acute psychiatric episodes who require a step-down level of care; alternative to inpatient hospitalization. These services are also provided 24 hours per day, 7 days a week, with access to psychiatric consultation.

Maine is working on enhancements to each program for better quality service and performance outcomes by implementing SAMHSA's "Core Elements in Responding to Mental Health Crisis" and through implementation of problem solving intervention models.

Maine's Crisis Services Programs are expected to be out for RFP within fiscal year 2016.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

Footnote

Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (SAMHSA, 2012). In September 2011 SAMHS published Mental Health Services: Practice Guidelines for Recovery-Orientated Care this document outlines 5 Practice Guideline Domains guided the feedback of consumer and family members. The Domains recognize that Recovery Orientated Care is Consumer Driven, Maximizes Natural Supports and Settings, Person Centered, Timely, Responsive, and Trustworthy as well as Effective, Equitable and Efficient.

SAMHS continues to work systemically and collaboratively with Consumer, Family Member and Provider Stakeholders on policy, program development and implementation efforts intended to more fully realize a community based system of recovery- orientated services and supports.

As an organization SAMHS has integrated staff members that identify as having lived experience with mental health and/or substance use recovery- this includes managerial positions. SAMHS promotes the practice of Peer Support as a vital component in a recovery orientated care system. The Maine Intentional Peer Support Training and Certification program provides specialized training for individuals to work as Peer Support Specialists in various mental health program modalities throughout the continuum of care. Programs that staff trained Peers include Certified Intentional Peer Support Specialists (CIPSS) include Assertive Community Treatment (ACT), Integrated Behavioral Health Homes, a Statewide Warm-line, Peer Run Crisis Respite, Peers in Emergency Departments, PATH and Peer Support at Riverview Psychiatric Center State Hospital.

SAMHS employs person centered service strategies focused on improving community outcomes by supporting program modalities that lower barriers to service access such as societal stigma and lack of resources. Housing First is an example of such a strategy, the Bridging Rental Assistance Program (BRAP), provides rental supports targeted to individuals being discharged from acute hospitals as well as residential treatment options. These Olmstead friendly housing vouchers provide consumers with choice, independence, and control over where they live and what services they choose to receive while simultaneously providing the hospital system and residential treatment facilities with a back door to facilitate discharges in a timely manner.

SAMHS supports the implementation of recovery practices and principles by funding workforce development training and technical assistance to Mental Health and Substance Abuse Providers through the Maine Behavioral Health Development Collaborative. This program provides online and in person training opportunities on topics related to Prevention, Intervention, Treatment and Recovery.

The State of Maine also supports the employment and the educational needs of individuals served through Community Support Services: Community Integration Services, Assertive Community Treatment, and Community Rehabilitation Services. Every 90 days, through the individual Support Planning process, individuals receiving these services are asked about their vocational status and about their unmet vocational needs. SAMHS funds specific employment services and collaborates with the Department of Labor and Vocational Rehabilitation to provide resources to address vocational needs.

The Community Service Network has Employment Specialists in mental health facilities that assist individuals living with SMI with securing employment and with additional employment issues as needed such as negotiating job accommodations and arranging for SAMHS funded Long Term Supported Employment Services. SAMHS contracts with Maine Medical Center Division of Vocational Services to embed Employment Specialists in seven mental health agencies across the state to serve Section 17 Community Integration clients. This service is a supplemental, not necessarily a replacement service for Vocational Rehabilitation services through the DOL. Total FY 15 allocation was \$544, 679 (state general funds), 367 unique individuals were served in FY 15 and 151 individuals were employed.

SAMHS Supported Employment (SE) Services (Long Term Support Services) provides individuals with SMI the support necessary to keep a job. This support may be provided on and/or off the job and is expected to decrease over time as the individual becomes accustomed to the job and as “natural supports” develop amongst coworkers, friends, and family. In FY14 184 individuals accessed this service. SAMHS currently contracts with 24 Community Rehabilitation Providers to deliver Long Term Supported Employment Services.

The SAMHS funded Work Incentives planning has five Community Work Incentive Coordinators (CWICS) that are available statewide to provide all Social Security beneficiaries with disabilities access to employment support services. This initiative is a collaboration between SAMHS, OADS, and the Department of Labor’s Bureau of Rehabilitation Services.

SAMHS also uses the clubhouse model for psychiatric rehabilitation, which helps support Clubhouse members with overcoming barriers to employment by offering a variety of services such as in-house prevocational programs, transitional employment, and competitive employment in the community with and without SE services. Prevocational programs give members the opportunity to contribute to the daily operation of the clubhouse on a volunteer basis while learning valuable job skills. Transitional employment offers members the change to work at temporary, part time jobs through Clubhouse partnerships with local employers, with on-the-job support from the Clubhouse and the employer. Members also work in permanent positions in the community, at a job of their choosing, with SE as needed. There are currently four clubhouses in Maine.

In addition, there are Employment Specialists who are part of ACT teams, as ACT teams are required to have Employment Specialists as part of the team. Contracts require that ACT teams meet the following obligations:

1. The ACT team shall assess vocational and educational needs of each consumer and explore a vocational goal on the Individual Support Plan (ISP) within 30 days of entering ACT service with all ACT consumers.
2. The ACT team shall have 1 FTE employment specialist per 50 ACT team consumers, and 90% of the ACT team Employment Specialist time will be spent on employment related activities.
3. The ACT Employment Specialist shall discuss different types of job settings that best match each consumer's interests/abilities, and provide employment supports as need to find, obtain, and keep competitive employment.
4. The ACT Employment Specialist shall assess for/update the status of the vocational goal on the Individual Support Plan at least every 90 days.

SAMHS also maintains a limited amount of funding for tuition assistance to support individuals living with SMI in pursuing the education needed to achieve their vocational goals.

Maine also has an employment Workforce Development System that is jointly funded by DHHS (SAMHS and OADS) and the DOL.

SAMHS and OADS contract with the Maine State Chamber of Commerce to maintain a state Business Leadership Network (BLN) affiliate. The Maine BLN is focused on assisting businesses with attracting and retaining new employees and customers with disabilities, developing business leaders who value diversity and actively work to promote strong communities that include individuals with disabilities, and increasing the opportunities for businesses to expand their diversity recruiting efforts. This is not in promotion of a particular social model, but rather as a business model that focuses on recruiting talent and helps to better serve their customers.

The Employment First Maine Act was enacted in 2013 that says that the first and preferred service option for persons with disabilities to be a choice of employment services that will support the acquisition of integrated community-based employment. This law established the Employment First Maine Coalition and is a collaboration of state agencies (DHHS, DOL, and DOE), advocacy groups, consumers, and providers.

Ongoing Stakeholder groups with a focus on employment include the Employment First Maine Coalition; Association of People Supporting Employment First; and the Mental Health Employment Promotion Collaborative. All of these groups include consumers.

Despite these numerous efforts to increase opportunities for individuals living with serious mental health conditions to engage in and maintain employment, employment rates for individuals receiving case management services such as Community Integration, ACT and Community Rehabilitation Services remain extremely low. SAMHS is continuing to identify avenues to support employment for persons served and will be putting additional focus in this area.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

17. Community Living and the Implementation of Olmstead

Footnote

In 1999, the United States Supreme Court issued its landmark decision in *Olmstead v. L.C. ex rel. Zimring*, requiring states to provide services to individuals with disabilities in the most integrated settings appropriate to their needs. In rendering its decision, the Supreme Court encouraged states to develop comprehensive plans for placing qualified disabled individuals in less restrictive settings. Maine undertook this work through collaboration between State departments, consumers, family members and advocates. This broad array of stakeholders, known as the Workgroup for Community Living, was charged with developing a coherent Olmstead plan for implementation for all of Maine.

The Workgroup released its final plan, titled *Roadmap for Change: Maine's Response to the Olmstead Decision*, in 2003. The product of three years' collaboration by the Workgroup, the Roadmap delivered a broad, detailed set of recommendations aimed at building on Maine's strong foundation for community integration of people with disabilities. The vision of the Workgroup—All of us together in community with equality in rights and dignity, in pursuit of happiness and fulfillment³ guided the group's effort and shaped the recommendations. The Roadmap details some 100 specific recommendations in all the important domains of a person's life, with a particular focus on improving access to community services, housing, transportation, and employment, as well as improving inter-departmental coordination. As a whole, the Roadmap sets out a framework to guide the development of public systems to serve people with disabilities living in communities. It also reorients the emphasis for individuals to move from institutional care to home- and community-based services and supports.

In 2013, a decade out from the publication of Maine's Roadmap, the Department of Health and Human Services issued an updated report to the initial plan. This particular report focuses solely on the status of services for individuals with intellectual disabilities or autism served by the Office of Aging and Disability Services / Developmental Services (OADS/DS) within DHHS. It is not a comprehensive review of the progress made by the State, or even inter-departmental efforts. Rather, it is a more targeted look at what has been accomplished by OADS/DS over the past decade and the challenges that still lie ahead for increasing community integration for people with intellectual disabilities or autism.

This report comes in two parts, the first of which is a comprehensive status update. The

Department gathered information from a wide array of sources in order to track progress against the original recommendations outlined in the 2003 Roadmap for Change: Maine's Response to the Olmstead Decision. This portion of the report is organized around the fourteen categories of recommendations laid out in the original Roadmap.

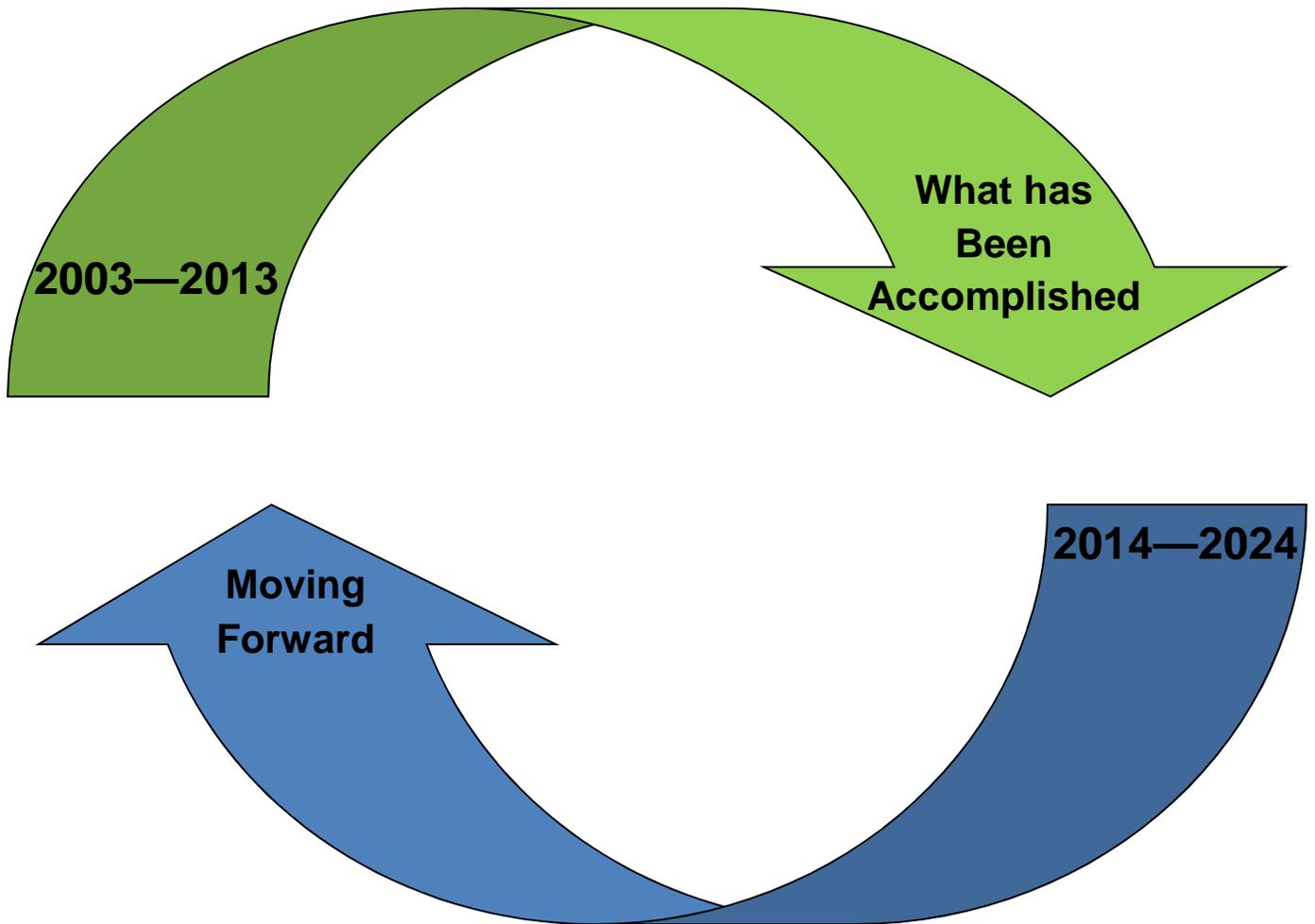
OADS/DS has made a great deal of progress on many of the categories, and still has ways to go to improve the system of services to enhance community integration for with intellectual disabilities or autism. As noted in the 2003 Roadmap, Maine has been moving in the direction of community integration for many years. The closure of Pineland was a significant impetus for the development of the community-based system. Maine was one of the early states across the nation to close its state institution for people with intellectual and developmental disabilities. Similarly, Maine's establishment of a comprehensive Home- and Community-Based Services waiver program for individuals with developmental disabilities individuals in 1983 was another milestone in building a community-based system that doesn't rely on institutional placement and improves services for people with disabilities. Those two significant events predate the timeframe for this report, but are clearly markers which set the direction for increased community integration for people with intellectual and developmental disabilities.

OADS/DS has continued to make significant decisions which have enhanced the efforts for community inclusion. Closing the State-run sheltered workshop and making the policy decision not to fund sheltered work demonstrated the State's strong commitment to work for people with disabilities in the most integrated settings. OADS/DS has also diversified and expanded its service system, adding, among many other things, a Supports Waiver to allow individuals capable of more independent living to thrive in the community.

The second part of this report details the Department's plan for continuing to strengthen community integration efforts over the coming decade. The plan touches upon several key areas, among them improving employment outcomes, building a better transition process for eligible youth moving to the adult service system, reducing wait lists for services, and improving access to health and dental care. While much has been accomplished there continue to be plenty of challenges. This review of progress has spurred new conversations and new thinking about the directions for future efforts.

Olmstead Roadmap for Change

Update for Developmental Services



Contents

Vision and Values 1

Introduction 2

Part 1: What Has Been Accomplished, 2003-2013..... 5

Consumer Voice and Organized Consumer Advocacy 5

Choice and Control..... 8

Person-Centered Services 11

No Wrong Door 13

Coherent System of Services..... 15

Responsive Service Coordination 16

Funding and Planning 18

Home- and Community-Based Service Waivers 20

Wait Lists..... 24

Availability of Direct Care Providers 26

Quality Services 30

Integrated, Accessible, Affordable Housing..... 31

Jobs..... 36

Part 2: How We Move Forward, 2014 – 2024 1

Introduction 1

Office of Aging and Disability Vision and Values

Mission:

We offer the highest level of independence, health and safety to older and vulnerable adults, and adults with disabilities.

Vision:

We promote individual dignity through giving respect, choice and support for all adults.

Values:

- Be centered on the person and focus on strengths and abilities
- Support each person to make their own informed choices
- Promote respect of adults and their valued roles within their communities
- Provide opportunities for quality employment that pays a fair wage and benefits
- Maximize opportunities for independence and self-sufficiency
- Provide quality case management services including conflict-free person centered planning
- Support and encourage family, friends and neighbors to help meet the individual's needs
- Ensure health and safety while promoting choices for new growth and development
- Build a coordinated, streamlined service and support system using resources wisely

Source: Maine DHHS, Aging and Disability Services. Service & Support Planning: Vision and Values. 2012. <http://www.maine.gov/dhhs/oads/disability/planning.shtml>¹

Introduction

In 1999, the United States Supreme Court issued its landmark decision in *Olmstead v. L.C. ex rel. Zimring*, requiring states to provide services to individuals with disabilities in the most integrated settings appropriate to their needs. In rendering its decision, the Supreme Court encouraged states to develop comprehensive plans for placing qualified disabled individuals in less restrictive settings. Maine undertook this work through a collaboration between State departments, consumers, family members and advocates. This broad array of stakeholders, known as the Workgroup for Community Living, was charged with *developing a coherent plan, across departments and programs, to make certain that the State is providing services to people with disabilities in the most integrated setting appropriate to the needs and preferences of the individual.*²

The Workgroup released its final plan, titled Roadmap for Change: Maine's Response to the *Olmstead* Decision, in 2003. The product of three years' collaboration by the Workgroup, the Roadmap delivered a broad, detailed set of recommendations aimed at building on Maine's strong foundation for community integration of people with disabilities. The vision of the Workgroup—*All of us together in community with equality in rights and dignity, in pursuit of happiness and fulfillment*³ guided the group's effort and shaped the recommendations. The Roadmap details some 100 specific recommendations in all the important domains of a person's life, with a particular focus on improving access to community services, housing, transportation, and employment, as well as improving inter-departmental coordination. As a whole, the Roadmap sets out a framework to guide the development of public systems to serve people with disabilities living in communities. It also reorients the emphasis for individuals to move from institutional care to home- and community-based services and supports.

Now a decade out from the publication of Maine's Roadmap, the Department of Health and Human Services is issuing this report as an update to the initial plan. This particular report focuses solely on the status of services for individuals with intellectual disabilities or autism served by the Office of Aging and Disability Services / Developmental Services (OADS/DS) within DHHS. It is not a comprehensive review of the progress made by the State, or even inter-departmental efforts. Rather, it is a more targeted look at what has been accomplished by OADS/DS over the past decade and the challenges that still lie ahead for increasing community integration for people with intellectual disabilities or autism.

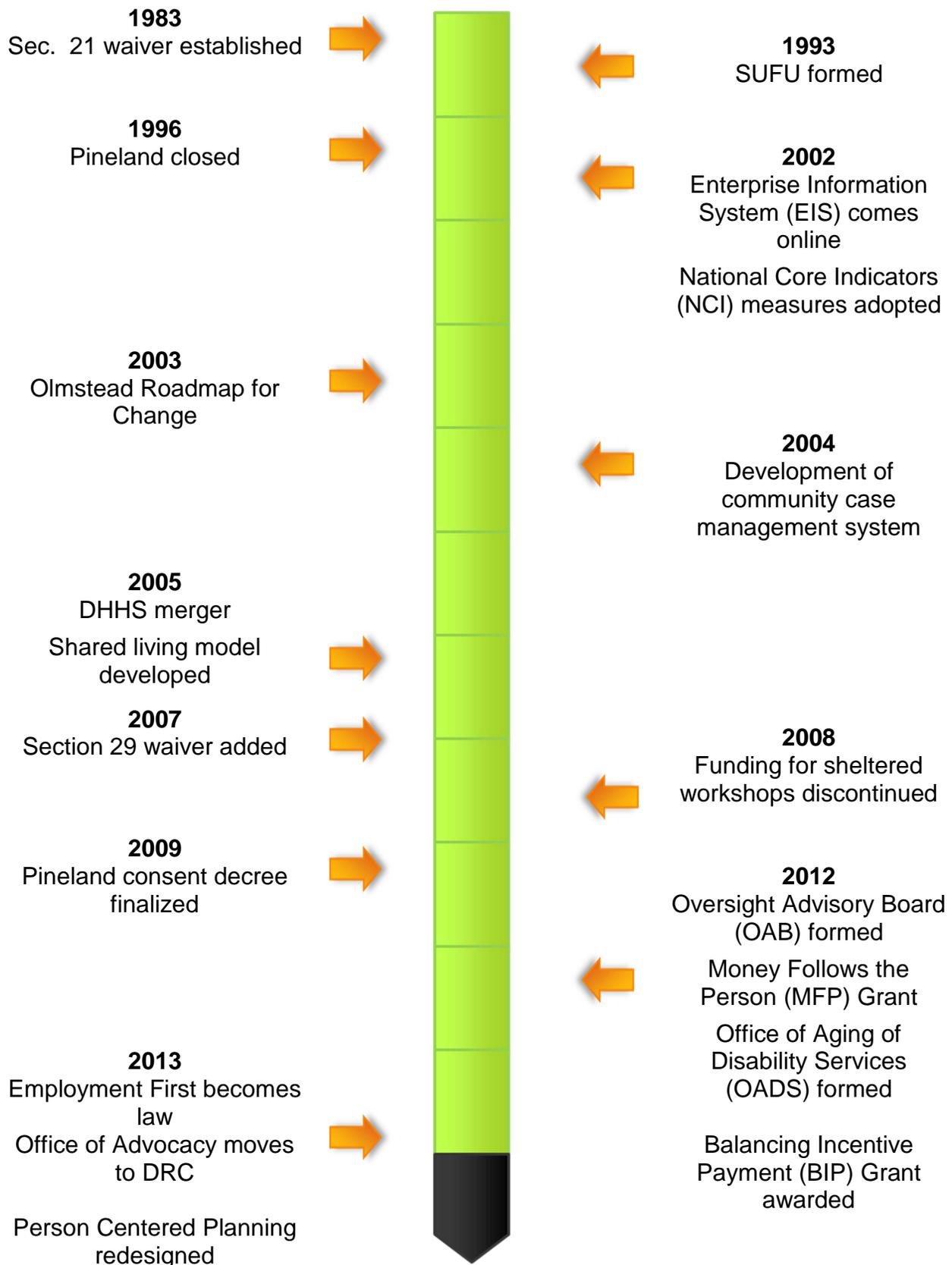
This report comes in two parts, the first of which is a comprehensive status update. The Department gathered information from a wide array of sources in order to track progress against the original recommendations outlined in the 2003 Roadmap for Change: Maine's Response to the *Olmstead* Decision.⁴ This portion of the report is organized around the fourteen categories of recommendations laid out in the original Roadmap.

OADS/DS has made a great deal of progress on many of the categories, and still has ways to go to improve the system of services to enhance community integration for people with intellectual disabilities or autism. As noted in the 2003 Roadmap, Maine has been moving in the direction of community integration for many years. The closure of Pineland was a significant impetus for the development of the community-based system. Maine was one of the early states across the nation to close its state institution for people with intellectual and developmental disabilities. Similarly, Maine's establishment of a comprehensive Home- and Community-Based Services waiver program for individuals with developmental disabilities in 1983 was another milestone in building a community-based system that doesn't rely on institutional placement and improves services for people with disabilities. Those two significant events predate the timeframe for this report, but are clearly markers which set the direction for increased community integration for people with intellectual and developmental disabilities.

OADS/DS has continued to make significant decisions which have enhanced the efforts for community inclusion. Closing the State-run sheltered workshop and making the policy decision not to fund sheltered work demonstrated the State's strong commitment to work for people with disabilities in the most integrated settings. OADS/DS has also diversified and expanded its service system, adding, among many other things, a Supports Waiver to allow individuals capable of more independent living to thrive in the community.

The second part of this report details the Department's plan for continuing to strengthen community integration efforts over the coming decade. The plan touches upon several key areas, among them improving employment outcomes, building a better transition process for eligible youth moving to the adult service system, reducing wait lists for services, and improving access to health and dental care.

While much has been accomplished there continue to be plenty of challenges. This review of progress has spurred new conversations and new thinking about the directions for future efforts. The Department invites comment from our stakeholders, which will play a critical part in shaping our future direction together.



Part 1: What Has Been Accomplished, 2003-2013

Consumer Voice and Organized Consumer Advocacy

At the very beginning of the 2003 Roadmap for Change; Maine's Response to the *Olmstead Decision*,⁴ the state is encouraged to seek out voices of people with disabilities and support consumer participation in policy-making and program development. Thirteen specific recommendations for improving consumer input and participation are offered, including recommendations for organizing consumer advocacy and increasing consumer leadership, advocacy supports and trainings. OADS/DS has made some progress on many of the recommendations and will continue to work on others.

Speaking Up for Us (SUFU)

Speaking Up for Us is Maine's self-advocacy network for people with intellectual disabilities and autism. First organized in 1993, SUFU trains and supports consumers to speak up for themselves in local, state, and federal policy arenas as well as in situations, such as Person-Centered Planning (PCP) meetings, where individual services and rights are at stake. SUFU provides a critical function by assuring that consumers have the skills, supports, and confidence to advocate for their interests at the individual and policy levels. SUFU is a member of Self Advocates Becoming Empowered (SABE), a national organization working for the full inclusion of people with developmental disabilities. OADS/DS supports SUFU through an annual contract. See SUFU website for more detailed information <http://sufumaine.org/>⁵

SUFU is a key resource for peer support and learning. The organization provides training and education aimed at enhancing individuals' abilities to advocate for themselves. Specific training programs range from Self-Advocacy and ADA Rights in the Community to skill-building programs on how to be an effective leader and/or a speaker. Developing leadership skills is a special priority area for SUFU, and the organization works with members to build leadership qualities through a variety of experiences. SUFU also holds regular conferences where members determine the topics and workshops based on the issues that are important to them. SUFU is a member of Self Advocates Becoming Empowered (SABE), a national organization working for the full inclusion of people with developmental disabilities. See <http://www.sabeusa.org/> for more information.⁶

OADS/DS senior staff are regularly present at SUFU workshops and attend SUFU meetings and conferences to hear directly from self-advocates about their concerns, suggestions and questions. SUFU representatives are consulted prior to major policy

and programmatic changes, with OADS/DS regularly seeking SUFU input and feedback on key issues. This two-way communication between OADS staff and SUFU is an important feedback loop to help assure that the services and supports offered meet the needs of the people served.

Consumer Participation

OADS/DS supports consumer participation in Departmental policy development using several strategies. In addition to contracting with SUFU, OADS/DS strives to ensure that written materials are available in plain language format and are accessible to a wide range of people-served. In partnership with MaineCare, all rules and communications are screened for readability. The Muskie School has also provided technical assistance in developing plain language materials. OADS/DS reimburses self-advocates for travel expenses related to participation in DHHS or OADS/DS approved meetings and/or events. These strategies help to reduce communication and financial barriers to participation.

Consumer Voice

Individuals are encouraged to register dissatisfaction with the Department's services, decisions, and/or providers using the OADS/DS's grievance process. OADS/DS regularly publicizes its grievance process to ensure that individuals are aware of their rights to file grievances. Every notice communicating an OADS/DS service decision contains information on the grievance process.⁷ Likewise, OADS/DS requires service providers to not only post notice of the Grievance Process in common areas but regularly remind individuals of their grievance rights and train all staff on the process. Additionally, OADS/DS offers a guide to the Grievance Process on its website, which outlines for consumers, family members and guardians how to proceed if they are unhappy with their services. Documents on the website include information about what a grievance is, who can help, the timeframe for solving problems, and levels of grievance up to the formal administrative hearing. Links to relevant statute and forms are included. The Grievance Process is an important mechanism for allowing consumers and their families to provide feedback on individual experiences. User-friendly forms and more information can be found at <http://www.maine.gov/dhhs/oads/disability/ds/grievance/home.html>

Consumer Input

OADS/DS meets quarterly with the following advocacy groups:

- The Developmental Disabilities Council,
- The Developmental Services Oversight and Advisory Board,
- The Disability Rights Center,⁸ and
- SUFU.

Part 1: What Has Been Accomplished, 2003-2013

These well-established linkages help ensure that consumers' voices are heard in the policy-making process and that problems with existing programs and policies are quickly brought to light.

The Maine Coalition for Housing and Quality Services (CHOM),⁹ a parent-led advocacy organization based in Portland, focuses on housing and quality services for people with intellectual and developmental disabilities. Comprised of self-advocates, family members, guardians and providers, this group meets regularly to advance important change initiatives. OADS/DS staff attend the meetings to provide information and solicit feedback on policy and program updates. In 2010, a subset of this group initiated ideas to redesign the service delivery system for people with intellectual disabilities and autism. Called the Continuum of Care model, this new service model puts the person at the center and examines the transition to adulthood with a goal of community inclusion maximizing natural supports within the community. The Continuum of Care Committee's work resulted in a whitepaper in 2011 and the development of legislation and action steps. OADS/DS is working collaboratively with CHOM as they redesign the service system to be more flexible and responsive to individual needs and preferences.

Change for Advocacy Office

Maine has long maintained a system of independent advocates to assist individuals with intellectual disabilities and autism in vindicating their rights. The Office of Advocacy, historically located within Maine DHHS (and the Department of Behavioral and Developmental Services prior to its merger with the Department of Human Services), was moved in 2013 to the Disability Rights Center, an independent non-profit organization that serves as Maine's protection and advocacy organization for people with disabilities. This move allows for a more independent relationship between the Office of Advocacy and OADS/DS and gives more autonomy to the consumer voice. As noted in the 2003 Work Group's recommendations, independent advocacy groups are necessary in order for consumers, family members, providers, and other stakeholders to challenge the State's positions without jeopardizing an organization's funding. The advocacy functions now conducted at the Disability Rights Center are partially funded through a contract with the State, but the Disability Rights Center is largely funded through federal grants and private donations. The Disability Rights Center's core mission is to protect individual rights and promote systems change.

Choice and Control

Self-determination was a dominant theme in the recommendations produced by the Work Group for Community Living and they identified policy and practice recommendations aimed at increasing consumers' control over their lives, and choices in services and supports. Specifically, the Work Group highlighted:

- Expansion of self-directed services
- Individual budgets for service purchases to meet their needs
- Independent employment management services
- Development of intermediate supports for people who don't want all the responsibility of self-direction.
- Development of standards for surrogate decision makers
- Strategies to reduce forced medications and involuntary hospitalization

OADS/DS has focused a great deal of attention in this area with significant policy changes that dovetail with many of the recommendations identified in 2003. Additional areas remain which continue to need attention.

Supporting Individual Success

Supporting Individual Success is currently a major initiative of OADS/DS. The aim of this initiative is to better match consumers' needs to resource allocation and continue to build a system that is person-centered and community oriented. Through these efforts individuals will get the services they require, no more and no less. And the system will be realigned to be more fair, efficient, sustainable and responsive to individual needs.

Individual standardized assessments are a central part of this effort. Trained interviewers use a standard assessment tool (the Supports Intensity Scale or "SIS,"¹⁰ which was developed by the American Association on Intellectual and Developmental Disabilities) to assess the support needs of individuals with intellectual and developmental disabilities served by the office. The results of those assessments are used to inform the Person-Centered Planning process and, in the near future, will be linked to resource levels. At the Person-Centered planning meeting individuals will have their assigned budget which they can use to purchase what they need from an array of services and providers.

The Human Services Research Institute (HSRI) has been a partner in this effort for the past four years. They analyzed expenditures and services for those individuals who received a SIS assessment prior to June 2013 in order to better understand how services, expenditures and assessed needs are currently aligned. In brief their study

Part 1: What Has Been Accomplished, 2003-2013

found that the SIS could be used to develop a resource allocation model in Maine. In addition the study allowed Maine to be placed in a national context. When compared to other states, Maine's population has somewhat lower scores on key SIS indicators and uses more residential habilitation services than other states. Their findings, published in a report dated June 2013, can be found at <http://www.maine.gov/dhhs/oads/disability/ds/sis/documents/Analysis-Expenditures-HSRI-Report.pdf>.¹¹

Using the findings, HSRI and OADS/DS have developed resource levels which take into account the individual's assessed needs, residential options and service packages that address those needs. In the future, individuals will be assigned to a level depending on the severity of their assessed need and living situation. At annual planning meetings individuals will know their funding level and will be able to choose services and supports to best meet their needs within their funding level and based on DHHS/OADS and CMS rules. Individuals will have much more control over the services they choose to meet their support needs as opposed to a one-size fits all approach of service delivery. This significant OADS/DS initiative holds a great deal of promise for transforming the current service system into one in which individual consumers have more control over their lives, and choices in their service packages.

See "Supporting Individual Success" section on the OADS website for further details on the initiative <http://www.maine.gov/dhhs/oads/disability/ds/sis/index.shtml>.

As part of this effort OADS/DS has undertaken a thorough analysis of the existing service system with an eye toward building a more flexible and responsive individualized system. This past summer through November 2013, OADS/DS staff led twelve separate discussions with a wide variety of stakeholders in order to elicit input regarding the Service Array. Participants were asked to comment on which services were working well and what services were either missing or inadequate. Data were collected and analyzed to inform future waiver amendments and other changes to help build a more flexible array of services to meet individual needs and preferences. As OADS/DS moves forward in re-designing the service system this information will continue to inform changes.¹²

Behavior regulations revised

In 2010, OADS/DS formed a Behavioral Regulations Committee¹³ in order to revise the regulation governing behavioral treatment for individuals with intellectual and developmental disabilities (Maine Regulation 14-197 C.M.R. Ch. 5). Among other things, this regulation outlines the process for approval of behavior management plans for individuals with intellectual and developmental disabilities, and implements Maine

Part 1: What Has Been Accomplished, 2003-2013

law regarding the Rights of Maine Citizens with Intellectual Disabilities or Autism at 34-B M.R.S.A. §§ 5601 *et seq.*

The Committee's overall goal was to improve Maine's system of monitoring and approval for behavioral treatment, behavioral management and safety plans in order to increase accountability and transparency. It focused on revising regulations so that they would reflect best practice by reducing the systemic use of restraint through increased use of positive behavioral supports, documented functional assessments, psychiatric medical support plans, and other clinical input. This has been a substantial effort and one that will result in significant revision to these regulations.

The membership of the Behavior Regulations Committee consisted of representatives from provider agencies, the Disability Rights Center, the Maine Psychological Association, the Consumer Advisory Board, and crisis workers, advocates, and other representatives from DHHS. Throughout the process the Committee also invited other stakeholders to participate and provide comment. The Committee met several times during this period and gathered extensive materials on best practices and policies from states, including New Mexico, Ohio, Vermont, and Washington.

Thirty-six attendees representing a broad array of stakeholders participated in this event including the Consumer Advisory Board, the Autism Society of Maine, the Maine Psychological Association, the Disability Rights Center, the Children's Center, the Center for Community Inclusion and Disability Studies, Speaking Up for Us in Maine, Maine's Developmental Disability Council, provider agencies, Maine's Office of Child and Family Services and OADS/DS met in June 2010 to provide input. Members facilitated a series of focus groups on five topic areas: *positive supports, environment and communication; medical treatment and medications; mental health and trauma; restrictions of rights (allowed/prohibited); and procedural requirements and review structure.* After a period of analysis and review the Committee used the information gathered to develop draft regulations.

The Behavioral Regulations Committee reconvened these stakeholders in a follow-up meeting in November 2010 to review the draft regulations and gather additional feedback. Their feedback was reviewed and analyzed and used to develop the latest version of *Draft Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine.*

In 2011 the Behavioral Regulations Committee established a hierarchy of review for the use of safety devices for persons with developmental disabilities. Those devices are defined by 34-B M.R.S.A. §5605(14-C) and distinguished safety devices under that law from mechanical supports, as that term is used in 34-B M.R.S.A. §5605(14-B). The

regulation also prescribes the frequency of review of the use of safety devices and the procedure for requesting approval for the use of safety devices. The Committee incorporated these regulations into the *Draft Regulations Governing Behavioral Support, Modification and Management for People with Intellectual Disabilities or Autism in Maine* in 2013. These regulations, which represent significant revision and are reflective of best practice in the field, are expected to be approved and implemented in 2014.

Crisis Services

OADS/Developmental Services has developed a comprehensive crisis response system available to anyone with an intellectual disability or brain injury that allows them to remain in their homes and local communities during and after a crisis. The crisis system is comprised of five major components: Prevention Services, 24-hour Crisis Telephone Services, Mobile Crisis Outreach Services, In-home Crisis Services, and Crisis Residential Services Through this system, assistance is provided to individuals, families, guardians, and providers.¹⁴

Person-Centered Services

Individualized, person-centered services were identified as a central pillar in the Workgroup's recommendations. Instead of a one-size fits all approach to services, the Workgroup recommended that the State implement a variety of strategies to enhance the person-centeredness across the systems. In particular the Workgroup identified:

- Organize services around the person
- Provide the option for one comprehensive resource plan
- Have an independent person facilitate the plan development
- Create accountability mechanisms
- Adopt accountability standards that allow consumers to actively participate in planning, register complaints, make informed choice and document progress.

OADS/DS has had a highly developed person-center planning process for many years, recently there has been a significant effort to refine and enhance the model and process through creating new tools and enhanced training for staff.

Person-centered planning is an annual event for most consumers served through OADS/DS and is the foundation for individualized services (Those residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities or ICF/IID, or nursing facilities participate in planning processes led by staff from the facility). In the late 2005 into 2006, OADS worked with international leader and consultant John O'Brien to raise profile of the Person-Centered Planning process and provide training

for staff leading the process. O'Brien has been a pioneer and leader in Person-Centered Planning and Community Inclusion. His approach involves learning with each person what direction their lives could take and setting goals to overcoming barriers.¹⁵

OADS/DS uses the "Five Essential Service Accomplishments" framework developed by O'Brien to drive the individual planning process.¹⁶ The aim of this framework is to ensure that programs promote community participation and staff assists people with severe disabilities to form and maintain a variety of community ties. Consumers determine their goals, which are not services but are instead individualized, personal goals that the consumer wants to achieve and that give meaning to their life. Planning is facilitated and coordinated by case managers, who are independent of agencies providing direct services in order to enhance choice and control by the person served. The consumer and his/her family drive the planning process and are assisted to identify goals. The case manager ensures that the person understands available services and how they can be used to help the person meet their goals.

Redesigned Person-Centered Planning process

Maine's Person-Centered Planning (PCP) process is defined to ensure personal choice, self-direction and opportunities. At the same time it meets regulatory requirements, addresses the resource allocation process, communicates changes and ensures consistency and accountability.¹⁷

OADS/DS most recently updated the PCP process with new guidelines going into effect in November 2013. Significant changes include the role of case managers in coordinating the PCP. Case managers, who are not employed by agencies providing other services for the consumer, facilitate and coordinate the planning process. In this manner the consumer's needs and choices remain the focus of the planning effort and the case manager provides neutral, conflict-free facilitation as required by CMS. It is a universal plan design facilitated by the Enterprise Information System (EIS), OADS/DS's management information system, which links all providers to the plan.

Each provider constructs their portion of the approved plan created by the team to meet the needs and desires of the individual. The online plan is then used to account for performance and efforts made to meet the individual's needs. More than 1000 case management and direct service staff were trained during the fall of 2013 in the use of the universal PCP plan. (Email from Lisa Sturtevant, Employment Services Specialist, OADS, January, 2014).

Consumer Driven

The newly revised process for Person-Centered Planning describes how service recipients and their families are involved in the planning process.¹⁷ Persons receiving services from OADS/DS are the drivers of the planning process. The individual (and family or guardian as appropriate) determines who will participate in the planning meeting, where the meeting will be held and when. He/she also decides who facilitates the meeting itself. These changes help to ensure that the consumer is an active, as opposed to, passive participant in the planning process and enhances the voice of the consumer.

OADS/DS has a standard practice of collecting feedback from consumers. As stated in the PCP Instruction Manual each plan must include a description of how the Planning Team will evaluate the person's ongoing satisfaction with:

- 1) The planning process
- 2) The plan that is developed, and
- 3) The progress being made in accomplishing the goals in the plan.

For additional information on the PCP see

<http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/index.html>

No Wrong Door

The 2003 Workgroup envisioned a system of long term services and supports that was easy to understand and navigate for people needing services. Instead of the existing patchwork of services, they aimed their recommendations at creating a coherent system of services. Critical to that system are multiple entry points that are integrated, provide necessary information to persons needing services, streamline eligibility and are easy to navigate.

OADS/DS has made some progress on those recommendations and has undertaken additional efforts to achieve these goals.

Organizational Realignment

In 2004, Maine's legislature approved the merger of the two legacy agencies, Department of Human Services and Department of Behavioral and Developmental Services, into the Department of Health and Human Services (DHHS), creating a foundation for a more integrated and efficient service delivery system. This organizational restructuring brought the various offices providing services across the

long term services and supports systems under one roof, along with the regulatory functions, to create more opportunity for coordination and streamlining.

More recently, in an effort to promote further consolidation, the Office of Elder Services and the Office of Adults with Cognitive and Physical Disabilities merged and integrated their operations, programs and services into the Office of Aging and Disability Services (OADS) in September 2012. This move realigns the Office and combines district operations under one organizational structure, creates clear lines of communication, coordinates central and regional office functions, and establishes a unified program and service model. The mission of OADS is to promote the highest level of independence for older citizens and for adults with disabilities. The safety and well-being of vulnerable adults is a priority. Both of these organizational realignments have built strong infrastructure for better coordinated and integrated systems for long term services and supports.

Increasing Access to Community-Based Services

The Balancing Incentive Program (BIP)¹⁸ is recently awarded federal grant that OADS will employ to continue to re-shape the long term services and supports (LTSS) system. BIP is a federal program that offers an increase in federal funding for non-institutional long term services and supports provided through state Medicaid programs. In return, states that are awarded BIP funding make a commitment to structural changes in the LTSS system aimed at rebalancing the programs toward community settings.

Specifically, DHHS agreed to make the following changes:

- 1) A No Wrong Door-Single Entry Point System
- 2) Conflict-free case management services; and
- 3) A core standardized assessment.

Access to community-based services was one of the key areas of focus for the Work Group for Community Living. These three elements identified in the BIP are the foundation of an accessible system of services for elders and people with disabilities. With the enhanced BIP funding, OADS has additional resources to continue expanding community options for people with significant disabilities and complex needs.

Getting the Word Out

OADS, leading the BIP effort for DHHS, is working to expand streamlined infrastructure to provide easy access to information about long term services and supports and eligibility. Maine 211, the toll-free statewide directory for health and human services, is a principal component of the resource infrastructure. As the guidance from Centers for

Part 1: What Has Been Accomplished, 2003-2013

Medicare and Medicaid Services (CMS) sets out, states can develop their No Wrong Door –Single Entry Point using several mechanisms including coordinated networks of information and referral, an agency or organization or, portal. The goal is the same; to provide easily accessible information for persons in need of long term services and supports. Under the BIP program, DHHS will explore a partnership with Maine 211 to broaden the reach and make this vital service readily available to Mainers needing help to find resources and navigate the service system, 24 hours a day/ 7 days a week. The 211 system, staffed by trained call specialists and accessible either by phone or over the internet, provides access to a broad array of health and human services including those specific to people with intellectual and developmental services as well as many others.

As part of the BIP program, OADS is working with various partners—including, but not limited to, the Aging and Disability Resource Centers (ADRCs), Maine’s Center for Independent Living (CIL), supported by Alpha One, Long Term Care Ombudsman (LTCOP), community providers and Maine 211—to enhance their capacity to provide comprehensive and accurate information about options for LTSS. These community based agencies already provide coverage statewide and, with enhanced efforts under the BIP program, there is an opportunity to expand their visibility and expand the information on available LTSS resources for Maine citizens. Under the BIP, the ADRCs will serve as a hub where individuals can inquire about community LTSS and receive comprehensive information, eligibility determinations, options counseling and enrollment assistance. The overall intent is to make it easier for Maine citizens looking for long term services and supports to find the information they need. With BIP resources, OADS and its partners will conduct a marketing campaign to increase the public visibility of long term services and supports in an effort to increase awareness of these valuable resources for Maine citizens needing services.¹⁹

Coherent System of Services

Since 2002, OADS/DS has used the Enterprise Information System (EIS) for its information management system. The EIS is the single information management tool for OADS/DS, providing fully integrated information from planning to service delivery for consumers of intellectual and developmental disability services. Emergency intervention and protective services can be activated and tracked through the EIS application. OADS/DS management can view the plan, case management documentation and other service delivery information through this one tool. Community-based case management providers also use this application in order to maintain a comprehensive system for all case management across the intellectual and

developmental disability system. (Email from Terry Sandusky, Information Services Manager, OADS, February 2, 2014).

Since 2002, DHHS has expanded use of EIS within OADS and in the Office of Substance Abuse and Mental Health Services (for adult mental health) and the Office of Child and Family Services (for children's behavioral health services). Within OADS, EIS is used to manage information on consumers with intellectual and developmental disabilities, brain injury, and other related conditions, as well as for aging services. The OADS EIS user base extends to over 2,000 state and community provider staff including case management services, provider work services, financial services and quality assurance and improvement services. Among the information managed through EIS is Reportable Event/Incident Information; Adult Protective Services Investigation information (for individuals with intellectual or developmental disabilities); prior authorization for Home- and Community-Based Services; eligibility determinations; youth transition documentation; crisis services documentation; and general case management information. CMS has given federal certification to the EIS because of its extensive management of MaineCare services. The application is built on an Oracle 11g database platform and meets today's general business standards for scalability and flexibility in large web-based applications. (Email from Terry Sandusky, Information Services Manager, February 2, 2014).

Responsive Service Coordination

Service coordination is a big topic and one that often generates a great deal of passionate conversation. Individuals served and their families want reliable, accurate, up-to-date information on services and supports. They count on case managers to help navigate a still confusing array of services. As the Workgroup identified in its recommendations strategies for service coordination must take into account neutral and independent coordination with appropriate levels of training for staff providing these key functions. These significant challenges, which are being addressed, will continue to require attention and resources to improve quality and consistency.

Community-Based Case Management

At the time of the 2003 Roadmap, case management for intellectually and developmentally disabled individuals was provided exclusively by State employees. In 2004, OADS/DS expanded the case management system to include community-based, private providers. The development of the community-based case management system has grown rapidly over the past ten years, with currently over 60% of the targeted case management provided through the community-based system. To promote this expansion while assuring quality services, OADS has adopted a standard practice for

approving agencies seeking to provide case management services to consumers with intellectual and developmental disabilities. Approval requires completion of a certification process that includes all core agency business practices. OADS/DS requires the use of the EIS by all case management providers to assure consistency and compliance with case management standards. Quality service coordination through the use of a common application remains the goal in developing the conflict-free case management system. For detailed description see <http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/Certification/introduction.html>.²⁰

The expansion of the case management system has enhanced the system of service coordination for people receiving home- and community-based services and has responded to the need for conflict-free case management services. Quality assurance mechanisms built into the case management program include standard qualifications for case managers and supervisors. Since 2012, all newly hired State case managers must be licensed social workers. This new regulation raises the qualifications for those staff providing targeted case management and is part of the quality improvement strategy. The case management system meets the recently adopted federal requirements for conflict-free case management with case managers acting as neutral facilitators for planning and coordination of services. For additional information see <http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/standards2/eligibility.html>

Training to Enhance Quality

A trained and qualified workforce is a critical component of a well-functioning community-based system of services and supports for people with disabilities. Case managers providing targeted case management services either as State employees or through community-based agencies must meet the qualifications outlined in the MaineCare Benefits Manual, Section 13 (See Maine Care Benefits Manual, §13.07-2(B)).²¹ For many years, OADS/DS has provided regular orientation training for newly hired case managers. OADS/DS has identified the improvement of case management services as an objective in its recent Biennial Plan. Currently, OADS/DS holds quarterly training sessions at the district levels, which are required for all new hires. Content for each session varies, but includes topics relevant to case managers promoting effective service coordination and linkage. Recent topics have included Individual Rights, Behavioral Regulations and Person-Centered Planning. In addition, OADS/DS is planning to convene a Best Practices in Case Management Conference in the coming year to promote quality training for incumbent case managers. In order to keep improving the knowledge and skills of the case management workforce, OADS/DS will need a regularly updated training plan and resources for implementing it. (Email, Karen Mason, Program Manager, OADS, February, 20, 2014).

Opportunities for Improvement

Young people transitioning from children's services to the adult service system can be vulnerable to gaps in service. Differing eligibility criteria, different funding streams, different regulations, different array of services and authorizing entities all can contribute to a less than seamless transition for some. The issue has received concerted attention in past years, and OADS/DS has recently spearheaded a renewed effort to improve the transition system as well as the individual experience. In 2012, internal staff from DHHS's Office of Child and Family Services (OCFS) and OADS/DS met at the district level to plan for and coordinate transition activities for individual consumers. With parental permission, the two offices shared information to develop a plan to support smooth transition to adult services for youth nearing the end of high school. In 2013, OADS/DS and OCFS built a "Youth in Transition" interface within EIS. Through this mechanism, tracking and documentation of service needs begin for youth aged 16 and continue through their transition years until the move to adult services. This process captures the current services as well as documents the projected needs of the youth. The district coordination work provides the primary information needed to facilitate the youth's move to adult services, and answers some of the historical shortcomings of the transition process. More recently, representatives from SAMHS have also been included in these Transition Committee meetings in an effort to better coordinate services for consumers who may have more complex needs or co-occurring disabilities.

Transition Committee members continue to reach out to partners in the Department of Education and local schools to identify youth who may need long term services and supports and begin their transition planning well before they are ready to leave school. While this approach is demonstrating success, more attention is needed to create systemic solutions so that the transition pathways are clear, parents know what to expect in this arena and eligible consumers receive the necessary services in a timely manner.

Funding and Planning

Using Data to Plan and Measure Progress

The 2003 Roadmap recognized that reliable data on the needs of the people with disabilities in Maine is a critical prerequisite to effective service planning and accurate budget requests. This is nothing new for OADS/DS. OADS/DS has collected information on the needs of those served since 1992, and, as discussed above, began leveraging the current EIS information management system to collect a variety of data starting in 2002. The information collected by OADS/DS is central to its work and is used in a number of ways. In addition to daily usage of data to oversee the provision of

services to its consumers, OADS/DS shares data with the Maine Legislature to inform decision-making regarding resource allocation for the OADS/DS service system.

OADS/DS also reports the data to several academic institutions that track developmental disability services nationwide. Maine's data is aggregated with data from other states and then published—in the annual *State of the States in Developmental Disabilities Report*²² and the University of Minnesota's annual *Residential Services for Persons with Developmental Disabilities: Status and Trends* report²³—allowing OADS/DS to compare its efforts to those of its sister agencies in other states, and thereby measure the State's progress. Finally, it should be noted that the service need and utilization data from EIS was the fundamental information used to validate compliance with Maine's Community Consent Decree, which came to a close in 2009.

Linking Data Across Programs

Within DHHS, information is now being shared by OADS, Office of Substance Abuse and Mental Health Services (SAMHS), Office of Child and Family Services (OCFS) and Office of MaineCare Services (OMS). Although there had been internal sharing of information in the past, it had mostly been through the exchange of paper reports. The development of electronic interfaces has improved the efficiency of the sharing and this internal sharing has been very useful to the efforts to improve transition from children's to adult services. Accessing and sharing data with school districts remains the greatest challenge. This is primarily due to the lack of integrated data across the 240 districts across the state. Overtures have been made by OADS and OCFS to both the Department of Education and the Maine Association of Directors of Special Education Services (MADSEC) to include them in the district level Transition Committees mentioned above which are now working across the state. Positive responses have very recently resulted in presentations at MADSEC's annual statewide meeting. Improving these relationships and assisting the required educational transition planning are considered important priorities for OADS and OCFS.

In the areas of work supports and employment services, data are currently being shared between OADS/DS, SAMHS and Department of Labor in order to monitor system performance and individual employment outcomes. Only data specific to employment services is shared through this agreement and other individual data remains confidential and secure. All three partners will gather data using the same assessment in the near future. Department of Labor uses a new large application for its consumers, but OADS and DOL are exploring the development of electronic interfaces so that employment data is shared in near real time using the same assessment currently used by OADS.

The goal is to have the interface in place by October 2014 so that all partners are entering, monitoring and reporting on the employment information.²⁴

Leveraging Federal Funds

OADS/DS has been very active in leveraging federal funding both to expand home and community-based programs for individuals with intellectual and developmental disabilities, and also to fund demonstration programs which can lead to improvements in the service system.

Home- and Community-Based Service Waivers

By far the primary and most effective means by which Maine has used federal funding to provide community-based services for people with intellectual and developmental disabilities is through the federal Home- and Community-Based Services Medicaid waivers (often referred to as “1915(c) waivers”). These waivers allow the use of Medicaid funds to provide comprehensive, community-based supports and avoid unnecessary institutionalization. Maine implemented its first 1915(c) Home- and Community-Based Services waiver for intellectually and developmentally disabled individuals (known as the “Section 21 Waiver”) in 1983.

Since the 2003 Roadmap was released, Maine has added a second waiver for individuals with intellectual and developmental disabilities, known as the Supports Waiver (or “Section 29 Waiver”). First implemented in 2007, the Supports Waiver is designed to provide supplemental supports for individuals who live with their family or are able to live independently. The purpose of the Supports Waiver is to provide additional supports in community, work or home supports to ensure that individuals served can continue to live successfully in the community. Like Section 21, this waiver is also funded through a combination of state and federal dollars. Maine is in the process of refining the waiver so that it can also provide flexible, supplemental home support services, making the services more versatile and useful to a broader population.

In 2013, the State introduced a Home- and Community-Based Services waiver for individuals with “Other Related Conditions,” and is currently preparing another waiver for individuals with acquired brain injury. While neither waiver is primarily oriented towards individuals with intellectual and developmental disabilities, they offer more choices for individuals with co-occurring diagnoses, and may ultimately free up resources to allow the Section 21 and 29 waivers to serve additional individuals.

Part 1: What Has Been Accomplished, 2003-2013

In addition to the waivers, individuals served by OADS/DS also access services through other programs, including State Plan services such as medical and hospital services, and other Home- and Community-Based Services waivers.

Federal Grants

In addition to the core Home- and Community-Based Service waiver programs, Maine's DHHS has leveraged a number of federal grants over the past decade to improve its long term support system. These include:

Real Choices Systems Change grants funded by Centers for Medicare and Medicaid Services (CMS) 2001-2007.

- *Quality Choices*. Project activities included a comparative analysis of personal assistance programs; and a focus on access to transportation, housing, recreational activities and strategies for integrated information systems.
- *Money Follows the Person* (2003). Developed a rate structure as a foundation for building consumer directed services for persons with intellectual and developmental disabilities. Provided foundation for current MFP grant activities.
- *Independence Plus* (2003). DHHS developed information, training materials and other tools for persons with intellectual and developmental disabilities to support their participation in consumer directed services. However, the waiver was never implemented due to budget constraints.
- *Medicaid Infrastructure Grants* (MIG) (2000-2009). Authorized under Ticket to Work and Work Incentives Improvement Act grant this program focused on enhancing and streamlining infrastructure to maximize employment for people with disabilities.

Funded jointly by Administration on Aging and CMS:

Maine Aging and Disability Resource Centers (ADRC) (2003). The purpose of the program is to streamline access to long-term services and supports for elders and persons with disabilities. DHHS piloted an ADRC in three of Maine's five Area Agencies on Aging. Now each of the five Area Agencies on Aging are ADRC's and have integrated information on aging and disability services and supports.

Maine is currently participating in two grants funded by CMS intended to increase options for community living for people with disabilities.

- *Money Follows the Person* (2012-2016). Grant program to expand options for people living in institutions to transition to community settings and give people with disabilities more choice in where to reside and receive long term services and supports.

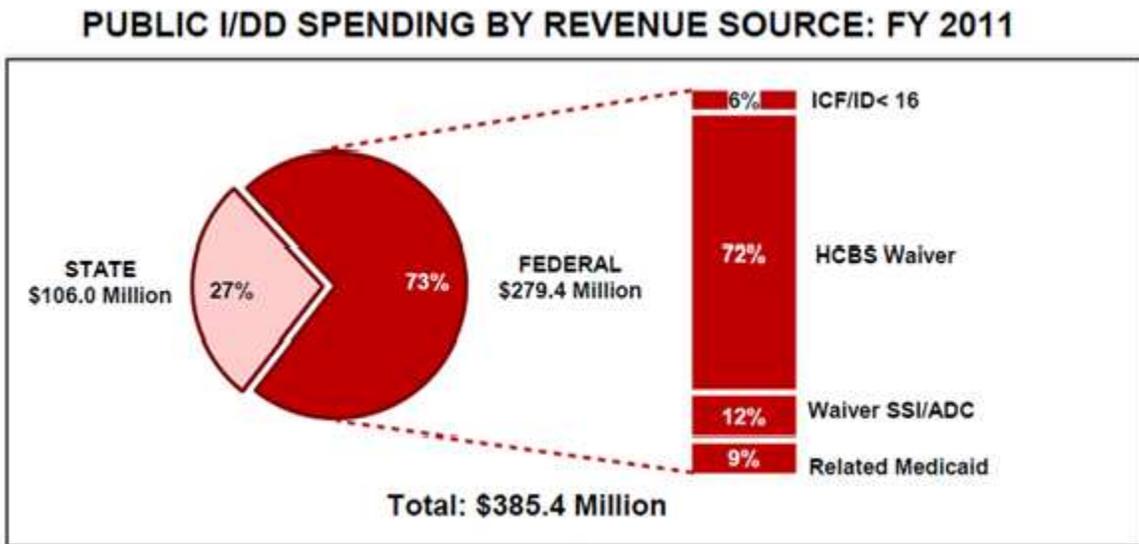
Part 1: What Has Been Accomplished, 2003-2013

- Balancing Incentive Payment Program (BIP) (2012) As described earlier, this program is aimed at re-balancing the system of services and supports to reduce reliance on institutional settings toward a community-based system that provides more choice for consumers to live in the least restrictive and appropriate settings.

Overall Federal and State Spending

As is shown in the following charts, the largest revenue source for Maine’s services for individuals with intellectual and developmental disabilities is the federal government. This trend has been increasing over time. The most recent data on disability services show that Maine ranks second in the nation in per capita spending on community services for individuals with intellectual and developmental disabilities.²⁵

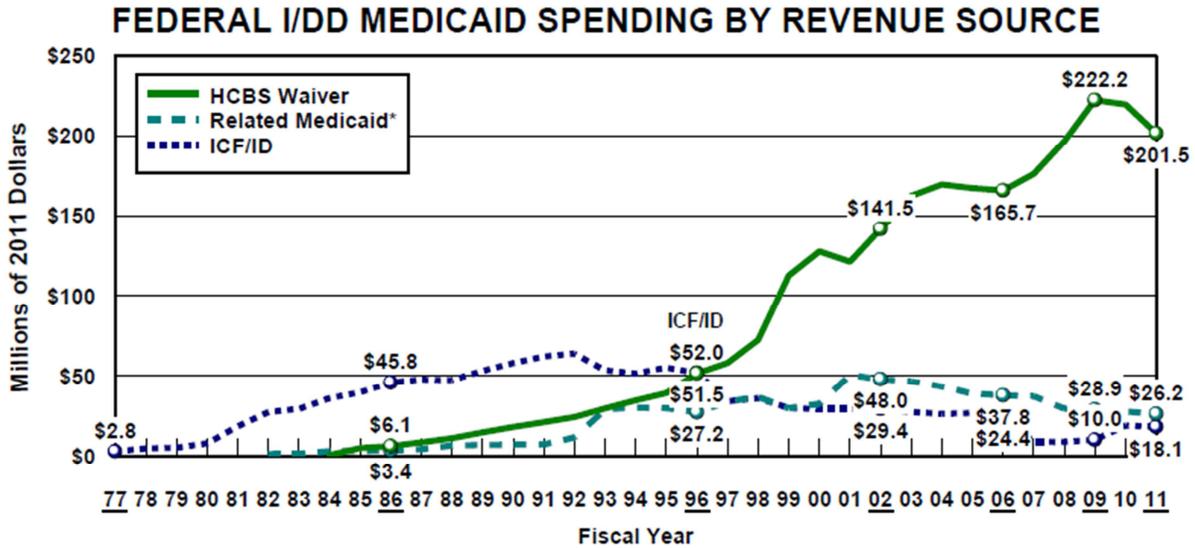
Object #1 This chart shows the proportion of state and federal dollars funding major service categories in Maine.



Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁶

Part 1: What Has Been Accomplished, 2003-2013

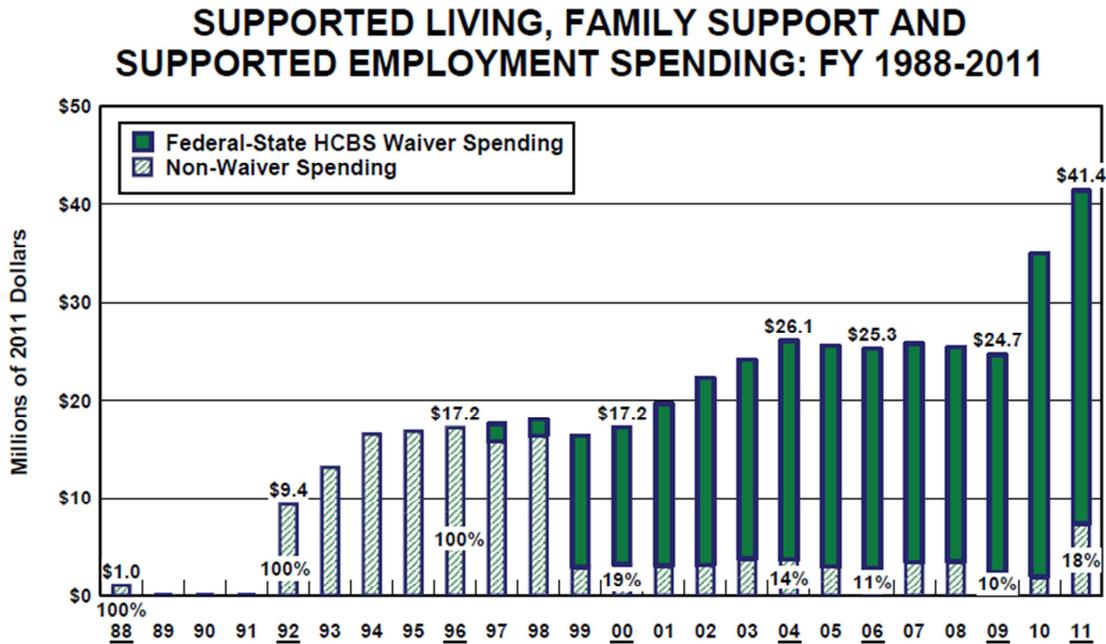
Object #2 This chart shows federal spending over time in Maine.



*In 2011, "Related Medicaid" was rehabilitative services (\$11.2 million), targeted case management (\$7.4 million) and administration (\$7.6 million).

Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁵

Object #3 This chart shows the change in spending in Maine from non-waiver to waiver over the course of 23 years.



Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁵

Wait Lists

Wait lists for OADS/DS waiver services were first established in 2008, and have been growing since. The combination of the finite number of waiver slots approved by the federal government and the limits of State funding have created long waits for services for many people. Despite Maine's robust participation in the federal waiver programs, the demand for services far outstrips the current supply.

Given limited capacity within the current system, it is critical both that access to services is provided in a fair, predictable manner and that services remain available to respond to those individuals with immediate, dire needs. To this end, OADS/DS has established policy and practice for how waiting lists are established and maintained for both the Section 21 and Section 29 waiver programs. As described below, the waiting lists for the two programs are handled in different manners, consistent with their distinct orientations.

For Section 21, priority for services is based on a hierarchy of need, with the most vulnerable members receiving a higher priority for accessing services first. Any member who is determined to be in need of adult protective services (APS) and is eligible for developmental services is assigned a Priority 1. Members who are at risk for abuse in the absence of services as identified in his or her individual service plan are assigned a Priority 2. And finally, members who are on the waiting list but not at risk of abuse are assigned a Priority 3.

When openings become available in the Section 21 waiver, OADS/DS staff review current assessments and other information maintained on EIS to identify the individuals who present with the highest need for services. Additional factors taken into consideration include the availability of capable service providers to adequately meet the member's service needs and the comparative degree of abuse, neglect or exploitation that each member will likely experience if they do not receive the services. Using this method, OADS/DS seeks to ensure that those consumers most vulnerable receive services first.

The wait list for Section 29 services, by contrast, is processed on a first come, first served basis. Members who are on the wait list for these services are served chronologically based on their date of eligibility for the waiver.

The chart below shows the current figures for both waivers. The total number of individuals on the waiting list for the Section 21 and Section 29 waivers—872 and 474, respectively—conveys only part of the picture. Some individuals have applied for and

Part 1: What Has Been Accomplished, 2003-2013

are on waiting lists for **both** waivers (n=286). (Ultimately, they would be served by one or the other of the waivers, not both; members can only receive services under one wavier program at a time.) Other individuals are currently receiving services under Section 29 but want to receive services under Section 21 (n=486). Finally, there are some individuals (n= 386) waiting for Section 21 but NOT receiving services under Section 29.

Stated another way:

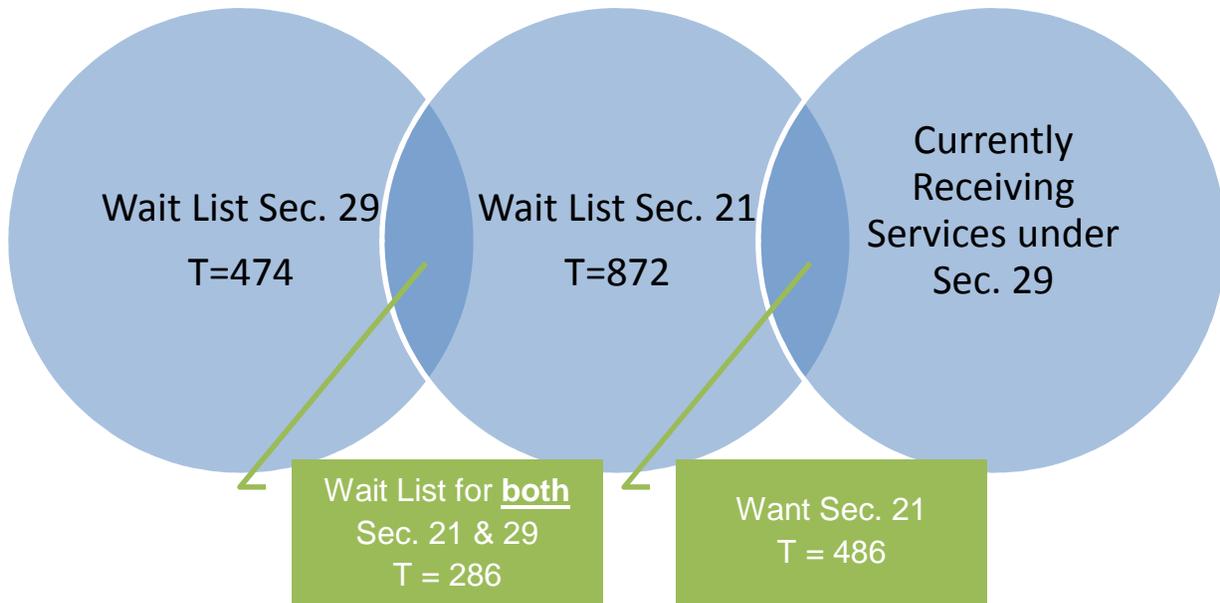
- Over half of the people waiting for services under the Section 21 waiver are currently receiving services under Section 29.
- Over half of the people waiting for services under the Section 29 waiver are also on the wait list for services under Section 21.

While on Wait Lists for waiver services, eligible individuals receive other funded services through OADS/DS. All people on the wait list can receive:

- Case management services
- Crisis services
- Medicaid State Plan Services (MaineCare) including: medical; dental; and hospital services as well as transportation to medical services.
- Guardianship services, if court ordered

Object #4 Maine

Wait List Current View



Source: Wait List Data (Email correspondence from Bridget Bagley, OADS, December 17, 2013)

The wait lists have been a growing concern since their inception. The Department has been concerned about how to address this and has worked with its' partners to seek solutions. In FY 2013, the department secured an additional \$28 million (state and federal match) in funding for the Section 21 and 29 waiver programs. With this additional funding, to date, OADS has served an additional 150 individuals. (Email, James Martin, Office Director, OADS, March 12, 2014.)

Availability of Direct Care Providers

In the 2003 Roadmap for Change report,⁴ Maine's Work Group for Community-Based Living highlighted a statewide shortage of direct care workers to support individuals with disabilities, and recommended that the State commence a number of new activities to expand the pool of qualified workers providing community-based services in Maine. Specifically, Maine's Work Group encouraged the State to:

- Build respect for the direct care worker profession;
- Improve recruitment and training practices;
- Create opportunities for growth and advancement;
- Solicit outside funding and grant support to develop sustainable solutions;
- Improve wages and benefits;
- Expand access to consumer-directed care options; and
- Collect data across departments to measure and track workforce shortages.

In the past decade, OADS/DS has made significant advancements in many of these areas and has work to do in others.

Build respect for the profession

In 2003, Maine's Work Group wrote of the need to enhance the status of the direct service worker to "a professional occupation commensurate with teaching, social work, or nursing." The Work Group suggested several possible strategies for doing this, including developing a communication plan to educate employers, consumers, and their families on the key responsibilities and importance of direct service workers.

In recent years, OADS has undertaken a number of initiatives aimed at educating direct service workers, potential workers, and the public about the importance of direct service positions and their critical role in Maine's current and future long term service and supports system.

With funding from the Health Resources and Services Administration (HRSA), DHHS, in partnership with the Muskie School of Public Service, developed a website for direct

Part 1: What Has Been Accomplished, 2003-2013

service workers, employers, and consumers.²⁷ The site contains video clips and shows Maine's direct service workers in action, serving in different job titles and carrying out various essential responsibilities. The site also outlines qualifications and training needed for different types of workers and contains information for consumers on what to look for and how to work with a direct service worker.

In the past, OADS/DS worked with provider agencies to plan biennial conferences for direct support professionals (DSPs). These were discontinued due to budgetary constraints. However, in the upcoming year (FY 2015), OADS/DS plans to resurrect the DSP conference with the dual goals of:

- 1) providing more opportunities for learning and mutual support and
- 2) recognizing the important efforts of this workforce in delivering high quality services and supports.

These goals are echoed in the current OADS Biennial Plan,²⁸ where next steps for improving developmental services include:

- 1) validating the importance of DSPs and their work and
- 2) transforming their role from "caretaker" to "supporter."

Improve Recruitment and Training Practices

While low retention rates continue to be a problem among direct support professionals (DSPs), OADS has launched a number of initiatives aimed at clarifying and streamlining DSP training requirements and strengthening training programs.

All DSPs, regardless of where they work, are required to earn certification through Maine's approved training and certification program. Since 2009, the approved training program has been provided through the College of Direct Support (CDS)/Elsevier. The training is largely online and consists of 46 lessons, including several that are specific to Maine's service systems and policies. All newly hired DSPs must complete this training within their first six months of employment.

In addition to Maine's College of Direct Support basic certification, DSPs who serve specialized functions must complete supplemental lessons and earn additional certifications. For instance, DSPs providing work supports must complete four additional on-line lessons, including Supporting Jobs and Careers in the Community and Exploring Individual Preferences for Job Attainment. DSPs working as Certified Residential Medication Aides (CRMAs) or performing First Aid, CPR, and/or Behavioral Interventions complete additional coursework as well.

Part 1: What Has Been Accomplished, 2003-2013

Maine's College of Direct Support basic training is offered through provider agencies. An OADS Training Manager manages the contract with the College of Direct Support/Elsevier and monitors trainings statewide.

Training has also been revised and strengthened for another category of direct service worker, the Employment Specialist. Employment Specialists provide direct support to individuals with disabilities as they find and maintain employment in integrated settings. Recently, OADS/DS changed training requirements for this job title to align with requirements set forth by Maine's Office of Substance Abuse and Mental Health Services (SAMHS) as well as Maine's Department of Labor's Bureau of Rehabilitation Services. This change allows workers who meet Employment Specialist requirements to work across systems (i.e., provide services to clients served by the Bureau of Rehabilitation Services, OADS/DS, or SAMHS.)

This coordinated training and certification effort has allowed Maine to certify an average of 100 new Employment Specialists per year, provide advanced training to 200 staff, and mentor up to 12 Employment Specialists annually.²⁹ It is an important forward step in expanding the workforce and elevating the credentials for this segment of the workforce.

Create Opportunities for Growth and Advancement

In recent years, OADS/DS has expanded the number of professional development activities and continuing education offerings aimed at direct service workers.

In 2010, OADS/DS worked with the Muskie School of Public Service to produce videos and toolkits designed to teach direct service workers practical strategies for involving consumers in their communities. The toolkits were used to enhance the level of knowledge among staff about the potential for individuals with intellectual and developmental disabilities to have meaningful involvement in their communities. Examples included volunteerism, job shadowing, employment and recreation and others.

Within the past year, with the support of a grant from the Health Resources and Service Administration (HSRA), OADS has again worked with the Muskie School of Public Service to launch four online continuing education modules aimed at DSPs and other direct service workers. Topics include: Infection Control and Prevention, Dementia Basics, Brain Injury Basics, and Substance Abuse. Each continuing education module is available to any direct service worker at no cost, 24 hours a day.

In addition to these modules, a project website provides educational materials about different career options for direct service workers and includes a quick roadmap for accessing training programs for various direct service positions.²⁶

OADS has begun exploring additional re-certification requirements mandating ongoing learning and professional growth. One such requirement would be targeted at Direct Support Professionals serving Home and Community Based Waiver recipients and would require a set number of continuing education hours per year.³⁰

Solicit Outside Support to Develop Sustainable Solutions

For the past three years, OADS has participated in a large, cross-agency project intended to streamline direct service training requirements for Maine's three largest categories of direct service workers. In 2010, DHHS was one of six states awarded a demonstration grant funded by the Health Resources and Services Administration (HRSA) to develop an integrated, competency-based model of training for direct service workers. Now entering its fourth year, the project has produced and piloted a competency-based core training module for entry level workers serving elders and consumers with intellectual and developmental disabilities, serious and persistent mental illness, and physical disabilities.

The training program, which blends traditional classroom training with online learning to enhance worker access to curriculum, allows workers to complete core and specialized modules while reducing redundant requirements and increasing opportunities for cross-training. The competency-based approach includes competencies identified through Maine's earlier training programs as well as those identified at the national level. Through the core training and associated specialized modules, workers can become certified as Mental Health Rehabilitation Technicians I, Personal Support Specialists, or Direct Support Professionals.

This project demonstrates OADS engagement in cross-agency collaboration and commitment to pursuing outside funding to develop sustainable solutions to Maine's direct service workforce shortage. Anticipated benefits of this integrated, competency-based training program include increased training opportunities for potential workers, improved worker mobility across multiple job categories, increased worker competence with consumers with complex health and service needs, and a more flexible workforce that can adapt quickly and apply skills to locations and populations where there is an immediate workforce shortage.

Quality Services

In the 2003 Olmstead Roadmap for Change, the Workgroup for Community-Based Living had several recommendations aimed at improving the quality of services provided. Some had an emphasis on consumers defining quality and an expanded perspective of measuring quality across all domains of a person's life. The recommendations also encouraged a framework that defined standards for quality and accountability with an ongoing effort to evaluate quality. OADS/DS has made significant progress on its Quality Management strategy and has specific goals for the coming years.

National Core Indicators project

Maine's Office of Aging and Disability Services has participated in the National Core Indicators project (NCI)³¹ developed by the National Association of State Directors of Developmental Disability Services (NASDDDS) and the Human Services Research Institute (HSRI) between 2002 and 2012. In 2014, OADS resumed participation. NCI measures states' performance and outcomes in the intellectual and developmental disability service systems. This effort allows Maine to benchmark its performance against other participating states, identify trends and track changes over time.

The surveys are designed to explore specific aspects of the service system's capabilities and effectiveness. Service planning; access and delivery of supports; opportunities for choices and input; connections with the community and outcomes of services received are areas that are included in the survey.

Members of the Developmental Disability Council are conducting NCI interviews and collecting the data from consumers in 2014. Subsequent years may also include surveys for families and guardians in order to collect data and enable Maine to benchmark against other states, to identify areas needing improvement and to steer program redesign. Maine's most recent report (2011-2102) can be found at http://www.nationalcoreindicators.org/upload/core-indicators/2011-12_Maine_ACS_State_Report.pdf

Additionally, HSRI is spearheading a parallel effort to develop a national set of core quality indicators for elders receiving services from aging program services. Maine's OADS is also participating in early pilot testing of these instruments.

On-going Quality Assurance Efforts

All Home- and Community-Based Services waivers for elders and adults with disabilities administered by OADS/DS require reporting to the federal Centers for Medicare and

Medicaid Services about quality and accountability. In addition, OADS/DS created a new Quality Assurance/Quality Improvement unit in 2012 that evaluates core services, conducts review and certification of community case management agencies serving adults with intellectual and developmental disabilities, administers assessments for adults with intellectual and developmental disabilities, participates in waiver reporting, and provides training to improve quality.

Expanding the Quality Domains

The 2003 Roadmap called for Maine to expand the scope of quality measurements to include the contribution of all supports in a person's life at home, at work, or in daily living activities, and community. This is being accomplished for adults with intellectual and developmental disabilities via the Supports Intensity Scale (SIS). The SIS is a standardized assessment that measures the support needs of an individual in the home, work, and community settings. Respondents in the assessment process include those providing direct supports to the adult at home, at work and in community programs. The assessment does not differentiate between formal paid supports and unpaid supports.

Integrated, Accessible, Affordable Housing

Affordable housing continues to be a challenge, varying geographically across Maine, and remains a significant barrier to providing alternatives to institutional level care. In the 2003 Roadmap for Change, workgroup members identified eighteen recommendations to improve community-based options for people with disabilities.

Measuring Housing Needs

OADS/DS systematically collects data on residential needs for persons served. Through EIS, OADS/DS tracks data on requests and needs for residential services along with current data on type and location of consumers' residences. These data are collected routinely through the person-centered plan and used to project service funding needs as well as types of residences requested and needed. These data are provided to partners including the Developmental Disabilities Council, Disability Rights Center, Oversight and Advisory Board and others to inform policy and rule changes in order to meet these system challenges.

Partnerships to Address Challenges

In the past decade, OADS/DS has formed strong partnerships with several housing organizations in order to strengthen the supply of housing options for adults with intellectual and developmental disabilities. Among those, Maine Housing has been a vital partner, along with community provider organizations, in developing housing options.

OADS/DS has also worked with the Maine Coalition for Housing and Quality Services (CHOM), which formed in 2006, on exploring and developing various housing models. Consisting primarily of parents of youth and adults with disabilities, CHOM has conducted advocacy and outreach around the need for quality housing and services, expanding resources and options across the state. OADS/DS staff regularly attends the CHOM monthly meetings, providing program updates and also participating in discussion about issues critical to families supporting members with intellectual and developmental disabilities. This vital partnership holds much promise for future service system improvements.

Community-Based Living

Maine has a strong system of community-based residential options for people with intellectual and developmental disabilities and a long and robust history of waiver participation. According to the most recent data available, in the past decade OADS/DS has almost doubled the number of consumers served through the waiver programs and is on track to continue substantial growth in these programs.

As noted earlier in this report, OADS has operated a Home- and Community-Based Services Waiver for individuals with intellectual and developmental disabilities since 1983. The purpose of these waiver programs is to provide long term services and supports in community-based settings under the Medicaid program. This has been the primary vehicle to provide services in community settings as opposed to relying on institutional settings. With guidance from the Centers for Medicare and Medicaid Services, the waiver program is designed to promote “choice, control and access to a full array of quality services that assure optimal outcomes such as independence, health and quality of life.” Maine’s comprehensive waiver (often referred to as the “Section 21” waiver) provides home, community and work supports. Using the Person-Centered Planning approach, individual plans for waiver services are developed with the person receiving services driving the planning process; the process is coordinated by a case manager who does not work for an agency that provides direct services to the person. This allows for more choice in service providers. ³²

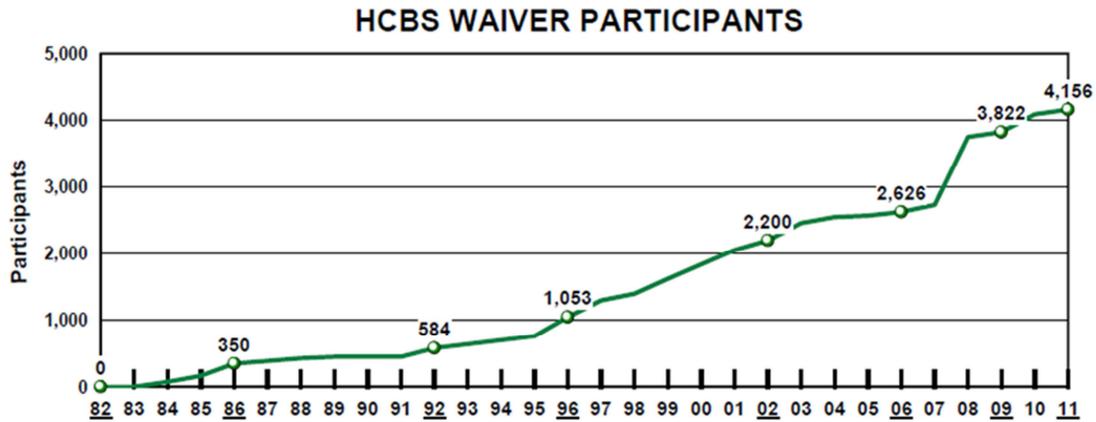
Choice of residence is a key component of a self-determining life. Maine’s residential options for individuals with intellectual and developmental disabilities include:

- Supported living;
- Shared living;
- Family centered support;
- Group living; and
- Non-waiver residential services.³³

Part 1: What Has Been Accomplished, 2003-2013

The chart below shows the growth in waiver participation from the earliest days to 2011, most recent data available. Figures include members receiving services under both waivers; Sections 21 and 29.

Object #5 Maine waiver participation.



Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2013.

<http://stateofthestates.org>

Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁵

Growing Residential Options

OADS/DS continues to develop an expanded array of residential models which can provide the supports necessary, meet the personal choices of individuals being served and maximize community inclusion. In 2005, OADS/DS developed the Shared Living model as an additional option for residential supports under the Section 21 waiver. In the Shared Living model, an adult with intellectual and developmental disabilities shares a home with a person who provides direct support. The home may belong to the member or to the provider. The person providing the supports must become certified as a Direct Support Professional and provides the home supports under a contractual relationship with an oversight agency. There has been strong growth in this residential model with currently over 617 individuals with intellectual and developmental disabilities using this service. (Email from Terry Sandusky, Information Services Manager, November 7, 2013).

Increasing Choice

OADS/DS has recently introduced changes to both Section 21 and 29 waiver programs to promote more flexibility in services. Included in those changes are remote supports—which include a range of monitoring and support services provided remotely by means of a data connection—and other technologies which can enhance consumer

Part 1: What Has Been Accomplished, 2003-2013

independence. Also recently added were respite services, which provide respite care to support family caregivers while allowing consumers to remain in the family home.

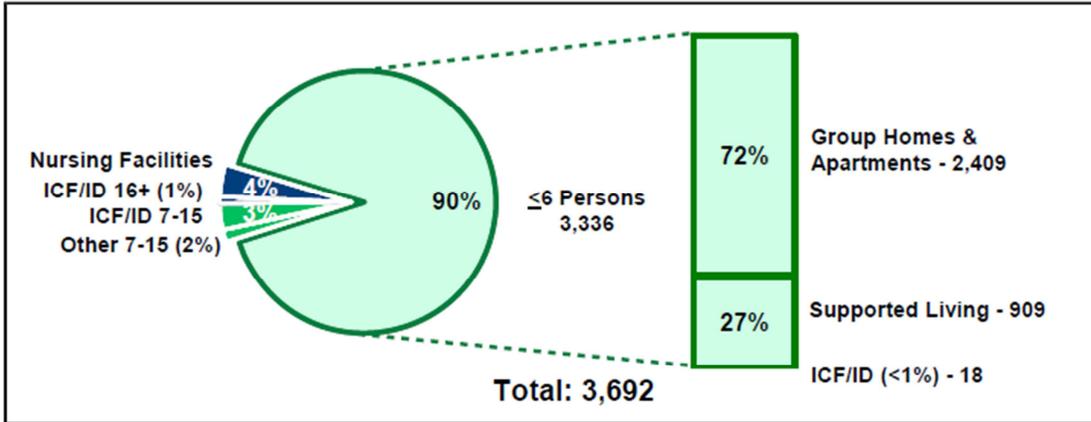
OADS/DS currently includes home modification funding in both Section 21 and 29 of the waiver programs.³⁴ Members receiving services under Section 21 can receive up to \$10,000 in a 5-year period in order to make adaptations to the home to ensure the health, safety and welfare for the member. The funding limit is capped at \$5,000 for members receiving services under Section 29.

OADS/DS continues to use federal dollars through specific programs to help reduce the reliance on institutional settings. OADS received a Money Follows the Person grant from the Centers for Medicare and Medicaid Services in State Fiscal Year 2012. This grant is another tool to expand access for home- and community-based services and reduce reliance on institutional settings. It is designed to help Medicaid beneficiaries who want to transition from institutional settings to community-based settings, and to make system-wide changes to support Medicaid beneficiaries with disabilities living and receiving services in the community. Currently Maine's plan calls for one hundred and one individuals to be supported in their transition from institutional setting to community setting over the course of five years. MFP is serving people with complex needs and it is possible to serve more than the projected numbers as there is no cap established for this program. (Email from Francis Ryan, OADS, March 10, 2014).

Using the most recent data available the charts below show the distribution of residential settings for individuals served in Maine. Object 6 represents where individuals served by OADS/DS reside. As this chart shows the vast majority (90%) of individuals served live in residences with 6 or fewer people.

Object #6 Maine

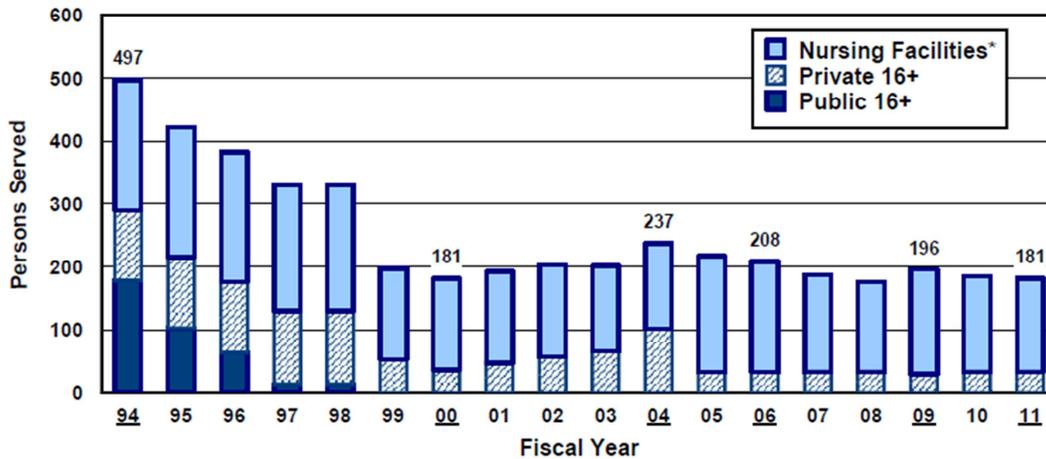
PERSONS BY SETTING IN FISCAL YEAR 2011



Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁵

Object #7 represents the numbers of individuals residing in institutional settings over time.

PERSONS IN PUBLIC AND PRIVATE 16+ INSTITUTIONS: FY 1994-2011



*Nursing facility data data for 1990-2004 were provided by the state; data for 2005-09 are from the CMS OSCAR online survey.

Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2013.

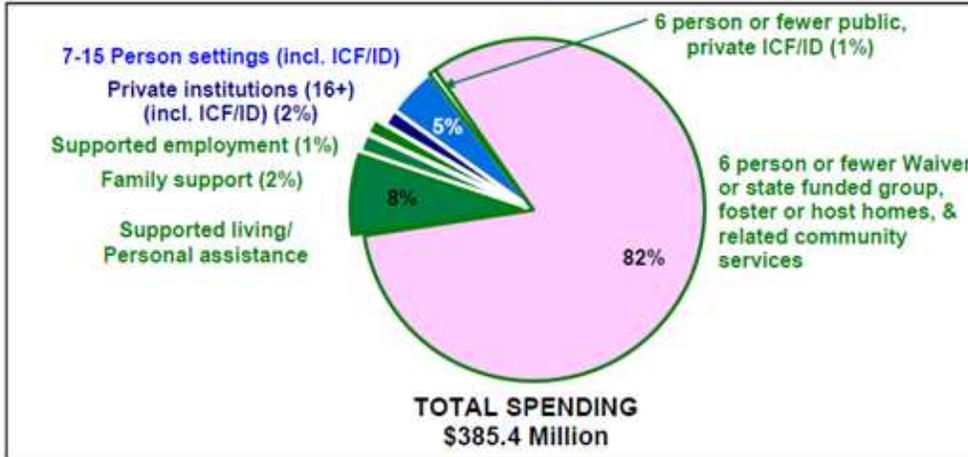
<http://stateofthestates.org>

Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁵

Part 1: What Has Been Accomplished, 2003-2013

Object #8 shows the proportion of spending by residential setting. It also includes spending for Supported Employment.

SUPPORTED LIVING, FAMILY SUPPORT, AND SUPPORTED EMPLOYMENT (INDIVIDUAL AND FAMILY SUPPORT) WAS 10.7% OF TOTAL SPENDING: FY 2011



Source: Braddock et al., Coleman Institute and Department of Psychiatry, University of Colorado, 2013.
<http://stateofthestates.org>

Source: *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine.*²⁵

Jobs

Employment for people served by OADS/DS has been an area of focus that dates back to the Vocational Policy crafted by the Department of Behavioral and Developmental Services in 2000. Since that time OADS, sometimes in partnership with the Office of Adult Mental Health Services (now Substance Abuse and Mental Health Services), and the Bureau of Rehabilitation Services in the Department of Labor, and sometimes as a single state agency, has made significant strides to make employment in integrated, community-based settings a real option for people with intellectual and developmental disabilities. The closure of the State-operated sheltered workshop, Freeport Towne Square, and the elimination of state funding for any sheltered workshop programming are two of the many policy decisions which paved the way for the current efforts to support employment in integrated settings. These are highlighted in a recent report to the Maine Legislature, the *2012 Report in Response to LD 28, resolve, To Improve Employment Opportunities for Persons with Intellectual Disabilities and Autistic Disorders.*³⁵

Numerous policy and practice changes have been implemented over the past decade that facilitate community integration through employment. In November 2010, DHHS adopted a policy related to employment of people with disabilities. "Employment of

Part 1: What Has Been Accomplished, 2003-2013

People Served” set the direction for the expansion of employment outcomes across DHHS in coordination with other state agencies and employment service providers. OADS/DS has built capacity in the service delivery system by providing best practice training for case management, direct support professionals and employment specialist staff to improve knowledge and skills for working with consumers to find and maintain employment.

OADS/DS eliminated funding for sheltered employment in 2008. In that same year Section 29, the Supports Waiver, was developed to increase supports for integrated, community-based employment options. The new waiver was the culmination of work undertaken between 2006 and 2008 to increase employment options for people with intellectual and developmental disabilities supported by MaineCare. The Support Waiver offers supportive services to consumers who live with their families or on their own, with a focus on Community Support and Work Support.

Under both Home- and Community-Based Services waivers, MaineCare covers work supports necessary to assist a person in the home setting to get ready for work. Work supports can also be used at the place of employment for assistance with personal hygiene and personal care based on the needs identified in the Person-Centered-Plan.

An Innovative Model

For a two-year period (2008-9), OADS/DS partnered with the Maine Developmental Disabilities Council and individuals with intellectual and developmental disabilities and the Muskie School to develop an educational program about employment opportunities for waiver participants. *“It’s Your Life”* was a peer-to-peer model focused on identifying opportunities for community-based employment in integrated settings. By using real stories from consumers who were successfully employed, consumers in segregated work settings had the opportunity to learn about wider options for employment as well as learn about supports available for them to pursue alternatives. Seventy consumers participated in these educational offerings to explore the possibilities of community-based employment. This was an important strategy to educate consumers about employment outside of segregated settings as a viable option regardless of diagnosis or disability.³⁶

Integrated Work Settings

Most supported employment efforts offered by OADS/DS focus on individual placement. Currently, only two models of small group employment are allowed under federal Dept. of Labor standards. These models are intended for between 2-8 workers with disabilities. Enclaves are business based workgroups and mobile work crews work in regular business, industry and community settings. These models do not include

vocational services provided in a facility based work setting. The overarching goal is to promote individual jobs in integrated, community-based settings at or above the state's minimum wage.

Under the federally funded Medicaid Infrastructure Grant (MIG), OADS/DS, in conjunction with partners from DHHS Adult Mental Health Services, the Department of Labor's Bureau of Rehabilitation Services, the Muskie School of Public Service, community providers, people with disabilities and other stakeholders, created a cross disability, one-stop informational clearinghouse on employment and disability. A website, www.employmentforme.org provides current, relevant information for people with disabilities, community providers and businesses. While providing a broad spectrum of information, the site specifically includes information for consumers to aid them in understanding their employment rights.

In expanding integrated employment options for individuals for disabilities, it is important to be cognizant of the manner in which additional income may impact consumer's existing services. To this end, OADS/DS helps fund Benefits Counseling provided by Maine Medical Center to assist consumers receiving either SSI or SSDI benefits to assess how earnings from employment will affect their federal and state benefits. The program works with consumers to navigate the rules regarding employment and disability benefits and provides analysis as well as linkage to other supportive resources which can aid consumers in attaining community employment.

Expanding Partnerships to Improve Employment Outcomes

Most recently, OADS has been a partner in Maine's Employment First initiative, a cross-disability legislative collaborative. The coalition includes representatives of various state agencies including DHHS, the Department of Education, the Department of Labor, as well as community service providers, advocacy organizations and persons with disabilities. The initiative's focus is on improving and enhancing employment outcomes for Maine citizens with disabilities by exploring employment goals as the first and preferred option when setting goals with people who have disabilities.

Significantly, Maine's Employment First coalition is cross-disability.²⁸ While these efforts nationally have sprung from the intellectual and developmental disability community; Maine has chosen to include a wide variety of disability groups. The Employment First Coalition reports to the Governor, the Legislature and the Joint Commissioners at least annually with recommendations for enhancing employment outcomes for people with disabilities. See <http://www.employmentfirstmaine.org/> for additional information.

Part 1: What Has Been Accomplished, 2003-2013

The Employment First Coalition promotes the value of employment for young people with disabilities and seeks to ensure that their employment experiences are typical of their non-disabled peers. In line with this focus, OADS/DS also partners with the Department of Labor to participate in the Youth Mentoring Day held annually each October. Through these efforts young adults with disabilities are partnered with businesses, learn from business panels or spend a day job shadowing in a business.

Part 2: How We Move Forward, 2014 – 2024

Introduction

As we look ahead to the next decade, our resolve to continue to strengthen the community integration efforts for people served through OADS/DS remains firm. Building upon earlier efforts to provide high quality community-based services that enable individuals to remain in their homes and communities we have identified these key areas of focus:

Employment

Employment is a core component of the services and supports to individuals served by OADS/DS. OADS/DS considers employment to be the first and preferred service or support option for each person. In the coming decade, OADS/DS seeks to expand integrated, community-based employment options (meaning employment in the competitive labor market that is performed on a full or part time basis or through self-employment, at or above the minimum wage) and improve employment outcomes for individuals served. OADS/DS will coordinate its efforts with other state and federal agencies to ensure maximum benefit for the individuals it serves. OADS/DS's specific employment-related goals include the following:

- Every person served is offered the opportunity to work, based on the idea that each individual can work.
- OADS will collect annual data reports from providers to analyze and assess employment outcomes for the state.
- OADS will ensure that individuals working at sub-minimum wage will transition to competitive wages.
- OADS will ensure that the Person Centered Planning processes will include consideration of employment in the community and the identification of barriers to employment.
- The Department will introduce new approaches, such as career planning and peer support models, to support individuals to successfully engage in employment. Where those approaches succeed - they will be added to the Comprehensive waiver (Section 21) and the Supports waiver (Section 29) programs.
- Working with the Department of Labor/Bureau of Rehabilitation Services. OADS will support business development and collaboration efforts to employ persons with disabilities.

Part 2: How We Move Forward, 2014 - 2024

- The Department will partner with Department of Labor/Bureau of Rehabilitation Services and other community support provider agencies to improve preparation for each individual for employment. The Department will engage these partners in discussion to identify barriers to employment and to create solutions.
- The Department will continually improve our ability to produce outcomes based on data in partnership with community providers. Individual employment sites, size of settings and wages will be electronically tracked and utilized for system improvement and measurement.
- The Department will improve training opportunities for professionals supporting individuals with intellectual and development disabilities in employment settings and improve mentoring programs based on ongoing needs and with guidance from the WorkForce Development Advisory Council.
- OADS will develop incentives to expand independence and community-based employment through a focus on alternative service delivery models, such as Assistive Technology. The Department will also explore increasing the amount of available work supports offered in the Sections 21 and 29 waiver programs.

Transition to Adult Services

Individuals entering Developmental Services deserve an improved process of transition that supports movement into adult life. OADS is committed to continual engagement with schools, case managers, parents and individuals to assist with planning and accessing appropriate services.

- Improve the transition process for eligible youth moving to the adult service system.
 - The Department is establishing early support and planning for individuals and their transition to and through adulthood. Beginning at the moment the youth is identified as potentially needing some type of support, there will be early intervention with an eye toward community integration and adulthood success. Collaboration will occur in all systems so that planning for transition is lifelong and comprehensive.
 - OADS will seek to continue to improve coordination with Department of Education and local school districts to ensure that the youth's future goals and need for adult services are in sync with the youth's educational plan and activities.
 - Maintain full Memorandums of Understanding between Department of Education and DHHS/OADS regarding sharing and dissemination of information.
 - Continually evaluate and identify gaps in the Department systems (i.e. child and adult services).

Part 2: How We Move Forward, 2014 - 2024

- OADS & Office of Child and Family Services will continue to move toward a common data system.
- Braid child and adult services during adolescence, incorporating full, person centered planning no later than the age 16.
- Enhance the ability of parents/family members to refer their adolescent for review of services needs in the adult service system.
- OADS will continue to streamline its intake and eligibility system to ensure a simple, direct and efficient process.

Supporting Individual Success

Each person will receive a standardized, individualized assessment of his or her strengths and needs which will inform the Person-Centered Planning process. Each person will be assessed for the natural support potentially available to them and every effort will be made to maximize all of these opportunities. A broad menu option model will be established to match the amount and kind of paid support services needed by each individual within both Section 21 and 29 waiver programs.

- Ensure that people with intellectual and developmental disabilities get the services and supports they need to live the life they prefer in their community.
- Establish an independent, conflict-free, service assessment process for each person.
- Maintain a person-centered, community-oriented approach to deliver services for people with intellectual and developmental disabilities. The approach emphasizes:
 - That people with intellectual and developmental disabilities be in charge of their lives as much as possible.
 - That people with intellectual and developmental disabilities have opportunities to use resources flexibly and in ways that enhance their lives and help them participate in their communities.
 - A shared responsibility for the wise use of public dollars and the contribution that people with intellectual and developmental disabilities and their families can make.
 - That the system is managed in a way that is efficient and fair to everyone
 - That the development of the Person-Centered Plan is completely individualized and reflects the specific values, goals and needs of the individual.
- Support for each person in further developing the skills to advocate for their own unique goals and need will be incorporated into the Person-Centered Plan. OADS will provide specific training in self-advocacy for all persons with

intellectual and developmental disabilities, and training for caregivers to support, enhance and encourage self-advocacy in each person served.

- Explore broadening the use of a standardized assessment tool and resource allocation model within the Supports Waiver (Section 29).

Reduce and Eliminate Wait Lists for Services; Fairness & Equity

In-home community support services should be provided under a streamlined, single program with a priority for persons with the greatest need, and the lowest cost of services:

- Improve the distribution of resources through efficiencies of a standardized approach to assessment of need, fair and equitable payment for services, and
- OADS will continue to implement performance based contracts with service providers, and improve forecasting of persons aging into the adult system.
- OADS will refocus and rewrite rules on quality and person-centered outcomes for each individual.
- OADS will explore alternatives to fee-for-service payment system with the goal to free up funds to add individuals to services.
- OADS will provide training and consultation to identify other services available for individuals with complex needs/issues.
- Increase appropriation for the intellectual and developmental disabilities waivers to meet the needs of additional individuals who qualify for home and community services.
- Reduce the wait lists for both waivers through instituting a process whereby every individual on a waitlist is regularly informed (at least annually, through Person-Centered Planning meetings) of alternative services that might meet their needs. Also, through regular reporting to the legislature on the status of waitlist, including the expected appropriation needed in order to reduce the waitlist.
- Reduce institutional use by providing significant, robust alternative home and community based services.

Improve the Independence and Self-sufficiency of Each Person Served

- Implement budgetary and rule changes to promote the use of technology to improve the independence of individuals through adaptations of communication, environmental control, and remote safety supports.
- OADS will actively recruit consumers, family members and advocates for participation in all aspects of the organization, including decision-making, program design, program implementation and evaluation of services provided.

Part 2: How We Move Forward, 2014 - 2024

- OADS will encourage and support provider agencies and state programs to eliminate barriers to consumer participation and input by making accommodations available as needed, including readers, note-takers, drivers and personal-care attendants and by providing reasonable reimbursement to consumers.
- OADS will work with provider agencies and advocacy organizations to train employers, community leaders, and others on the rights of individuals with disabilities, as individuals who have little or no representation.
- OADS will work with agencies and advocacy organizations to make advocacy materials more user-friendly so it is possible for more people to advocate on their own.

Improve the Direct Service and Frontline Supervisory Workforce

OADS seeks to enhance and improve the value of and respect for direct care workers and their supervisors.

- Strengthen partnerships with educational departments and colleges to increase the workforce development and build training or career opportunities.
- Identify and increase opportunities for improving the integrity of current and future training programs.
- Create measurable outcome data on the core competencies within training programs.
- Streamline and enhance efficiencies training programs within DHHS.
- Develop strategies to import to Maine necessary workforce to provided critical services.
- Create and build career ladders through ongoing communication and partnerships with universities and colleges.

Further Enhance the Quality Assurance/Quality Improvement Efforts

- OADS will establish easy access to a clearing house of information about services for persons with intellectual and developmental disabilities. This will be designed to provide clear, understandable descriptions of the service system and it will be thorough and continuously updated.
- OADS will continue to streamline and consolidate Medicaid waivers to improve consistency and quality, and enhance benefits.
- OADS will implement the new CMS Home and Community Based Services definition and requirements.
- OADS will insure that payment rates for services are both efficient and sufficient through the establishment of a regular schedule of rate reviews/adjustments.

Support for Families and Persons in Their Own Homes

- OADS/DS will work to “right-size” the capacity of institutional settings vs. home and community settings.
- Seek new models to improve coordination and engagement of volunteer resources.
- Seek creative ways to enhance transportation support for members who live in rural parts of Maine.
- Explore opportunities for support through participation in virtual communities.
- Provide transition services in times of need for individuals and families through innovative models for respite and intermittent support.

Improve access to health and dental care

OADS/DS will work with stakeholders to understand the scope of the issues, identify challenges and collaborative opportunities to access to health care for persons with intellectual and developmental disabilities.

- Maximize the health of each individual through improved health monitoring, communication among caregivers and effective care coordination.
- Reduce Medicaid costs through improved health and independence. Reduce unnecessary medical services or institutionalization.
- Achieve integration of electronic health records of persons with intellectual and developmental between their healthcare providers and their home and community-based service providers.

Understand the Issues of Persons with Intellectual Disabilities or Autism Who Become Involved in the Criminal Justice System.

- Work with stakeholders to understand the scope of the issue, identify challenges and collaborative opportunities to protect the public and meet the needs of these individuals. Issue a report with recommendations.
- Work with State Government partners to study the systems issues and create possible solutions to be proposed for legislative action.

Endnotes

- ¹ State of Maine, Department of Health and Human Services, Aging and Disability Services. *Service & Support Planning: Vision and Values*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/planning.shtml>. Accessed February 3, 2014.
- ² Maine's Workgroup for Community-Based Living. *Roadmap for Change, Maine's Response to the Olmstead Decision*. Portland, ME: University of Southern Maine, Muskie School of Public Service; October 2003, p. 3
- ³ Maine's Workgroup for Community-Based Living. *Roadmap for Change, Maine's Response to the Olmstead Decision*. Portland, ME: University of Southern Maine, Muskie School of Public Service; October 2003, p. 4.
- ⁴ Maine's Workgroup for Community-Based Living. *Roadmap for Change, Maine's Response to the Olmstead Decision*. Portland, ME: University of Southern Maine, Muskie School of Public Service; October 2003.
- ⁵ Speaking Up For Us of Maine, (SUFU). *Speaking Up for Us of Maine: Maine's Self Advocacy Network*. 2006. Available at: <http://sufumaine.org/>. Accessed February 21, 2014.
- ⁶ Self Advocates Becoming Empowered (SABE). *Self Advocates Becoming Empowered Website*. n.d. Available at: <http://www.sabeusa.org/>. Accessed February 21, 2014.
- ⁷ State of Maine, Department of Health and Human Services, Aging and Disability Services. *Developmental Services - Grievance Process*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/grievance/home.html>. Accessed February 21, 2014.
- ⁸ Disability Rights Center. *Disability Rights Center Website*. 2013. Available at: <http://www.drcme.org/>. Accessed December 3, 2013.
- ⁹ Maine Coalition for Housing and Quality Services. *Maine Coalition for Housing and Quality Services Website*. n.d. Available at: <http://www.maineparentcoalition.org/>. Accessed February 3, 2014.
- ¹⁰ State of Maine, Department of Health and Human Services, Aging and Disability Services. *Developmental Services - Support Intensity Scale (SIS)*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/sis/index.shtml>. Accessed February 21, 2014.
- ¹¹ Human Services Research Institute. *Maine Supporting Individual Success: Analysis of Individual Expenditures for Those Receiving Supports Intensity Scale*. Tualatin, OR: HSRI;2013. <http://www.maine.gov/dhhs/oads/disability/ds/sis/documents/Analysis-Expenditures-HSRI-Report.pdf>
- ¹² State of Maine, Department of Health and Human Services, Office of Aging & Disability Services, Bowe T, Edris N. *Service Array Report*. Augusta, ME: University of Southern Maine, Muskie School of Public Service; forthcoming, 2014. Internal Draft.
- ¹³ State of Maine, Department of Health and Human Services, Aging and Disability Services. *Developmental Services - Behavioral Regulations/Three Person Committee*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/threeperson/behavior-regulations.htm>. Accessed February 21, 2014.
- ¹⁴ State of Maine, Department of Health and Human Services, Aging and Disability Services. *Developmental Services - Crisis Services*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/crisis.shtml>. Accessed February 21, 2014.
- ¹⁵ State of Maine Department of Health and Human Services, Office of Adults with Cognitive and Physical Disabilities, (2005). *Strengthening Communities Pilot Project Report*.
- ¹⁶ Options. *John O'Brien's 5 Service Accomplishments*. 2010. Available at: <http://www.options-empowers.org/people-we-support/john-obrien-5-service-accomplishments/>. Accessed February 21, 2014.

Roadmap for Change: OADS/DS Update

-
- ¹⁷ State of Maine, Department of Health and Human Services, Aging and Disability Services. *Developmental Services - Person-Centered Planning*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/pcp-action-plan/index.html>. Accessed February 21, 2014.
- ¹⁸ Centers for Medicare and Medicaid Services, Center for Medicaid, CHIP and Survey and Certification. *Letter to State Medicaid Directors*. Baltimore, MD: CMS; September 12, 2011. SMDL# 11-010; ACA#20.
- ¹⁹ State of Maine, Department of Health and Human Services. *Balancing Incentive Payment Program Application*. Augusta, ME: Maine DHHS;2013. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/Maine-BIP.pdf>
- ²⁰ State of Maine, Department of Health and Human Services. *Developmental Services - Case Management: Certification Process*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/Certification/index.html>. Accessed February 21, 2014.
- ²¹ State of Maine, Department of Health and Human Services. *MaineCare Benefits Manual: Chapter II , Section 13: Targeted Case Management Services*. n.d. Available at: <http://www.maine.gov/sos/cec/rules/10/ch101.htm>. Accessed February 3, 2014.
- ²² University of Colorado. *State of the States in Developmental Disabilities Project*. n.d. Available at: <http://www.stateofthestates.org/>. Accessed February 3, 2014.
- ²³ University of Minnesota. *National Residential Information Systems Project and Policy Studies (RISP)*. 2014. Available at: <http://rtc.umn.edu/risp/main/>. Accessed February 21, 2014.
- ²⁴ Griffin E, Fralich J, McGuire C, et al. *A Cross-System Profile of Maine's Long Term Support System: A New View of Maine's Long Term Services and Supports and the People Served*. Portland, ME: University of Southern Maine, Muskie School of Public Service and the Maine Department of Health and Human Services;2009.
- ²⁵ University of Colorado. *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine*. n.d. Available at: <http://www.stateofthestates.org/documents/Maine.pdf>. Accessed February 3, 2014.
- ²⁶ University of Colorado. *The State of the States in Developmental Disabilities: State Profiles for I/DD Spending During Fiscal Years 1977-2011: Maine*. n.d. Available at: <http://www.stateofthestates.org/documents/Maine.pdf>. Accessed February 3, 2014.
- ²⁷ State of Maine, Department of Health and Human Services, Maine Direct Service Worker. *Welcome to the Direct Service Worker Site*. 2010. Available at: <http://www.maine.gov/dhhs/mainedirectserviceworker/index.shtml>. Accessed February 3, 2014.
- ²⁸ State of Maine, Department of Health and Human Services, Office of Aging and Disability Services. *Biennial Plan for Services to Adults with Intellectual Disabilities or Autism, 2013-2014*. Augusta, ME: Maine DHHS; December 15, 2013.
- ²⁹ Employment for ME. *Workers with Disabilities: Contributing to Maine's Workforce*. 2014. Available at: <http://www.employmentforme.org/>. Accessed February 21, 2014.
- ³⁰ State of Maine, Department of Health and Human Services, Aging and Disability Services. *The Maine College of Direct Support*. 2012. Available at: <http://www.maine.gov/dhhs/oads/disability/ds/cds/rerquirement-list.shtml>. Accessed February 3, 2014.
- ³¹ Human Services Research Institute, National Association of State Directors of Developmental Disabilities Services. *National Core Indicators*. 2014. Available at: <http://www.nationalcoreindicators.org/>. Accessed February 21, 2014.

³² Medicaid.gov. *Long-Term Services & Support*. n.d. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Long-Term-Services-and-Support.html>. Accessed February 3, 2014.

³³ Griffin E, Fralich J, McGuire C, et al. *A Cross-System Profile of Maine's Long Term Support System: A New View of Maine's Long Term Services and Supports and the People Served*. Portland, ME: University of Southern Maine, Muskie School of Public Service and the Maine Department of Health and Human Services;2009, p. 10.

³⁴ State of Maine, Department of Health and Human Services. *MainCare Benefits Manual: Chapter II, Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder*. n.d. Available at: <http://www.maine.gov/sos/cec/rules/10/ch101.htm>. Accessed February 21, 2014.

³⁵ Mayhew M, Hamilton R. *Report Prepared in Response to LD 28: Resolve, to Improve Employment Opportunities for Persons with Intellectual Disabilities and Autistic Disorders* Augusta, ME: Maine Department of Health and Human Services;2012. Prepared for the Joint Standing Committee, 125th Legislature, Health and Human Services Committee.

³⁶ Winton S. *It's Your Life: Building Connections through Work*. Portland, ME: University of Southern Maine, Muskie School of Public Service; October 5, 2009. Project Summary Report.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

The following items are a guide that can be used when preparing a description of the state's children and adolescent behavioral health services:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?

Maine is committed to developing a comprehensive system of care to address the specialized needs of children with severe emotional disturbances, who also have trauma histories. Collaboration with child welfare, education, juvenile services and other service delivery systems is essential to effectively treat and support children and youth with trauma histories and their families. Prevention, early intervention, treatment, parent involvement, youth empowerment, funding streams, natural supports, state regulations and local decision-making, all must be integrated into a comprehensive approach at the state and local levels.

Over the past thirty year, Maine has been at the forefront of system of care development. History of System of Care Development:

- 1984: Maine was one of the first 10 states to receive a Child & Adolescent Services System Program (CASSP) grant. Maine was one of the few states with established, regular collaboration on children's issues by the Commissioners of the child-serving Departments
- 1985-1989: Care coordination and local collaboration developed in two regions through the CASSP grant. And by 1989 this structure was adopted state wide.
- 1989-1995: Extensive training in wraparound planning & family strengths
- 2002: Purchase of Mary Grealish's Wraparound Process curriculum
- 2004: Collaboration with the Department of Education in the provision of training on the Wraparound Process at the annual Statewide Special Education Director's Conference, followed by local cross-training events with school staff and Targeted Case Management providers
- 1993-1998: Through Maine's Infrastructure Grant (Center of Mental Health Services) which systematized local and state level collaboration based on child and family strengths and parent involvement.
 - Local Case Resolution Committees replicated statewide with parents paid for participation as standing members.
 - All Child serving departments committed to joint funding for individualized services identified by committees.
 - Establishment in statute (1995) Children's Cabinet added additional commissioners from Public Safety and Labor.
 - Continued extensive statewide Wraparound Training, included Legislators, Children's Cabinet and Juvenile Justice.
 - Grant-funded research included hiring parents as evaluators to interview other parents about the effectiveness of the Local Case Resolution Committees.
 - System of Care grant (1993) established Wings for Children and Families an agency based entirely on the principles of family driven, family centered, family

focused wraparound service provision. Services were focused on four rural counties in northern Maine.

- Kmihqitahasultipon (meaning “We Remember) Behavioral health services to be provided to the children of the Passamaquoddy tribe by trained tribal members.
- 10/1/2005 – 9/30/2011 Trauma Informed System of Care: Goal is to build an infrastructure and implement a trauma-informed system of care for children ages birth through age 12 with serious emotional disturbances who live in three counties in western Maine. Later expansion of services for youth, development of a youth committee which resulted in the formation of Youth Move Maine Chapter of the national Youth Move Federation.
- 10/1/2011-9/30/12: Expanding Trauma Informed System of Care
- 10/1/2009- 9/30/2015 Emerging Adult Initiative The Moving Forward Project Transition to Independence Process Model of Case Management.
- 10/1/2015-9/30/2019 “Now is the Time- Healthy Transitions- The Moving Forward Initiative. Expansion of the Transition to Independence Process Model of Case Management, Peer Mentor services and the implementation of the Portland Identification and Early Intervention services.

Structure of the System of Care

Maine’s mental health authority for children’s mental health services is the Children’s Behavioral Health Services (CBHS) unit within the Office of Child and Family Services (OCFS) program unit within the Department of Health and Human Services. Children’s Behavioral Health Services staff provides leadership, in systemic planning and policy development, budget oversight, interdepartmental collaboration, legislative initiatives and systems advocacy on behalf of children with emotional and behavioral needs and their families. Mental health services for children are delivered at the local level through a district structure.

Focal Point of Responsibility for Children's Mental Health

The State mental health authority is the Department of Health and Human Services. The focal point for children's mental health the Children’s Behavioral Health Services (CBHS) unit within the Office of Child and Family Services (OCFS) program unit within the Department of Health and Human Services... The statutory authority for the Children’s Mental Health Program is cited in PL1998, Chapter 790.

Children’s Behavioral Health Services within OCFS support and serves children, age birth through 5, who have developmental disabilities or severe developmental delays, and children and adolescents, age birth through 20, who have treatment needs related to severe emotional disturbance, intellectual disability, autism spectrum disorders, developmental disabilities, or emotional and behavioral needs, and the families of these children.

The OCFS statutory mission includes a strong family support focus. It is mandated to "strengthen the capacity of families, natural helping networks, self-help groups and other community resources to support and serve children in need of treatment" (M.R.S.A. Title 34-B. section 6204.1.A.) and to "(provide) in-home, community-based, family-oriented services." (34-B. section 6203.1.B.)

Target Populations

OCFS Children’s Behavioral Health Services has three operational target populations:

- a. Children who have developmental disabilities or severe developmental delay, age birth through 5;
- b. Children and adolescents, age birth through age 20, who have emotional/ behavioral needs including children with serious emotional disturbance;
- c. Children, age birth through age 20, who have intellectual disability, autism spectrum disorders or pervasive developmental delay

In accord with P.L. 102-321, Maine defines serious emotional disturbance in terms of the Federal definition.

System of Integrated Services

Chapter 790, Public Law 1997 - A Coordinated System of Children's Mental Health Services

One year after the 118th Legislature commissioned a study of mental health services to Maine children and their families (LD 1744), which resulted in A Plan for Children's Mental Health Services, the legislature completed the reform process by passing LD 2295, Chapter 790, P.L. 1997, titled "**An Act to Improve the Delivery of Mental Health Services to Children.**"

The law amends Title 34-B M.R.S.A by adding Chapter 15, Children's Mental Health Services. Chapter 790 focuses on the mental health needs of children who are served by all child-serving departments, introduces the principle that there should be a system in place that addresses these needs, and designates DHHS to be responsible for coordinating that system. The major sections of the law include:

- Creation of a Children's Mental Health Program,
- Defining the responsibilities of the four (4) child-serving departments,
- Establishment of a Children's Mental Health Oversight Committee,
- Planning for children with autism, developmental disabilities and intellectual disability

Section 15002: Children's Mental Health Program:

This program represents the structure that will coordinate the children's mental health care provided by all child serving departments. The program is now under the supervision of the Commissioner of DHHS. The Director of the Office of Child and Family Services has responsibility for the implementation, monitoring and oversight of the program.

This program will track the mental health care and services of all child serving departments, as well as the development of new resources and funds used to provide mental health services from each department's budget. The program does not diminish any entitlements already in place that are the responsibility of the various Departments by virtue of state or federal law, rule or regulation.

Fundamental values endorsed by the LD 1744 planning process are made explicit for all children and families. They include a child and family centered program and planning process, focusing on child and family strengths as the starting point for an individualized plan of services.

Principles of care delivery stress local service provision, prevention and early intervention services, and choice of care through a case management system. The program must implement uniform intake and assessment protocols and identify a central location for obtaining information and access to the program. The system of providing care must be a functionally integrated, network based system, with OCFS as the single point of accountability.

Section 15003: Responsibilities of the Departments:

Each Department has entered into memoranda of agreement that recognize, DHHS as responsible for the implementation and operation of the Children’s Mental Health Program, and specifies the other Departments’ respective responsibilities.

DHHS Office of Child and Family Services is responsible for developing policies and rules regarding access to care, eligibility standards, uniform intake and assessment tools, and access to information among departments. This includes responsibility to coordinate with the other Departments on developing community resources and support services and for monitoring care and services. The Departments must also determine existing service capacity, unmet needs, and the need for increased service capacity. The law instructs DHHS to adopt rules for mental health care for children under the Medicaid (MaineCare) program.

Chapter 790 requires that the Departments implement fiscal information systems that can track all appropriations, expenditures, and transfers of funds that are used for children’s mental health services. This capacity exists within the Office of Child and Family Services through the integration of behavioral health services, early childhood services and child welfare services and fiscal data managed by the OCFS Program Fiscal Coordinator. Chapter 790 requires that federal block grant monies are to be used for children who are not eligible for Medicaid. General funds will be used to maximize the use of federal funds, including Title IV-E and other federal funds for the care of children living at home and in residential placements.

Management information systems must focus on care and support services delivered, needs and unmet needs for care, waiting lists, resource development, and costs of the program. Information is to be kept by treatment need, care provided, geographic area, and Department involvement. Information will cover children placed out of state who transfer to care in the State of Maine. Both internal and external evaluation processes of the program’s effectiveness are required.

The law (Chapter 790) placed considerable emphasis on regular reporting to newly created oversight committee and to the legislature’s Joint Standing Committee on Health and Human Services. All child-serving Departments continue to provide information to their legislative committees of jurisdiction, such as the Joint Standing Committee on Health and Human Services that oversees DHHS Office of Child and Family Services. Other committees of jurisdiction include the Joint Standing Committees on Education and Cultural Affairs and Criminal Justice and Public Safety.

AVAILABLE SYSTEM OF TREATMENT, REHABILITATION AND SUPPORT SERVICES

The Department, in concert with all other child-serving state agencies, parents, community service providers and legislators who participated in the 1997 planning process culminating in A Plan for Children’s Mental Health Services, identified a full array of services and supports essential to the children’s system of care. Funding sources identified in the Plan include sources available to and employed by any of the four child-serving state agencies.

Six core mental health service components were identified and described below. Each core service is available in varying degrees of intensity, depending on the level of need. In addition to the core services, flexible resources (called individual planning funds) are available to provide for individual

needs identified through the individualized planning process that cannot be addressed through categorical services or funding sources.

In Maine, the core service array is intended to provide a blueprint for developing service capacity in each geographic area of the state. The core service array with service components is summarized as follows:

- **Prevention/Consultation Services** include early intervention services for pre-school and very young children and includes identification of at-risk children, clinical consultation and information/education components. Services are designed to identify problems and intervene early. Information about health and emotional development can identify children “at risk” and trigger treatment services. Education activities inform the community about mental health problems; consultation services address individual cases and assist other agencies in handling mental health problems.
- **Crisis Intervention and Stabilization Services** are accessed through a single statewide, toll free 1-888-568-1112 crisis telephone line. Services include mobile crisis outreach services, crisis resolution, and short-term crisis stabilization units. Crisis services provide support and stabilization services to children and youth in their homes, schools or other community settings. Services are available 24 hours a day, 7 days a week. Crisis outreach includes an assessment of risk, identification of immediate needs, and development of a crisis stabilization plan, a crisis plan to follow in the event of re-occurrence, referral and follow up. Specific crisis interventions may involve a variety of in-home support services or short-term, out of home treatment in the community
- **Individual Planning/Case Management Services** consist of screening and assessment, individual service planning, homeless youth, outreach and targeted case management. Case management services for children entail an individualized planning process. Assessment involves determination of an individual or family’s strengths and needs, contributing factors, and existing assets and resources, as well as screening instruments that profile the child’s functional abilities. These assessment instruments, the Child and Adolescent Functional Assessment Scale or the Children’s Habilitation Assessment Tool, are administered at the time of service entry, and re-administered every ninety days and at completion of services.
- **Family and Child Supports** include respite care, parent and peer support services, information and referral services, individual planning funds and social and recreational services. These natural and extended supports are designed to strengthen the ability of families/caregivers to maintain children in their home and community. Family support and respite provide relief from constant caregiving, and support for each caregiver’s problem-solving, communication skills, behavioral interventions, and advocacy
- **Community Outpatient and Treatment Services** consist of psychological/psychiatric evaluation; medication management; individual, group, and family counseling; and children’s home and community-based treatment services that include several evidence-based practices. Clinical services represent a wide range of community-based treatment, including specialized interventions for substance abuse, trauma, etc. Problem-oriented counseling, skills training, and in-home behavioral treatment services to strengthen and stabilize the family living environment are designed to minimize the risk of out-of- home placement. School-linked mental health

services provide a variety of educational/ psychological assessment and referral, individual and family counseling, special education, and other support services geared specifically to support the child or youth in the school environment.

- **Residential Services** include therapeutic (treatment) foster care and regular foster care for children in child welfare services care, and short-term intensive residential treatment for children with behavioral health treatment needs. Out-of-home residential services include specialized therapeutic homes with foster parents recruited and trained to care for children with serious emotional and behavioral challenges. Behavioral health services provide short-term, intensive temporary out-of home treatment services (ITRTS).

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?

OCFS will be meeting with Georgetown in early fall to obtain technical assistance to enhance our current system of care for children. We will be reviewing assessment and outcome measure tools that other states are using. We are currently meeting with stakeholders to create a person centered planning process within our Targeted Case Management services. We are reviewing bringing back Wraparound Planning as a consistent statewide practice.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

Office of Child and Family Services has developed strong and viable relationships with other child-serving state agencies, notably the Department of Corrections, Juvenile Services, the Department of Education, and the DHHS Office of Substance Abuse.

These relationships are nurtured and strengthened through active collaboration within the system of care. Collaboration and partnerships are developed at the regional level where services are delivered to children and their families; at the policy level where strategies are formulated and values are supported; and at the practice level where behavioral health services are shaped, evaluated, and promoted, based on outcomes beneficial to children and their families. OCFS promotes the interests of families through relationships with other state agencies and their divisions, and affiliates such as the Department of Education through the Maine Association of Special Education Directors.

OCFS is also connected with other state agencies and entities that are not directly involved with services for children and their families, but are important potential, future service providers for some youth as they begin to transition to adulthood. These agencies include the Office of Substance Abuse and Mental Health Services (SAMHS) which may be a provider for young adults with Serious Mental Illness (SMI) and the Office of Aging and Disability Services that

could be a destination for high need youth whose emotional, physical and behavioral needs require intensive and long term attention and support that would be available under the Home and Community-based Waiver offered through that office.

OCFS enjoys a close and productive working relationship with the DHHS Office of MaineCare Services (OMS), the Maine Center for Disease Control and Prevention (MCDC), and the Office of Quality Improvement (OQI). These units of the Department provide essential subject matter expertise to OCFS and they have been long standing partners in key areas within the behavioral health services program

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

Maine is looking at the entire Children's Behavioral Health System of Care. We are re writing policies and looking at ways to improve services and outcomes for children and families. We will be working with Georgetown to choose the most appropriate tools for measuring service and treatment outcomes. In collaboration with other state agencies we are looking at employment opportunities for transition age youth, as well as, expanding and finding ways to sustain the Transition to Independence (TI) model within our Targeted Case Management System.

Maine responded to ta Federal Partnering for Success RFI and was one of four sites to be awarded this opportunity to be trained and build clinical capacity to deliver evidence – based CBT Plus services to child welfare-involved youth and families. The kick-off event occurred July 7, 2015 and training begins in October.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

OCFS has the capability to track client level outcomes at the individual client level. Providers receiving Community Mental Health Services Block Grant are required to collect individual client level data. Respite Services data is also tracked at the individual client level and transferred to the Department for analysis.

Implementation of Evidence Based Practices and linkages to Medicaid, the single largest funding source, are very strong and consistent. This includes formal development and joint implementation and of performance measures and contracting, as well as implementation of these performance measures into formal Rule Making.

Monitoring of success occurs at multiple levels: through the Office of Continuous Quality Improvement, and within SAMHS's own team – Data, Quality Management, and Resource Development. These Offices work closely together in the design, development, implementation, review, and monitoring of the performance measures referenced above.

6. **Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?**

OCFS Children's Behavioral Health Services regularly participates with staff from the state Department of Education on a wide variety of policy level issues as well as specific operational initiatives. Included among these activities is the Interdepartmental Resource Review Committee which identifies priority needs for all children, and reviews new or enhanced program models

7. **What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.**

The Children's Behavioral Health Services unit strives to ensure that to any child between the ages of 0-21 and their family identified as needing a behavioral health intervention have access to and receive this service in the most effective, least restrictive setting as possible.

Within the OCFS there is a single Youth Transition Protocol with the Office of Aging and Disability (OADS). A memorandum of Understanding exists between OCFS and SAMHS regarding transitioned aged individual. Below is brief description of each.

Intellectual Disability Services Transition

Prior to the merger of the two Departments Children's Services and the former Adults with Intellectual Physical and Cognitive Disability Services began working collaboratively on service transition to adulthood . These discussions resulted in agreement on a number of points. Youth should have flexibility in choosing which system to receive service from between the ages of 18 and 21 years. Information sharing between children and adult systems for planning purposes will begin at age 16. There will be a collaborative financial planning process when development of resources for children will impact the adult services system. Training in the adult intellectual disability services has been delivered for all CBHS contracted case managers in all regions Adult services will provide advisory eligibility for young people, so that planning can be done understanding the adult services that the young person is eligible for. A website is available for the public, case managers and service providers to be informed on eligibility at:

http://www.maine.gov/dhhs/oads/disability/ds/comm-cm/CM_Manual/Eligibility.html

MOU between OCFS and SAMHS Regarding Transition Age Individuals

An important product of the *Moving Forward* Initiative has been the concurrent development of an updated **Memorandum of Understanding** between the Office of Child and Family Services and the Office of Substance Abuse and Mental Health Services. This MOU, effective May 14, 2009 formally addresses the roles, responsibilities, and commitments of Maine's Mental Health Authorities to enhance and sustain a high quality mental health system of care for transition age

individuals. Both offices recognize the need to enhance and coordinate policies, procedures, services, and supports for individuals from ages 16-25.

Using the TA text box provided in BGAS, please indicate areas of technical assistance needed as it relates to this section.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

Please indicate areas of technical assistance needed related to this section.

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

20. Suicide Prevention

Footnote

The current Maine Suicide Prevention Program Strategic Plan 2012-2017 is focused on reducing one of the largest public health issues facing Maine citizens. The plan is a result of a collaborative effort of the Maine Suicide Prevention Program (MSPP), the MSPP Advisory Council, and many engaged stakeholders who provided input into development of this plan. The MSPP is a multi-agency effort led by Maine CDC Injury Prevention Program in the Department of Health and Human Services. Other state agency partners include the Departments of Education, Labor, Corrections, and Public Safety. The purpose of the MSPP Strategic Plan 2012-2017 is to guide Maine's statewide suicide prevention efforts across the lifespan. The Plan's implementation requires the engaged efforts of state and local agencies, decision-makers, health care providers, service organizations, educators, planners, employers, community members, and others to integrate suicide prevention best practices and initiatives within their settings.

The plan contains five overarching goals and utilizes a public health approach to reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens. New opportunities in this plan target primary care settings and engage a widening circle of partners that are fundamental to this effort. Maine has historically been at the forefront of the development, implementation, and evaluation of youth suicide prevention programs. The commitment to youth suicide prevention, working with schools and colleges is a continuous, unending process.



Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 287-8016
Fax (207) 287-9058; TTY (800) 606-0215

Dear Citizens of Maine,

It is with great pleasure that I present the Maine Suicide Prevention Program Strategic Plan 2012-2017 focused on reducing one of the biggest public health issues facing Maine citizens – suicide. The plan is the result of a collaborative effort of the Maine Suicide Prevention Program (MSPP), the MSPP Advisory Council and many engaged stakeholders who provided input into development of the plan. The MSPP is a multi-agency effort led by the Maine CDC Injury Prevention Program in the Department of Health and Human Services. Other state agency partners include the Departments of Education, Labor, Corrections and Public Safety.

Suicide is widely recognized as a public health problem requiring national attention and urgent action nationwide. Every 14 minutes, someone dies by suicide in the United States. In 2011, 224 Maine citizens, 4 each week, died by suicide. In 2012, a revised U. S. Surgeon General National Strategy for Suicide Prevention was issued to build upon a decade of accomplishments and incorporate recent advances in suicide prevention, reemphasizing that suicide is a major public health problem, which can only be reduced through integrated efforts by all sectors of society.

The purpose of the MSPP Strategic Plan 2012-2017 is to guide Maine's statewide suicide prevention efforts across the lifespan. The Plan's implementation requires the engaged efforts of state and local agencies, decision-makers, health care providers, service organizations, educators, planners, employers, community members, and others to integrate suicide prevention best practices within their settings and initiatives. The Plan contains five overarching goals and utilizes a public health approach to reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens. New opportunities in this plan target primary care settings and engage a widening circle of partners that are fundamental to this effort. Maine has historically been at the forefront of the development, implementation and evaluation of youth suicide prevention programs. The commitment to youth suicide prevention, working with schools and colleges, continues.

No single agency or individual can do this work alone. The Maine Suicide Prevention Program Strategic Plan 2012-2017 is a call to action; providing an excellent blueprint for partners in the public and private sector to use to increase awareness of suicide, promote collaboration, and facilitate opportunities for suicide prevention activities in their communities. Ultimately, the purpose is to prevent the tragedy of suicide from impacting Maine families, schools and communities and, over time, to save thousands of lives and millions of dollars.

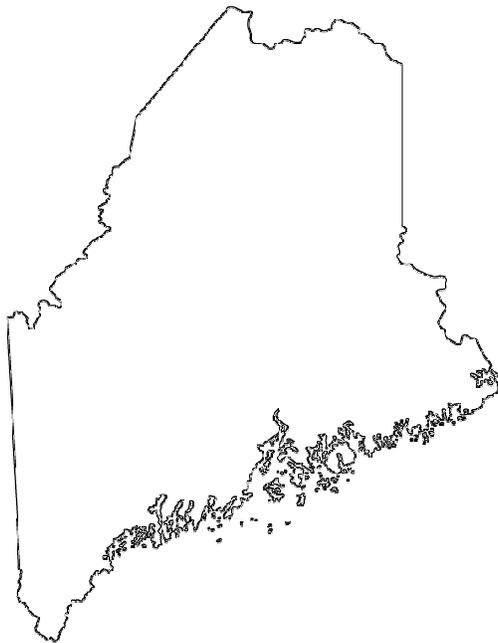
Thank you to the members of the Maine Suicide Prevention Program's Advisory Council for their dedication to this plan's development.

Sincerely,

Dr. Sheila Pinette
Director, Maine CDC

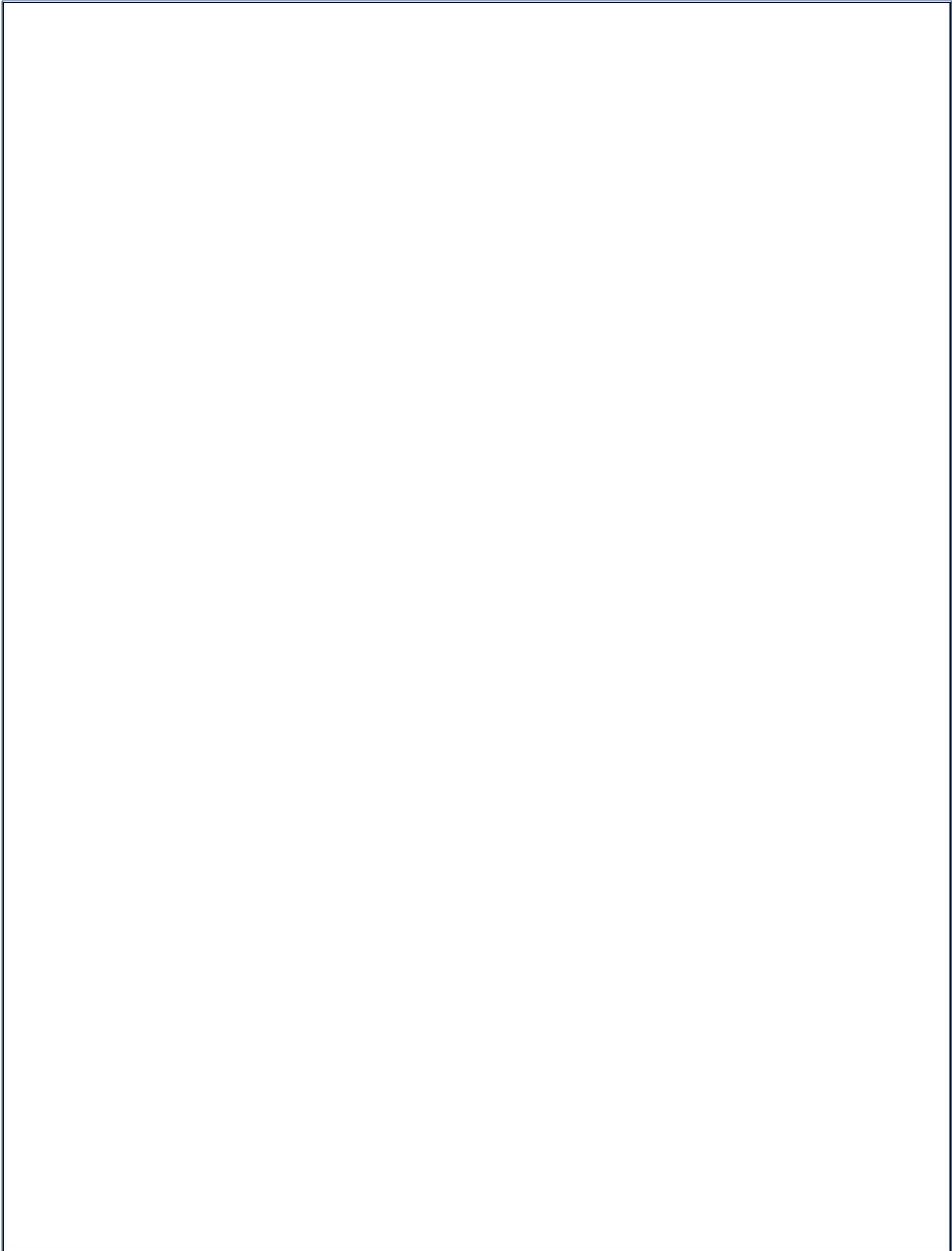
Maine Suicide Prevention Program Strategic Plan 2012-2017

*To reduce the incidence of fatal and non-fatal
suicidal behavior among Maine citizens
across the lifespan*



**Maine Suicide Prevention Program
Led by the
Department of Health and Human Services
Maine Center for Disease Control and Prevention**





Maine Suicide Prevention Program Strategic Plan 2012-2017

Table of Contents

Acknowledgements	
Executive Summary	
Introduction	1
Background	5
Public Health Approach	7
The Costs of Suicide	8
Suicide and Suicidal Behavior	10
Research Based Practices for Suicide Prevention	22
MSPP Plan	
Guidelines for Suicide Prevention	31
Goals, Objectives, Activities	34
Appendix 1: Glossary of Terms	48
Appendix 2: MSPP Advisory Council	53
Appendix 3: Resources	56
Appendix 4: Agencies and Organizations that Could Partner in Suicide Prevention	59
Appendix 5: Clinical Treatment of Suicidal Behavior	63

Acknowledgements

This plan was developed by the Maine Suicide Prevention Program, led by the Maine Center for Disease Control and Prevention (Maine CDC) of the Department of Health and Human Services, with input from about 70 individuals from around the state. The program is greatly indebted to everyone who shared their expertise and their perspective on development of this statewide suicide prevention plan for 2012-2017.

A draft of this plan was widely distributed to obtain feedback from government officials, service provider agencies, families, educators, military, health care, public safety and many other sectors. Three public forums were held in Augusta, Bangor and Portland. In addition, an online forum was held and an online survey was sent to those who wanted to provide feedback but could not participate in one of the forums.

The individuals who attended one or more meetings or provided their input in other ways share a strong commitment to preventing suicide in Maine. They represent diverse sectors including families and individuals affected by suicide, state government agencies, community-based organizations, education, health care, public health, colleges and universities, and tribal entities from many geographic regions around the state.

Special thanks goes to the members of the Maine Suicide Prevention Program Advisory Council who, through their discussions, decided to encompass the lifespan in this program plan and who contributed their input to all aspects of plan development. A Maine Suicide Prevention Program Advisory Council member list is in Appendix 2.

Authors and Editors:
Cheryl DiCara, Carrie Horne, Greg Marley, Laura Wilder, and Katharyn Zwicker

The Advisory Council members acknowledge and thank Mary Mayhew, Commissioner, Maine Department of Health and Human Services and Dr. Sheila Pinette, Director, Maine CDC for their support in the creation of this plan and for their dedication to the work of the Maine Suicide Prevention Program.

Executive Summary

Suicide has been widely recognized as a public health problem requiring national attention and urgent action nationwide. Every 14 minutes, someone dies by suicide in the United States. In 2011, 204 Maine citizens, 4 each week, died by suicide. In 2001, acknowledging the devastating impact and costs of suicide, the U.S. Surgeon General issued the first National Strategy for Suicide Prevention. The National Strategy emphasized that suicide is a major public health problem, which can only be reduced through integrated efforts by all sectors of society. Many of the risk and protective factors for suicidal behavior are known, and the evidence for effective suicide prevention

programs is growing. In 2012, a revised National Strategy was issued to build upon a decade of accomplishments and incorporate recent advances in suicide prevention.

Maine has historically been at the forefront of the development, implementation and evaluation of youth suicide prevention programs and has achieved demonstrable success. Since program inception, the percent of students reporting suicide ideation or attempts on the school-based Youth Risk Behavior Survey (YRBS) has significantly declined and the rate of suicide among 10 to 19 year olds decreased by 7 percent from 2001-2005 to 2006-2010. The Maine Suicide Prevention Program (MSPP) is a multi-agency effort led by the Maine CDC's Injury Prevention Program in the Department of Health and Human Services (DHHS). In addition to the DHHS, state agency partners include the Departments of Education, Labor, Corrections and Public Safety.

In 2009, the Maine Youth Suicide Prevention Program began the process of updating Maine's Youth Suicide Prevention Plan and also to initiate the development of a draft Plan for the Prevention of Suicide Among Adults in Maine that was completed in 2011. The adult plan represented the first time that Maine moved beyond its historic focus on youth suicide prevention. The purpose of this 2012-2017 Strategic Plan is to guide Maine's suicide prevention efforts across the lifespan. The implementation of this plan requires the engaged efforts of new stakeholders and partners to integrate suicide prevention best practices within their settings and initiatives.

Suicide and Self-Inflicted Injuries in Maine

Suicide takes nearly 37,000 lives each year in the United States and 1 million lives worldwide. Suicide rates have been increasing in the U.S. and Maine since 2007. In Maine, suicide is the 10th leading cause of death and the leading cause of violent death, killing almost seven times as many Maine citizens each year as homicide. From 2006-2010, 913 Maine residents died by suicide, an average of 183 annually. This represents an increase of 11 percent from the previous 5 years. Preliminary data for 2011 reveal a continued increase with 204 suicides. Suicide is the second leading cause of death for youth and adults ages 15-34.

Males die by suicide at much higher rates than females, 80 percent of suicides are male. For many years, the highest suicide rate has been among white males ages 85 and older. The overall number of suicide deaths and the associated rate of suicide have both increased in adults of working age since 2007. During 2006-2010, the highest rate of suicide was among adults ages 50-54 with the most notable increase among middle aged white males. Comparing the time period of 2001-05 to 2006-10, the rate of suicide in males ages 40-44, 45-49 and 50-54 increased by 40 percent, 35 percent and 65 percent respectively. The rate of suicide among females has also been rising in Maine and in the nation. Females attempt suicide at higher rates.

Many Maine families, schools and communities have been torn by the tragedy of a suicide involving someone they care about. Suicide occurs in all socio-economic groups and at all educational levels. Firearms are the most common method used to complete

suicide and the method most commonly used by males. Hanging and poisoning are the second and third leading suicide methods respectively. Poisoning the most common method used in female suicides.

Suicide attempts significantly outnumber deaths. On average, from 2005-2009, the most recent years for which data are available, there were 2,136 emergency department visits and 1,116 hospital discharges for self-inflicted injury annually. Young people attempt suicide at much higher rates than adults; young females experience the highest rates of hospitalization for self-inflicted injuries. It is estimated that there are as many as 100 youth suicide attempts for every youth suicide and most of these attempts do not result in medical intervention.

Suicide Prevention

The evidence base for suicide prevention has grown in the decade since the first National Strategy for Suicide Prevention. Several strategies have strong evidence of effectiveness from more than one study.¹ These strategies include: screening and treatment for depression in primary care practices and emergency departments, community based education strategies, comprehensive school-based programming, and restriction of highly lethal methods of suicide.

Suicide prevention at the individual and group level relies on an understanding of the risk and protective factors in a person's life. There is no exact combination of risk factors and triggering events that predict an individual's suicide risk. As the research continues to develop, it is becoming clear that some risk factors for suicide are more prevalent than others. Because so many people are potentially at risk, effective prevention strategies must employ a public health approach addressing the entire population.

Maine Suicide Prevention Program Plan

The purpose of the 2012-2017 MSPP Strategic Plan is to guide efforts statewide to prevent suicide across the lifespan. The plan is the result of a collaborative effort of the Maine Suicide Prevention Program (MSPP), the MSPP Advisory Council and many engaged stakeholders who provided input into development of the plan. The plan is intended to be used by state and local agencies, decision-makers, health care providers, service organizations, educators, planners, employers, community members and others interested in preventing suicide in their communities and in their lives. Ultimately, the purpose is to prevent the tragedy of suicide from impacting Maine families, schools and communities and, over time, to save thousands of lives and millions of dollars.

¹ Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association (JAMA)*, 294(16), 2064-74; Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.

The long-term goal of the MSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens across the lifespan. The MSPP Plan contains five overarching goals that reflect an integration of goals identified in the Maine Youth Suicide Prevention Program Plan and the draft Adult Suicide Prevention Plan. The goals utilize a public health approach to address the lifespan problem of suicide. New opportunities identified in this plan target primary care settings and engage a widening circle of partners that are fundamental to this effort. The commitment to youth suicide prevention, working with schools and colleges, continues.

Maine Suicide Prevention Strategic Plan 2012-2017 Goals:

Because suicide takes a life in Maine every two days...

GOAL 1: Statewide leadership and coordination guides suicide prevention among Maine people.

Because people need access to comprehensive health care...

GOAL 2: Maine's people can access suicide prevention and intervention services in health care settings across the state.

Because preventing suicide is up to all of us...

GOAL 3: Maine's people are protected through integration of effective suicide prevention efforts within public and private organizations statewide.

Because people need to know how to help prevent suicide...

GOAL 4: Professionals working with Maine people are knowledgeable in suicide prevention, intervention and postvention.

Because seeking help saves lives...

GOAL 5: A culture of help-seeking for people in need exists in Maine.

Introduction

In the past decade in the United States, suicide has been widely recognized as a public health problem requiring national attention and urgent action. Many of the risk and protective factors for suicidal behavior are known. The evidence for effective suicide prevention interventions is growing. The U.S. Surgeon General issued the first National Strategy for Suicide Prevention in 2001, emphasizing that suicide is a major public health problem, which can only be reduced through integrated efforts by government, public health, mental health, human services, public safety and education working with communities, schools, employers, families, youth and other public and private partners.

In a 2003 report *Achieving the Promise: Transforming Mental Health Care in America* issued by then President Bush, suicide prevention was included in the first of six goals for the nation. In 2004, Congress passed the Garrett Lee Smith Memorial Act to provide federal funding to states for youth suicide prevention.

In light of significant progress made in the decade since the first National Strategy for Suicide Prevention was issued, the Office of the Surgeon General and the National Action Alliance for Suicide Prevention released an updated National Strategy for Suicide Prevention in 2012 to build upon accomplishments and incorporate recent advances in suicide prevention knowledge. When the first National Strategy was released, there were almost no “Best Practices” for suicide prevention. In 2012, there is a national registry of over 100 Best Practices and the knowledge base continues to grow.

Suicide is preventable. Like chronic health conditions, suicidal behavior is multi-determined. Preventing suicide is similar to preventing a heart attack. The general risk and protective factors are known and practitioners recommend health-promoting actions to their patients, but it is difficult to accurately predict when a heart attack may happen for a particular individual. Early detection and appropriate treatment and supports are necessary components to effective suicide prevention. By raising awareness of suicide prevention and increasing knowledge and intervention skills among a wide range of professionals and service providers, promoting help-seeking and effecting policy change, Maine can achieve lower suicide rates.

Maine Suicide Prevention Program

The Maine Suicide Prevention Program (MSPP), led by the Maine CDC Injury Prevention Program in the Department of Health and Human Services (DHHS), with our partners, is committed to excellence in suicide prevention, intervention, and postvention. Maine was one of the first states to plan, implement and evaluate a suicide prevention program. Multiple state agencies participate in carrying out MSPP activities. In addition to the Maine CDC, state agency partners engaged in suicide prevention include the Maine Substance Abuse and Mental Health Services and Child and Family Services in the DHHS and the departments of Education, Labor, Public Safety and Corrections.

The MSPP employs a public health approach to suicide prevention. The program is based upon the assumption that collaboration among state agency leaders and staff, along with significant involvement from professionals, youth, suicide survivors, organizations and others, is essential to planning and conducting effective suicide prevention activities. Since inception in 1998, the program has maintained an Advisory Council that provides guidance to program development and implementation. Membership includes government and private sector stakeholders.

The work of the MSPP is founded on the shared belief that suicide is preventable. Most suicidal behavior occurs during a time of crisis in an individual's life; when personal coping ability is overwhelmed, feelings of hopelessness prevail, and few or no alternative paths out of the situation are apparent to that individual. Many of these crises are short-lived and resolution of the crisis leads to improved mood and safety. With information, support and intervention, many suicides can be averted. Recovery from physical and emotional pain can allow a person to move forward with their life. Suicide prevention is based on the belief that people can overcome crises and recover from mental illness and live productive lives.

Current MSPP activities include:

- Statewide Information Resource Center
- Statewide Crisis Hotline answered in-state 24/7; 1-888-568-1112
- Web sites containing information and resources for adults and youth
- Gatekeeper Training;
- Awareness Education Programs and Resources
- Training of Trainers to conduct awareness education
- Clinician Assessment Training
- Annual Conference;
- Protocol Guidelines and protocol development training
- Training for educators who will teach "Lifelines", Middle School and "Transitions" student lessons
- Assistance and Consultation to schools, community agencies, health care providers and others to effectively prevent suicide
- Media education and guidelines for safe reporting on suicide
- Fact sheets and other resource materials
- Suicide and self-inflicted injury data monitoring and analysis

Purpose of the Plan

This strategic plan is intended to serve as a guide to address suicide prevention across the lifespan. It builds on two previously developed Maine plans: one focused on adults and the youth suicide prevention plan. This plan lays out strategies to reduce the burden of suicide across the lifespan by strengthening partnerships between state and local organizations and integrating suicide prevention capabilities into existing programs and services. The plan establishes priorities for suicide prevention initiatives and activities over a five-year period.

This plan is meant to inspire action. Individuals reading this plan are encouraged to take an active role in working to prevent suicide among youth and adults. The resources, authority and skills to conduct effective suicide prevention activities do not reside within a single organization. While the state level program has a significant leadership role to play, only by joining efforts across agencies and communities can Maine realize the common goal of preventing suicide.

The Planning Process

Maine's Suicide Prevention Strategic Plan 2012-2017 is the result of a process obtaining the input of many partners involved in suicide prevention activities in Maine. In 2009, the Maine Youth Suicide Prevention Program engaged in a strategic planning process to update the state's youth suicide plan. This involved acquiring extensive input through a series of facilitated meetings with the Advisory Council and state and contracted staff. Significant individual and group work followed to craft goals and objectives, and the activities to meet those objectives.

In 2010, a small work group of individuals from diverse settings was convened by the program to develop an adult-focused suicide prevention plan. The **Plan for the Prevention of Suicide Among Adults in Maine** was completed in 2011 and represented the first time Maine moved beyond its initial focus on youth suicide prevention.

In 2011, following an Advisory Council decision to expand the program focus to adults and youth, a small work group synthesized a set of goals, objectives and activities for lifespan suicide prevention, working from the youth and adult plans, research and national guidance documents. A draft of this plan was widely distributed to solicit feedback from the people of Maine to ensure a responsible and responsive approach to suicide prevention. In order to gain diverse, professional and public feedback, four venues were planned so that statewide participation could be available. Three public forums were hosted in Augusta, Bangor and Portland, Maine. One forum was hosted virtually through a "Go-To-Meeting" format. Those who could not participate in the scheduled forums were sent a link to an on-line survey to give their feedback.

Invitations to participate in the forums and the on-line survey were emailed to a variety of people including state government officials and employers, school staff, suicide survivors, public safety and corrections officials, LGBT advocates, health care professionals, members of the clergy, those working in military or veteran's affairs, mental health agencies and health agencies. Overall, hundreds of e-mail invitations were sent to encourage participation. In addition, specific invitations were made to key stakeholders identified by the planning committee. People were invited to provide feedback directly to planning committee members if they were unable to participate in any of the public venues. All feedback was gathered into an aggregate report to the program for use in revising the goals, objectives, and activities contained in the Maine Suicide Prevention Strategic Plan. Quotes from the stakeholder process are interspersed throughout this plan.

Background

Maine Suicide Prevention Program History

The Maine Youth Suicide Prevention Program (MYSPP) began as an initiative of Governor Angus S. King's Children's Cabinet which included the commissioners of the Departments of Health and Human Services, Education, Corrections, Labor and Public Safety. The original MYSPP plan was created in 1997 through an extensive process that included input from suicide survivors, youth, and many clinicians and professionals from around the state. That plan was updated in 2007.

When implementation began in 1998, staff in every agency of the Governor's Children's Cabinet were instructed to include youth suicide prevention as a priority using existing agency funds. Each agency was asked to assume leadership in implementing specific parts of the plan in order to build and sustain a state level infrastructure. The plan was built upon the Governor's Task Force recommendations and the best available information at the time. In 1999, the Children's Cabinet provided funds to initiate priority program activities. Many activities in the initial plan are still being implemented.

Since inception, the MYSPP has received regional and national recognition for its efforts. Staff and partners have made many presentations at state, regional and national events. Maine has contributed to the national suicide prevention evidence base through its work, most notably through implementing and evaluating *Lifelines*, a comprehensive school-based program, with a grant from the U.S. Centers for Disease Control and Prevention (CDC). This project was conducted in 12 Maine high schools from 2002-2006. Project evaluation enabled the program to bring the *Lifelines* student lessons into the National Registry of Evidence-based Programs and Practices (www.nrepp.com).

In September 2005, the MYSPP was awarded a Garrett Lee Smith Memorial Act (GLS) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a three-year youth suicide prevention project reaching 6 Maine high schools and selected community agencies. In 2006, an additional grant award to conduct an in-depth evaluation of the SAMHSA project was obtained from the U.S. CDC. In 2008, a second SAMHSA GLS three-year grant award was received and another 11 Maine high schools, several Maine tribes and Maine colleges became engaged in implementing suicide prevention programs. Through the two SAMHSA funded projects, 17 schools and 29 community agencies serving these school communities identified over 500 youth at risk and referred them for help.

In 2011, the program, with the Advisory Council, decided to expand the focus from youth aged 10-24 to a lifespan focus. This decision was based on emerging data showing that the highest and fastest growing rate of suicide in Maine is among adults. At that time, the program became the Maine Suicide Prevention Program (MSPP).

Components of the Maine Suicide Prevention Program 2012

Statewide Crisis Hotline 1-888-568-1112: A statewide crisis hotline automatically connects in-state callers to the crisis service provider in the area from which they are calling. This line is for ALL individuals in crisis or concerned friends or loved ones and provides immediate, local assistance in a crisis situation 24/7.

Statewide Information Resource Center (IRC) 1-800-499-0027

<http://osairc.informe.org> The Office of Substance Abuse and Mental Health Services IRC in the Department of Health and Human Services has a wide selection of suicide prevention materials. Resources include print and audio-visual educational materials.

MSPP Website: www.maine.gov/suicide contains resources, downloadable materials and links to national suicide prevention sites.

Guidance and Support for School-based Prevention Policies and Crisis Intervention Teams: Careful, advanced planning is crucial to preventing suicide, managing a crisis, and preventing additional crises in the school setting. School Administrative Unit (SAU) administrators and Crisis Intervention Teams have an essential role to play to assist youth in crisis while maintaining control of the learning environment. Part of advanced planning for an effective crisis response is the development of written cooperative agreements between School Administrative Units and local Crisis Service providers.

School-based plans and procedures: Procedures to guide staff in effectively identifying, screening and assisting students at risk for a variety of issues, including suicide, are vitally important. MSPP School Guidelines help school administrators establish crisis intervention and suicide prevention procedures.

MSPP Training: Training is a cornerstone of the MSPP. Because suicide can happen in any age group, in any community, in families of any income or educational level, everyone has a role to play in learning about preventing suicide. A variety of training and education programs provide learning opportunities to increase knowledge and practice intervention skills to prevent suicide. MSPP is committed to offering quality educational opportunities to mental health clinicians, and individuals working in schools, colleges and health care settings who need risk assessment and intervention skills and resources.

Student Suicide Prevention Education: Training for schools in *Lifelines*, an evaluated suicide prevention curriculum, Transitions and Middle School Lessons are offered. These programs are designed to integrate into comprehensive school health education and address a variety of youth risk behaviors and build youth help-seeking skills.

Lethal Means Education: An impulsive act by a suicidal person can be fatal. From 2006-2010, 53 percent of all suicides among Maine residents involved a firearm. A number of studies have shown that, when lethal means are less available or those that are available are less deadly, suicide rates by that method, and overall suicide rates, decline.²

² Harvard School of Public Health, Means Matter Basics

A Public Health Approach To A Public Health Problem

In the past decade, suicide has been widely recognized as a public health problem requiring national attention and urgent action in the United States. Prior to the issuance of the National Strategy to Prevent Suicide, suicide was viewed as a mental health issue, and only the highest risk groups were addressed, primarily through clinical intervention. These strategies only had a modest effect on population suicide rates, and as a result, population-based strategies are now promoted to reduce suicide in the entire population.³ Within the last two decades a public health approach to suicide prevention has emerged based upon a good understanding of the biological and psychosocial factors that contribute to suicidal behaviors. The 2001 National Strategy for Suicide Prevention issued by the U.S. Surgeon General emphasized that suicide is a significant public health problem, which requires integrated efforts by all sectors of society, and applications of a broad range of interventions, programs and policies.

Because suicide is such a serious public health problem, public health methods are promoted as the most effective means to address it. The public health approach represents a rational and organized way to organize prevention efforts and ensure their effectiveness. The basic-steps of the Public Health approach are: 1) clearly define the problem; 2) identify risk and protective factors; 3) develop and test interventions; 4) implement interventions; and 5) evaluate effectiveness.

Maine follows this approach. An important foundation to interventions is an array of training programs which serve as the cornerstone of the Maine Suicide Prevention Program (MSPP). The MSPP offers a variety of training and education programs that provide a face-to-face learning opportunity to dispel myths, address misconceptions, increase knowledge and *practice intervention* skills to prevent suicide. Because suicide can happen in any age group, in any community, in families of any income or educational level, *everyone has a role to play in preventing suicide* and can benefit from education and training.

Training and education in effective suicide prevention strategies are essential for professionals in direct contact with individuals who may be at risk. Training facilitates the early identification, effective support and appropriate treatment of persons at risk. Suicide prevention is most effective when direct service staff are trained and suicide prevention knowledge is integrated into organizations and agencies across the spectrum from service agencies, health care providers, first responders to employers. Addressing suicide prevention in schools, community-based agencies and organizations and health care settings is vital to the health and well-being of all persons living in Maine.

³ PSF Yip, "A Public health Approach to Suicide Prevention". Hong Kong Journal of Psychiatry 2005; 15: 29-31.

The Costs of Suicide

Suicide deaths have immediate and long-term emotional, financial, and social consequences. The impact of suicide is not, however, limited to untimely death. Many more people survive suicide attempts than die by suicide. Nationally, researchers estimate that for every person who dies by suicide, 25 to 100 others attempted suicide.⁴ The rate of suicide attempts is highest in adolescents and young adults. The single best predictor for dying by suicide is a previous suicide attempt. Prevention programs strive to reduce the burden of suicide by identifying people at risk of suicide and getting them the help they need, ideally before they make an attempt.

While families suffer the greatest impact from suicide deaths and attempts, the economic burden is spread through many layers of society: families, employers, government, insurers, and taxpayers. Some costs are known: for example, emergency department visits and hospitalizations for self-inflicted injuries; other costs are hidden: such as the cost of police officers who investigate suicide deaths or threats. The available economic data are startling, but they underestimate the true financial cost of suicide deaths and attempts.

Direct and Indirect Economic Costs

- The annual medical cost of deaths by suicide in Maine averages \$573,841.48 (in 2010 dollars)
- The annual medical cost of suicide attempts requiring hospitalization in Maine averages \$15,139,952 (in 2010 dollars)
- The annual lost productivity cost for deaths by suicide in Maine averages \$206,977,005 (in 2010 dollars)
- The annual lost productivity cost for suicide attempts requiring hospitalization in Maine averages \$16,222,580 (in 2010 dollars)

Source: Children's Safety Network Economics & Data Analysis Resource Center, at Pacific Institute for Research & Evaluation (PIRE), Calverton, MD, 6/2013. Incidence Data: Fatal injury incidence obtained from the National Center for Health Statistics Multiple Cause-of-Death File, 2006-2010, divided by 5 to annualize. Incidence of hospital admissions based on 2009 data from Maine and obtained from the Maine State Inpatient Databases (SID), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality (AHRQ). Incidence of hospital admissions exclude patients who were dead at the time of discharge, readmission cases, transfers (e.g., from another short or long-term care facility), medical misadventures, and/or suffered non-acute injuries. All counts based upon the patients' state of residence. All costs were adapted using state specific price adjusters and calculated in year 2010 dollars.

⁴McIntosh, JL. (2009). *U.S.A. Suicide 2006: Official Final Data*. Washington, DC: American Association of Suicidology. Retrieved from <http://www.suicidology.org>.

Emotional and Social Costs

The emotional burden of suicide spreads through the layers of our communities, impacting families, friends, peers, teachers, employers and co-workers, health care professionals, and public safety officials in many ways. The most immediate and severe burden is experienced by the family and friends closest to the victim. A conservative estimate is that there are six survivors for every person who dies by suicide;⁵ thus in Maine, almost 1000 citizens become survivors of suicide yearly. In this plan, a suicide survivor is defined as someone who lost a family member or friend to suicide. People who attempted suicide and survived their attempts are also called suicide survivors.

“The person who dies by suicide puts his psychological skeleton in the survivor’s emotional closet.” ...Edwin Shneidman, referred to as the “father of suicidology” by experts in the field.

The death of a loved one by suicide is itself a risk factor for suicide. Survivors frequently report difficult problems and challenges following the suicide death of a loved one. These include:⁶

- A prolonged and intense search for the reason for the suicide
- Feelings of rejection by the deceased
- A distorted sense of responsibility for the death and the ability to have prevented the suicide
- Feelings of being blamed, by others or themselves, for causing the problems that led to the suicide; and
- Elevated levels of anger, family dysfunction, and feelings of social stigmatization

The widespread costs of suicide, the deep impact of suicide on survivors, and the fact that suicide itself can lead to additional deaths by suicide, underscore the importance of a public health approach to suicide prevention.

“I learned about suicide and suicide prevention after the worst nightmare in my life, through the loss of my 19 year old son, Joe Day, who died on November 18, 2005 by suicide. I cannot tell you the devastation this has brought to me, my family, and all the people who loved Joe so much.” ...Cheryl Morin

⁵American Association of Suicidology (2007). *Suicide in the U.S.A.* Retrieved from [www.suicidology.org/associations/1045/files/Suicides in the US.pdf](http://www.suicidology.org/associations/1045/files/Suicides%20in%20the%20US.pdf).

⁶National Association of State Mental Health Program Directors. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Alexandria, VA: National Association of State Mental Health Program Directors.

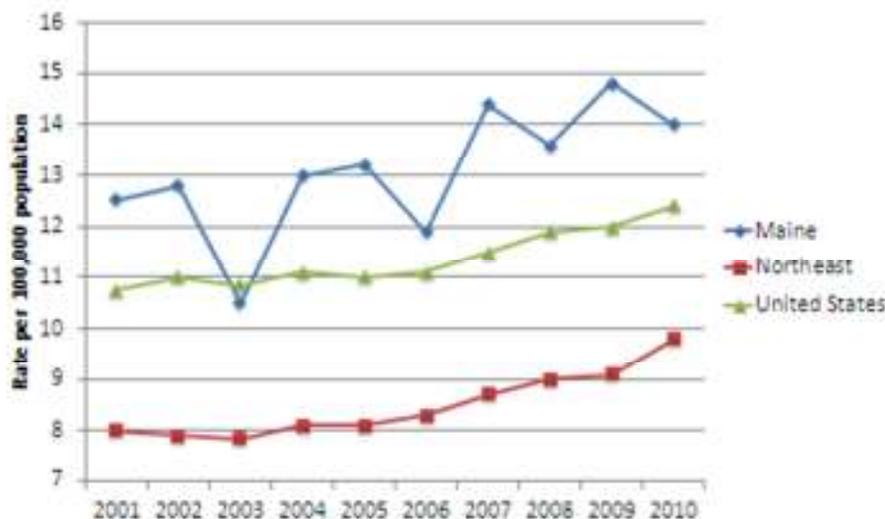
Suicide and Suicidal Behavior

Suicide as Cause of Death

The suicide rate in Maine is currently higher than the national rate; and the second highest in the Northeast. This is, in part, a reflection of Maine's demographic composition, rural nature and high gun ownership. Suicide rates vary by age, ethnicity, and gender, and are highest among white males, both of working age and seniors.⁷ According to 2010 census data, Maine has the highest percentage of white non-Hispanic people in the country, and the most rapidly aging population.⁸

Historically, the rate of suicide in Maine has been fairly stable. Recently there has been an increase in the number of deaths, from an average of 162 per year between 2001 and 2005, to an average of 183 deaths from 2006 to 2010. In 2011, preliminary data indicate that 204 Maine citizens died by suicide.⁹ This increase is cause for concern and provides a strong impetus for action.

Suicide Rates; Maine, the Northeast and the Nation



Data Source: 2000-2010 U.S. CDC WISQARS; 2011 preliminary Maine Medical Examiner's Office data

⁷Minino AM, Anderson RN, Fingerhut LA, et al. (2006) Deaths: Injuries 2002. *National Vital Statistics Reports*, 54 (10). Hyattsville, MD: National Center for Health Statistics.

⁸Miller, K. (2010). Census: Maine Oldest, Whitest State in Nation. *Bangor Daily News*, April 20, 2010. Retrieved from <http://bangordailynews.com/detail/105991.html>.

⁹U.S.CDC WISQARS 2000-2010; 2011 preliminary Maine Medical Examiner data

Suicide is the leading cause of violent death in Maine ¹⁰ killing almost seven times as many people each year as homicide between the years 2002-2010. For all ages combined, suicide is the tenth leading cause of death. Suicide is the second leading cause of death for youth and adults ages 15-34, the fourth leading cause of death for adults ages 35-54, and the eighth leading cause of death for adults ages 55-64. Suicide is not among the top ten causes for adults over age 65 as other medical issues increase mortality.

Suicide Across the Lifespan: Rates and Percent of Total for 2001-05 and 2006-10

Age Group	2001-05 Number	Rate per 100K	Percent of Total	2006-10 Number	Rate per 100K	Percent of Total	%Change in Rate
10-19	48	5.21	5.9%	42	4.84	4.6%	-7.1%
20-24	53	13.94	6.5	62	15.27	6.8	+9.5%
25-29	54	15.80	6.67	57	15.15	6.2	-4.1%
30-34	70	17.26	8.6	47	13.01	5.1	-24.6%
35-39	76	15.91	9.4	73	17.42	8.0	+9.5%
40-44	73	13.35	9.0	97	20.14	10.6	+80.8%
45-49	84	15.52	10.4	103	18.82	11.3	+21.2%
50-54	84	16.81	10.4	126	23.38	13.8	+39.1%
55-59	70	17.04	8.6	85	17.28	9.3	+1.4%
60-64	41	13.18	5.0	60	15.03	6.6	+14.0%
65-69	41	15.98	5.0	45	15.36	4.9	-3.8%
70-74	41	18.01	5.0	31	13.38	3.4	-25.7%
75-79	21	10.79	2.6	30	15.38	3.4	+42.5%
80-84	24	17.21	2.9	25	16.71	2.7	-2.9%
85+	30	24.41	3.7	30	21.70	3.4	-11.0%
	T=810			T=913			

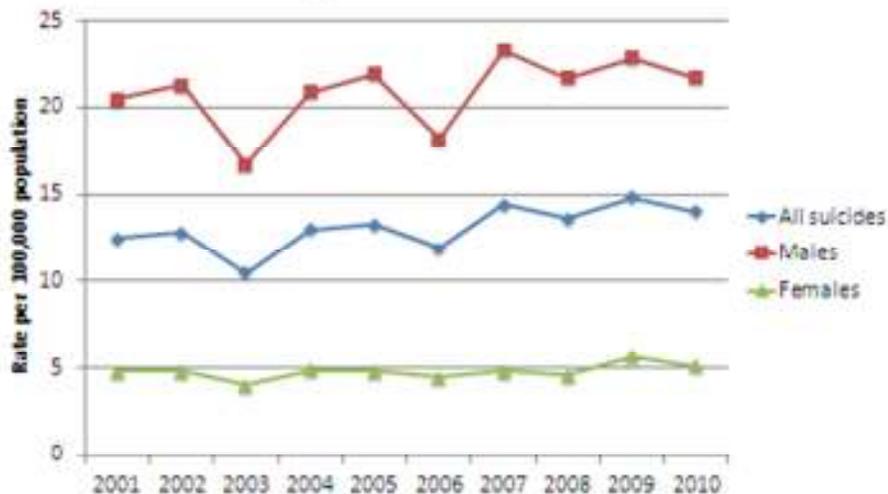
Data from *Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC

Eighty percent of Maine citizens who die by suicide are male; rates have traditionally been highest among men over age 85, though the rates have increased sharply among middle aged men over the past half-decade. Comparing the time period of 2001-05 to 2006-10, the rate of suicide in males ages 40-44, 45-49 and 50-54 increased by 40 percent, 35 percent and 65 percent respectively. Among women, the highest suicide rates are experienced by those 35 to 64 years of age. The greatest gender disparity in suicide rates is among elders and youth. Nationally, almost 85 percent of suicides after age 65 are male; in Maine, 92 percent of suicides in elders were men in years 2001-05.¹¹ Males comprised 85.5 percent of the completed suicides in youth age 10-24 in years 2005-09. The best single explanation for the higher suicide rate for men is that a much greater percentage of men use firearms as the means for their suicide attempts.

¹⁰*Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC Website: <http://www.cdc.gov/ncipc/wisqars/default.htm>.

¹¹*Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC Website: <http://www.cdc.gov/ncipc/wisqars/default.htm>.

Suicide Deaths in Maine Trends by Gender: 1999-2010



Data Source: 2000-2010 U.S. CDC WISQARS; 2011 preliminary Maine Medical Examiner's Office data

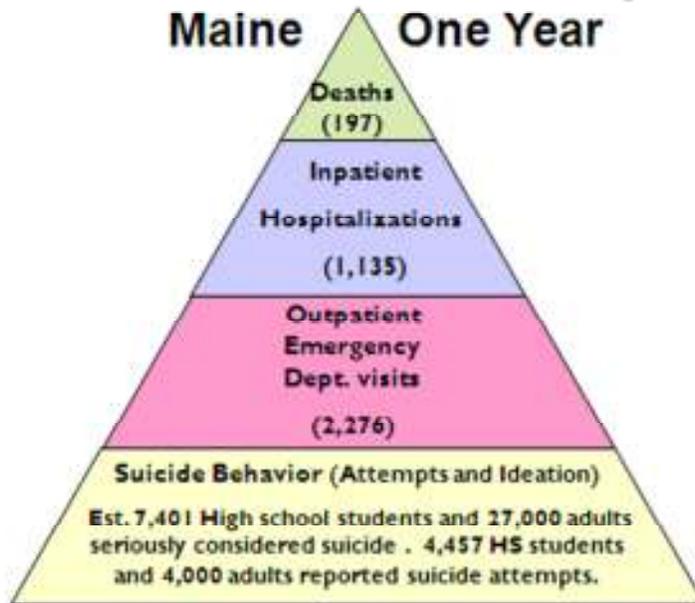
Suicidal Behavior as Cause of Injury

Some non-fatal suicidal behavior comes to the attention of health care professionals, but much does not. Experts estimate that for every death by suicide, another 25 to 100 people attempt suicide, depending on the age group. Suicide attempts result in significant health care costs, such as hospital and emergency department visits.¹² Maine survey data confirm that a significant number of youth and adults report considering suicide every year. During 2006-2008, three percent of Maine adults surveyed reported thinking about, planning, or attempting suicide in the previous twelve-month period.¹³

¹²McIntosh, JL. (2009). *U.S.A. Suicide 2006: Official Final Data*. Washington, DC: American Association of Suicidology. Retrieved from <http://www.suicidology.org>. See also Centers for Disease Control and Prevention. (2009). *Suicide Facts at a Glance, Summer 2009*. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf>. The number of attempts varies by age. For young adults age 15 to 24 years, there are 100-200 attempts for every completed suicide; for older adults, there are approximately four suicide attempts for every completed suicide.

¹³State of Maine, Center for Disease Control and Prevention. (2007). *Maine Behavioral Risk Factor Surveillance System 2006-2007*. Retrieved from <http://www.maine.gov/dhhs/boh/phs/odrvs/brfss/index.shtml>.

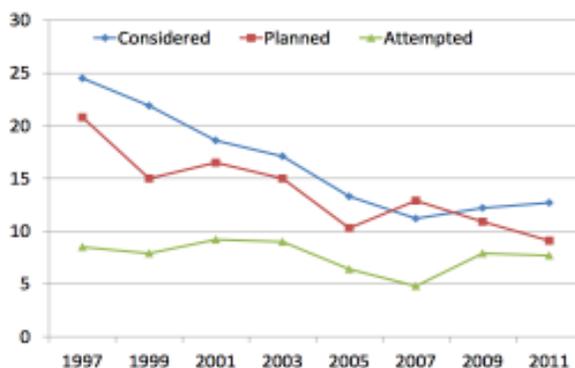
Suicide and Self-inflicted Injuries, Maine One Year



Data Source: 2000-2010 U.S. CDC WISQARS; 2009 Hospital Discharge database, 2011 MIYHS Survey, 2006-08 BRFSS Data

During 2011 among high school students, an estimated 12.7 percent reported seriously considering suicide, 9.1 percent planned their suicide, and 7.7 percent reported attempting suicide. An estimated 4,030 seventh and eighth grade students reported that they had ever seriously considered suicide and 1,656 had ever made an attempt.¹⁴ The good news is that these numbers represent a significant decline in the percent of students reporting suicide ideation or attempts since the initial survey in 1997.

Maine HS Students who Considered, Planned or Attempted Suicide in Past 12 Months



Data Source: 1997-2007 YRBS; 2009-2011 MIYHS YRBS Module

¹⁴State of Maine, Center for Disease Control and Prevention. (2007). Maine Behavioral Risk Factor Surveillance System 2006-2007. Retrieved from <http://www.maine.gov/dhhs/boh/phs/odrvs/brfss/index.shtml>.

From 2005-2009, the average number of hospitalizations in Maine for self-inflicted injury was 1,100 per year. The rate of hospitalizations, per 10,000 population, has remained fairly steady from 2005 to 2009, at an age-adjusted rate of about 10.4 hospitalizations per 100,000 population¹⁵. Outpatient visits to hospital emergency departments for self-inflicted injury increased significantly from 2000 to 2009. The actual number of emergency department visits more than doubled during that time, and the rate of visits rose from 10.2 in 2000 to 21.9 in 2009 (per 10,000 population).

Youth and young adults between ages 15 and 34 have the highest rates of hospitalization and emergency department visits and combined, making up a significant majority of self-inflicted injury visits. The rates of both hospitalizations and emergency department visits decrease sharply after age 44.

While men are four times more likely to die by suicide, women are three times more likely to attempt suicide with the highest gender disparity among young adults.¹⁶ Women are more likely to be hospitalized for self-injurious behavior. Though the overall rate for self-injury emergency department visits in the years 2005-09 was 18.3, the rate for females was 22.7¹⁷.

Means of Suicide and Self-Injury

Firearms are the most common and most lethal method of suicide across all age groups, accounting for just over half (53%) of all suicides in Maine. From 2006 to 2010, a firearm was used in 59 percent of male suicides and 27 percent of female suicides.¹⁸ Because men die by suicide at a higher rate than women, the result is a firearm suicide death rate that is much higher for males than females. Concern about firearm availability and its associated impact on suicide is due to the very high lethality of firearms when compared to other means of suicide.

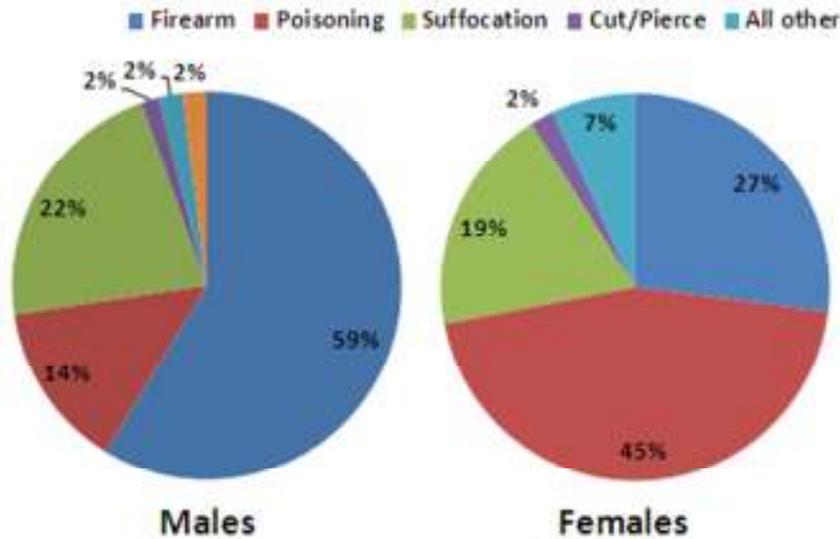
¹⁵ State of Maine, Maine Health Data Organization. (2005-2009). Hospital Discharge Inpatient Data and Hospital Emergency Department Data. Retrieved from <http://mhdo.maine.gov/imhdo/datasetsavailable.aspx>.

¹⁶Krug EG, Dahlberg LL, Mercy JA, et al. (2004). *World Report on Violence and Health*, May 2004. Retrieved from [who.int/violence_injury_prevention/violence/world_report/wrvh1/en](http://www.who.int/violence_injury_prevention/violence/world_report/wrvh1/en).

¹⁷ State of Maine, Maine Health Data Organization. (2005-2009). Hospital Discharge Inpatient Data and Hospital Emergency Department Data. Retrieved from <http://mhdo.maine.gov/imhdo/datasetsavailable.aspx>.

¹⁸ *Web-based Injury Statistics Query and Reporting System*. (2010). Retrieved from National Center for Injury Prevention and Control, CDC Website: <http://www.cdc.gov/ncipc/wisqars/default.htm>.

Means of Completed Suicides By Gender: 2006-2010



Data Source: 2000-2010 U.S. CDC WISQARS; 2011 preliminary Maine Medical Examiner’s Office data

Poisoning and suffocation (hanging) are the next most common methods in completed suicides, each accounting for about 20 percent of all suicides between 2006-10. Suffocation accounts for an equal proportion of suicides among both males and females, while poisoning is the leading cause of suicide death in females. These three methods account for over 90% of all suicide deaths.

For youth age 10-24 years, the means used in completed suicides from 2005-2009 was almost equally divided between firearms and suffocation (hanging). These two methods accounted for 88 percent of youth deaths with poisoning responsible for slightly more than 7 percent.¹⁹

Methods for self-inflicted injury requiring hospital care are those less likely to result in death. The most prevalent self-injury method resulting in hospital care is poisoning, then cutting and other forms of self-injury. This is true for males and females.

¹⁹ State of Maine, Center for Disease Control and Prevention. (2011). *Youth Suicide Deaths in Maine; 2005-2010*. Joseph Riddick.

Location of Suicide and Self-Injury

Maine does not compile statistics on the location of suicide deaths, but federal data²⁰ indicate that almost all (88.7 percent) suicides occur at home or in public places. Very few people (2.7 percent) die in supervised settings such as schools or colleges, jails, hospitals, or health care facilities. A recent study conducted by the MSPP reviewing data from the Maine Violent Death Reporting System,²¹ revealed that youth between the ages of 10 to 24, align with national data on place of death.

Causes of Suicide and Suicidal Behaviors

Why people engage in suicidal behavior is the most vexing question confronting research about suicide, and the most important question for suicide prevention. As the American Foundation for Suicide Prevention says, “Suicide is not a disease – but can be the worst possible outcome of many illnesses and conditions.”²² Suicide is the result of many complex factors, with current thought indicating that suicide requires mental preparation for a person to become capable of taking his or her life.²³ Although suicides or suicide attempts may seem impulsive, when individual cases are examined more closely they generally have a vulnerability toward suicide, including several identified risk factors and warning signs for suicide. Many persons at risk for suicide have active suicidal thoughts for some time before an attempt or death by suicide.

“I will live the rest of my life wishing I had known what I know today. My hope is that by telling my story, no one will have to say I wish I had known. I can no longer save my son, but I hope to save other families from having to live with the pain that my family will live with for the rest of our lives.” ...Sandra Fisher

Researchers have focused on identifying risk and protective factors, but even this poses a paradox: for example, many people who die by suicide have a mood disorder such as depression, but most people with depression do not kill themselves. Current thinking is that the interaction of multiple risk factors, buffered by certain protective factors, often combined with a triggering event, influences a person’s decision to die by or to attempt suicide.²⁴

²⁰U.S. Centers for Disease Control and Prevention. (2008). Surveillance for Violent Deaths – National Violent Death Reporting System, 16 States, 2005. *Morbidity and Mortality Weekly Report*, 57(14), April 2008.

²¹State of Maine, Center for Disease Control and Prevention. (2011). *Youth Suicide Deaths in Maine; 2005-2010*. Joseph Riddick.

²²American Foundation for Suicide Prevention. (2009). *Suicide Prevention Priorities for Health Reform 2009*. Retrieved from <http://healthyamericans.org/assets/files/Suicideprevention.pdf>.

²³Joiner, T. (2010). *Myths about Suicide*. Cambridge, MA: Harvard University Press.

²⁴National Association of State Mental Health Program Directors. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Alexandria, VA: National Association of State Mental Health Program Directors.

Risk factors can be divided into various domains; some examples are:²⁵

- **Societal:** Unsafe media portrayals of suicide, or availability of lethal means
- **Community:** Few available sources of supportive relationships or barriers to healthcare
- **Relationship:** High conflict or violent relationships, family history of suicide
- **Individual:** Mental illness, substance abuse, previous suicide attempt, impulsivity/aggression

There is no exact combination of risk factors and triggering events that predict an individual's suicide risk. As the research continues to develop, it is becoming clear that some risk factors for suicide are more prevalent than others. These considerations are important when developing a public health-oriented prevention plan: because so many people potentially are at risk, effective prevention strategies need to involve everyone; knowing who is at risk helps to identify the most effective interventions.²⁶

Groups at Increased Risk of Suicide

The greatest risk of suicide is posed by people who made a **previous suicide attempt**. Between 12 and 30 percent of suicide attempters will make subsequent attempts within a year.²⁷ Studies have shown that following a significant suicide attempt, approximately 10 percent of suicide attempters will die by suicide within 10 years.

It is estimated that up to 90 percent of people who die by suicide suffer from **depression or other diagnosable mental illnesses**.²⁸ Many of these individuals were not diagnosed or in treatment before their death. Suicide is the leading cause of early mortality among people who have schizophrenia.²⁹ Depression, other mood disorders and anxiety, are the most common diagnoses. Research indicates that between 60 and 85 percent of people who die by suicide suffer from depression.³⁰ In study after study,

²⁵ Dahlberg LL, Krug EG. Violence—a global public health problem

²⁶ Caine, ED. (2005). *Suicide Prevention in 2005 – Moving from Identified Risk Factors to Prevention Programs*, University of Rochester CSPS, 2005. Presentation to meeting of National Council on Suicide Prevention, New York City, January 20, 2005. Retrieved from http://www.omh.state.ny.us/omhweb/savinglives/volume1/vol1_a_publichealthstrategy.htm.

²⁷ Vaiva G, Vaiva G, Ducrocq F, et al. (2007). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: randomized controlled study. *British Medical Journal*, 332(7552), 1241-1245.

²⁸ Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*, 294(16), 2064-74; Nock M, Borges G, Bromet E, et al. (2008) Suicide and Suicidal Behavior. *Epidemiological Review*, 30(1), 133-154.

²⁹ National Association of State Mental Health Program Directors. (2008). *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority*. Alexandria, VA: National Association of State Mental Health Program Directors.

³⁰ Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*, 294(16), 2064-74; Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry*, 51(3), 143-154; Conwell Y, Duberstein PR, Hirsch JK, et al. (2009). Health Status and suicide in the second half of life. *International Journal of Geriatric Psychiatry*.

depression is the single most common risk factor identified in specific population groups, such as older adults and ethnic or sexual minority groups.

The fact that depression is the most common risk factor for suicide confirms the importance of a public health approach to suicide prevention. Depression and other mood disorders affect people of all ages, geographic locations, socioeconomic levels and educational levels. Almost 21 million adults – 9.5 percent of the population over age 18 – have a mood disorder, often co-occurring with anxiety disorders and substance abuse. About half of Americans will be diagnosed with one of these disorders sometime in their life, with first onset of symptoms usually in childhood or adolescence. Median age of onset is much earlier for anxiety and impulse-control disorders (11 years) than for substance use (20 years) and mood disorders (30 years). Half of all lifetime cases of mental illness start by age 14 and three-fourths by age 24.³¹

Effective treatment exists for mood disorders, but the National Institute for Mental Health estimates that only 20 percent of people diagnosed with depression receive treatment consistent with current practice guidelines.³² One study estimated that if major depressive episodes were effectively treated in older adults, the suicide rate would decrease 75 percent in this group.³³

Most people across the spectrum of suicidal behaviors do not receive treatment for either mental illness or substance abuse. Currently, crisis centers and mental health resources are not accessed by most people who need help.³⁴ Eighty percent of adults with a diagnosable mental illness who died by suicide were untreated at the time of their death (this figure is 90 percent for youth).³⁵ National risk behavioral surveys have found that for young adults in college, 85 percent with depression who were thinking about suicide were not receiving any treatment.³⁶

“I will continue to speak out about suicide and depression because I am determined to remove the stigma associated with suicide and to help people talk about it without shame. There is no shame.”...Sandra Fisher

³¹Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*. 2005 Jun;62(6):593-602

³²National Institute of Mental Health. (2010) *Science Update: Just Over Half of Americans Diagnosed with Major Depression Receive Care*, January 4, 2010. Retrieved from <http://www.nimh.nih.gov/science-news/2010/just-over-half-of-americans-diagnosed-with-major-depression-receive-care.shtml>

³³Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America*, 31(2), 333-356.

³⁴Joffe P. (2008). An empirically supported program to prevent suicide in a college student population. *Suicide and Life Threatening Behavior*, 38(1), 87-103.

³⁵Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*, 294(16), 2064-74.

³⁶Tompkins TL, Witt J. (2009). The short-term effectiveness of a suicide prevention gatekeeper training program in a college setting with residence life advisers. *Journal of Primary Prevention*, 30(2), 131-149.

Substance abuse increases the risk of suicide for adolescents, young adults, and middle-age adults.³⁷ Acting as a disinhibitor, alcohol is involved in up to 64 percent of suicide attempts or completions, many of them associated with a combination of impulsivity, anger, and relationship losses.³⁸ At least one-third of people who die by suicide have an alcohol use disorder;³⁹ the findings from several autopsy studies reveal that 25 percent of all individuals who died by suicide were intoxicated at the time of death.⁴⁰ While depression and alcohol abuse frequently co-occur in people who are suicidal, depression can be a consequence of the substance abuse. One study of people with a history of alcohol abuse who attempted suicide found that while 87 percent had depression, for 55 percent their depression was alcohol-induced, which rapidly resolved with substance abuse treatment.⁴¹

The suicide rate is typically high among white **older men**. Mental health is a significant risk factor for suicide in older adults, along with isolation. Between 71 and 95 percent of adults, ages 65 and older who die by suicide, have a mental illness, primarily a mood disorder (54-85 percent).⁴² There is added risk for suicide from most chronic physical illnesses.⁴³ Although many older adults seen in primary care practices who subsequently died by suicide brought physical complaints to their physicians, it was actually mental illness factors that were associated with their deaths.⁴⁴

Men in their mid-adult years, from their early 20s through their 50s, account for the largest number of suicides and the majority of years of life lost due to suicide.⁴⁵ Studies suggest that the factors that may increase the risk for suicidal behaviors in this group are similar to those among other age groups and in both sexes: mental illness that can be discerned from retrospective analyses (particularly mood disorders), substance use

³⁷Garlow, SJ. (2008). Depression, desperation, and suicidal ideation in college students: results from the American Foundation for Suicide Prevention College Screening Project at Emory University. *Depression and Anxiety*, 25(6), 482.

³⁸Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press. Retrieved February 12, 2008, from http://www.nap.edu/catalog.php?record_id=10398.

³⁹Conner KR, Hesselbrock VM, Schuckit MA, et al. (2006). Precontemplated and impulsive suicide attempts among individuals with alcohol dependence. *Journal of Studies in Alcoholism*, 67(1), 95-101.

⁴⁰Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (Eds.). (2002). *Reducing suicide: A national imperative*. Washington, DC: The National Academies Press. Retrieved February 12, 2008, from http://www.nap.edu/catalog.php?record_id=10398.

⁴¹Conner KR, Hesselbrock VM, Schuckit MA, et al. (2006). Precontemplated and impulsive suicide attempts among individuals with alcohol dependence. *Journal of Studies in Alcoholism*, 67(1), 95-101.

⁴²Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America*, 31(2), 333-356; Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry*, 51(3), 143-154.

⁴³Conwell Y, Duberstein PR, Hirsch JK, et al. (2009). Health Status and suicide in the second half of life. *International Journal of Geriatric Psychiatry*.

⁴⁴Pfaff JJ, Almeida OP. (2005). Detecting suicidal ideation in older patients: identifying risk factors within the general practice setting. *British Journal of General Practice*, 55(513), 269-273.

⁴⁵Knox K, Caine E. Establishing priorities for reducing suicide and its antecedents in the United States. *Am J Public Health*. 2005;95 (11):1898-1903.

disorders (particularly alcohol abuse), and access to lethal means.⁴⁶ These factors are likely to be exacerbated by other risk-related characteristics that occur more frequently among males, such as the underreporting of mental health problems, a reluctance to seek help, engagement in interpersonal violence, distress from economic hardship (e.g., unemployment), and dissolution of intimate relationships.^{47,48}

People living in rural areas appear to have a greater risk of suicide. Rural states have the highest suicide rates in the country. One study of people diagnosed with bipolar disorder found that people in rural areas had higher rates of suicide attempts when compared to people with similar life situations living in urban areas.⁴⁹ This may be a result of higher poverty rates, a higher percentage of older adults in rural populations, the impact of stigma in small communities, and decreased access to mental health services.⁵⁰ The greater sense of isolation from social and professional support and intervention adds to the increased risk in rural areas. According to the 2010 US Census, Maine is considered the most rural state in the nation, with almost 62 percent of its citizens living outside an urban setting.

Race and ethnicity contribute to suicide risk. In the United States, the highest rates of suicide deaths are among American Indians and Native Alaskans with 17.48 suicides per 100,000 and Non-Hispanic Whites with 15.99 suicides per 100,000.⁵¹ Suicide statistics related to American Indians are considered to be unreliable because of the small population size, the small number of reported suicide deaths and death records that lack designation of ethnicity. Suicide is, however, a leading cause of death among American Indians and Alaskan Natives in the U.S. between ages 15 and 24.⁵²

A Department of Defense report found that suicide by **active military personnel** in the Army and Marines “increased sharply” from 2005 to 2009, with the rate more than doubling in the Army during this period.⁵³ The Veterans Administration (VA) estimates

⁴⁶ Tondo L, Baldessarini RJ, Hennen J, et al. Suicide attempts in major affective disorder patients with comorbid substance use disorders. *J Clin Psychiatry*. 1999; 60 Suppl 2:63-69.

⁴⁷ Oliffe JL, Phillips MJ. Men, depression and masculinities: A review and recommendations. *J Mens Health*. 2008; 5(3):194-202.

⁴⁸ Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol*. 2003; 58(2):5-14.

⁴⁹ Gamm, L.D., L. Hutchison, B.J. Dabney, et al, eds. (2003). *Rural Healthy People 2010: Volume 2*. College Station, TX: Texas A&M University System Health Science Center.

⁵⁰ Suicide Prevention Action Network. (2005). Lost in rural America. *Advancing Suicide Prevention*, July/August 2005, 16-20.

⁵¹ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. Suicide Rates Among Persons Ages 10 years and Older by Race/Ethnicity, United States, 2005-2009. <http://www.cdc.gov/ViolencePrevention/suicide/statistics/rates01.html>.

⁵² *Web-based Injury Statistics Query and Reporting System*. (2005). Retrieved from National Center for Injury Prevention and Control, CDC Website: <http://www.cdc.gov/ncipc/wisqars/default.htm>

⁵³ U.S. Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces. (2010). *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives*. Washington, D.C: Department of Defense.

that as many as **5,000 veterans** die by suicide every year.⁵⁴ The elevated risk for suicide is highest among those who have severe mental illness; combat-related post-traumatic stress disorder (PTSD); traumatic brain injury, amputation or disfigurement; military sexual trauma; and spinal cord injuries. A study of veterans receiving care through the VA found that suicide occurs in different patterns than in the general population. Suicide risk is higher for younger rather than older veterans, especially when PTSD is present, and suicide rates are more equal for male and female veterans than in the general population.⁵⁵ Based on the 2010 US census, Maine has the second highest proportion of veterans in the country at 10.4 percent.

Lesbian, Gay, Bi-Sexual and Transgender (LGBT) status is considered a risk factor for suicide though the actual numbers and rate of suicide in this population is difficult to know accurately. Sexual orientation is not information that is collected, or necessarily known at the time of death. Studies have found that LGBT youth have a significantly higher rate of suicide attempts than others in their age group. The driving force behind LGBT suicidal behavior is seen as the familial and societal stigma and rejection associated with minority sexual status.⁵⁶

Despite a significant decrease in the rate of suicides in prisons and jails, primarily because of the strong focus by corrections departments on identifying and managing inmates at risk of suicide, suicide by **incarcerated people** remains a leading cause of death in state prisons and local jails. The suicide rate in jails is three times higher than in prisons. Although many risk factors contribute, mental illness is the most common; half to two-thirds of inmates have a mental illness that increases their risk for suicide.⁵⁷

⁵⁴U.S. Department of Veterans Affairs. (2007). *Healthcare Inspection: Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*. Report No. 06-03706-126, May 10, 2007. Washington, D.C.: VA Office of the Inspector.

⁵⁵Zivn J, Kim M, McCarthy JF, et al. (2007). Suicide mortality among individuals receiving treatment for depression in the Veterans Affairs Health System: associations with patient and treatment setting characteristics. *American Journal of Public Health*, 97(12), 2193-2198.

⁵⁶Ryan C. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual youth and adults. *Pediatrics*, 123, 346-352.

⁵⁷Blasko B. (2008). Suicide risk assessment in jails. *Journal of Forensic Psychology Practice*, 8(1), 473.

Suicide Prevention: Research-based Best Practices

Recent published studies of suicide prevention programs clarify what types of prevention programs work and why, and what types should be discarded as ineffective or harmful. The best suicide prevention programs are multidimensional and use a variety of proven or promising strategies often called “best practices”. While continued research is needed and program impact must continue to be evaluated, more knowledge about preventing suicide is available now than in the past.

From 2003 to 2005, the Suicide Prevention Resource Center (SPRC) in collaboration with the American Foundation for Suicide Prevention (AFSP) developed a registry of evidence-based programs for suicide prevention to answer an objective of the 2001 National Strategy for Suicide Prevention to “establish and maintain a registry of prevention activities with demonstrated effectiveness for suicide or suicidal behaviors.”⁵⁸ The goals of this Evidence-Based Practices Project (EBPP) were to review the effectiveness of suicide prevention programs and to create an online registry of information about these programs.

In 2005, SAMHSA began reviewing and listing programs for suicide prevention and intervention in their National Registry of Evidence Based Programs and Practices (NREPP). To be considered for registry listing, programs must have incorporated what are known to be effective, safe and ethical practices; have demonstrated face validity; and/or have been based on an expert review. The NREPP, and the full list of Evidence Based Practices on this registry, can be accessed at <http://www.nrepp.samhsa.gov/>.

Five categories of Evidence Based Programs for Suicide Prevention and Intervention have been identified through the SPRC/AFSP EBPP. They are:

- Community-Based Programs
- Emergency Room Programs
- Primary Care
- School-based Programs; and
- Service Delivery Programs

Several strategies have strong evidence of effectiveness from more than one study.⁵⁹ They include: screening and treatment for depression in primary care practices and emergency departments, community based education strategies, comprehensive school-based programming, and restriction of highly lethal methods of suicide.

⁵⁸ US Department of Health and Human Services, 2001, National strategy for Suicide Prevention (NSSP), Objective 10.3, p 115.

⁵⁹ Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association (JAMA)*, 294 (16), 2064-74; Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.

Promising strategies range from inexpensive follow-up with clients after a suicide attempt to long-term psychotherapy. The use of specific promising medical and psychotherapies is for clinicians to decide on behalf of their patients, but those with evidence to support their effectiveness are use of anti-depressive and mood-stabilizing medication, and cognitive behavioral, dialectical, and problem-solving psychotherapies.⁶⁰ See Appendix 5 for promising information on clinical treatment of suicidal behavior and psychosocial interventions.

Integrating Suicide Prevention into Health Care Settings

Primary care health providers are in a unique position to assess suicidality in their patients.⁶¹ Primary Care Providers serve as patient-centered medical homes that use a chronic disease management model, suitable for assessing for depression and the more than 25 other illnesses that have been identified with significantly elevated risks for suicidal behavior. Primary care providers serve people of all age groups, gender, race and ethnicity, as well as subgroups at elevated risk of suicide, such as veterans and LGBT individuals. Many risk factors and warning signs are easily observed in primary care settings, and primary care providers regularly include patient education in their practices.

In the United States, primary care, including school-based health centers, is the number one source for mental health care, and in many areas, especially rural ones, it is the patient's only source for mental health treatment of any kind.⁶² People who died by suicide are more than twice as likely to have seen a primary care provider than a mental health provider before their death. For all age groups, 45 percent of people who died by suicide saw their primary care provider within one month of their death, and 77 percent within one year of their death.⁶³ The numbers are even more striking for older adults, who infrequently use mental health services. For older adults who died by suicide, 20

⁶⁰Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*, 294(16), 2064-74.

⁶¹Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf>.

⁶²Litts D. (2010). Linking Together a Chain of Care: How Clinicians Can Prevent Suicide. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf>.

⁶³Luoma, JB, Martin CE, Pearson J. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, 159(6), 909-916. Numerous subsequent studies have confirmed these findings. See also Tadros G, Salib E. (2006). Elderly suicide in primary care. *International Journal of Geriatric Psychiatry*, 22(8), 750-756; Mann JJ, Apter A, Bertolote J, et al. (2005). Suicide prevention strategies: a systematic review. *Journal of the American Medical Association*, 294(16), 2064-74; Pfaff JJ, Almeida OP. (2005). Detecting suicidal ideation in older patients: identifying risk factors within the general practice setting. *British Journal of General Practice*, 55(513), 269-273; Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America*, 31(2), 333-356.

percent visited a physician within 24 hours of their death, 41 percent within one week, and 75 percent within one month.⁶⁴

The greatest need perceived by people experiencing suicidal thoughts is for therapy or counseling.⁶⁵ Common barriers to receiving treatment include: the person not realizing that he or she needs help; not believing that treatment works; stigma associated with a diagnosis of mental illness or substance abuse; lack of insurance; waiting lists for services; limited number of available psychiatrists, especially in rural areas; not knowing how or where to get help; and problems with transportation, child care, or scheduling appointments.⁶⁶

Primary care providers are in the forefront of integrated suicide prevention programs to address these problems. Mental health care is one of the six areas identified by primary care providers as important for research.⁶⁷ At the same time, providers recognize the importance of training: as of 2003, fewer than 50 percent of primary care providers felt competent to manage suicide.⁶⁸ In Maine, federally-qualified Community Health Centers have begun the process of integrating suicide prevention into their practices. Assessment is performed by primary care providers, and mental health treatment is either provided on-site by psychiatrists and therapists, or through formal referral and treatment protocols with off-site mental health providers. Published studies using random controlled trials of integrated primary care, suicide assessment, and treatment for depression have found significant decreases in suicidal behavior.⁶⁹

An example is the PROSPECT (Prevention of Suicide in Primary Care Elderly) program,⁷⁰ which focused on primary care patients, 60 years and older, diagnosed with major or minor depression. Trained case managers helped physicians recognize depression, made treatment recommendations and offered psychotherapy, monitored

⁶⁴U.S. Department of Health and Human Services. (2009). *National Strategy for Suicide Prevention: At a Glance – Suicide Among the Elderly*. Retrieved from <http://www.mentalhealth.samhsa.gov/suicideprevention/elderly.asp>. See also Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America*, 31(2), 333-356.

⁶⁵Pagura J, Fotti S, Katz LY, et al. (2009). Help seeking and perceived need for mental health care among individuals in Canada with suicidal behaviors. *Psychiatric Services*, 60(7), 943-949.

⁶⁶Suicide Prevention Resource Center. (2007). *US Suicide Prevention Fact Sheet*. Retrieved from <http://www.cdc.gov/nchs/data/databriefs/db07.pdf>; 23/945-946.

⁶⁷Litts D. (2010). *Linking Together a Chain of Care: How Clinicians Can Prevent Suicide*. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf>.

⁶⁸Litts D. (2010). *Linking Together a Chain of Care: How Clinicians Can Prevent Suicide*. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicide/docs/Linking%20Together%20a%20Chain%20of%20Care%20Maine%206-29-10.pdf>.

⁶⁹Heisel MJ. (2006). Suicide and its prevention among older adults. *Canadian Journal of Psychiatry*, 51(3) 143-154; Unutzer J, Tang L, Oishi S, et al. (2006). Reducing suicidal ideation in depressed older primary care patients. *Journal of the American Geriatric Society*, 54(10), 1550-1556.

⁷⁰Alexopoulos GS, Reynolds CF, Bruce ML, et al. (2009). Reducing suicidal ideation and depression in older primary care patients: 24-month outcomes of the PROSPECT study. *American Journal of Psychiatry*, 166(8), 882-90.

depression symptoms, and followed up with patients during the one year trial and one year after mental health treatment was completed. Results were compared to a control group that received the usual care offered in the practices. Researchers found that the PROSPECT-treated adults were more likely to receive medication and/or psychotherapy, had a decrease in the severity of their depression symptoms and a higher rate of remission from depression, and had more than twice as great a reduction in suicidal behavior during treatment and one year after treatment. An ancillary result was that the PROSPECT group had an overall lower mortality rate than the control group, unrelated to death by suicide.

There is growing interest in **emergency departments (EDs)** as sites for suicide prevention. In the developed world, the majority of life-threatening and medically severe suicides attempts are treated in EDs. In fact, EDs are the first to see the less medically severe attempts and those who present with suicidal ideation. While suicidologists are paying increasing attention to EDs as sites for screening and intervention, traditionally, suicide prevention has not been a focus for emergency physicians and other ED staff. For these reasons, there is a need a need for improved collaboration between experts in emergency medicine, psychiatry, and suicide prevention.

Substantial advances have been achieved in understanding suicide risk factors. Interventions designed to reduce re-attempts are being tested for use by professionals working in primary care and ED settings. However, there have been fewer studies conducted with respect to screening, risk assessment, and management of suicidality, particularly within the ED setting. More research is needed on the most effective treatments for individuals considered to be at risk - from brief interventions, to a course of psychotherapy and/or medication, or inpatient hospitalization.

In 2009, the NIMH funded the [ED Safety Assessment and Follow-up Evaluation \(ED-SAFE\)](#) trial as an effort to develop the evidence base for effective suicide screening and case management for adults who present for emergency medical care. The proposed initiative aims to build upon the findings from this research by stimulating development and validation of screening tools for reliably characterizing suicide risk status among youth who present for emergency medical care. Developing such tools will meet a critical need of ED staff who currently lack practical and effective strategies to screen, triage, and make treatment decisions for at risk youth.⁷¹

Maine primary care physicians and health centers have utilized best practice resources compiled for the identification and treatment of persons at risk of suicide in the primary care setting. Of particular importance is the *Suicide Prevention Toolkit for Rural Primary Care Practices* developed by the Western Interstate Commission for Higher Education (WICHE) and the Suicide Prevention Resource Center (SPRC). This Toolkit is a compendium of resources for use in primary care settings complete with resources for providers to use with patients.⁷²

⁷¹ Goldstein A. (2012) Emergency Department Suicide Prevention in Youth. Concept clearance 2012, Preventive interventions Research Program. www.nimh.nih.org

⁷² A Primer for Primary Care Providers. Boulder, Colorado: Western Interstate Commission for Higher Education. <http://www.sprc.org/for-providers/primary-care-tool-kit>

Gatekeeper Programs

Gatekeepers “open the gates” to help for people at risk of suicide. Gatekeepers programs are much more than suicide awareness: they not only impart knowledge but also train people in the skills needed to immediately intervene when a person appears to be considering suicide. It is important to train as many gatekeepers as possible in a particular setting in three skills:

- Identification of risk factors and warning signs of suicide,
- Communication skills for asking people if they are thinking about suicide, and
- Making appropriate referrals for help.

Evaluations of Maine’s Gatekeeper program, a one day program that includes skills practice, have shown significant increases in respondents’ knowledge of warning signs and risks factors and increased confidence in their ability to intervene. Respondents maintain the training program effects at six months. To date, over 5,000 Gatekeepers have been trained in Maine, and qualitative data indicate that students who are thinking about suicide are identified earlier, before a crisis point is reached. Most training participants report that they receive little or no prior training in suicide prevention.

Most studies of Gatekeeper training programs have focused on programs reaching youth. These studies demonstrate that Gatekeeper training successfully increases participants’ knowledge, changes attitudes about suicide, and develops intervention skills. Programs have also demonstrated some evidence of a reduction in the rate of suicidal behaviors.⁷³ A 2007 study in Quebec found that 63 percent of trainees had intervened with suicidal youth, and an earlier study of Native American youth in New Mexico, which included gatekeeper components, reported a 73 percent reduction in suicidal behaviors, although there was no decrease in the suicide rate.⁷⁴

There are different models of Gatekeeper training; programs that include skill training are most successful. Maine’s experience is that it is essential to include active learning techniques in training, and to integrate Gatekeeper programs with other strategies. In particular, Gatekeepers need adequate referral networks for crisis management and mental health treatment.⁷⁵

Lifelines: A School-based Suicide Prevention Program

Lifelines is a comprehensive, school-wide suicide prevention program for middle and high school students. The goal of *Lifelines* is to promote a caring, competent school

⁷³Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.

⁷⁴Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. *Canadian Journal of Psychiatry*, 54(4), 260-268.

⁷⁵Wyman PA, Brown CH, Inman J, et al. (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting Clinical Psychology*, 76(1), 104-115.

community in which seeking help is encouraged and modeled and suicidal behavior is recognized as an issue that cannot be kept secret. *Lifelines* seeks to increase the likelihood that school staff and students will know how to identify at risk youth, provide an appropriate initial response, and obtain help, and be inclined to take such action.

Lifelines includes a set of components to be implemented sequentially: a review of resources and establishment of administrative guidelines and procedures for responding to a student at risk; training for school faculty and staff to enhance suicide awareness and an understanding of the role they can play in identifying and responding to suicidal behavior; a workshop and informational materials for parents; and implementation of lessons for students to inform them about suicidal behavior and discuss their role in suicide prevention.

The research reviewed for this summary assessed the *Lifelines Student Lessons*, the last component to be implemented in the *Lifelines* program. It consists of four 45-minute or two 90-minute lessons that incorporate elements of the social development model and employ interactive teaching techniques, including role-play. Health educators and/or guidance counselors teach the lessons within the school health curriculum. The *Lifelines Student Lessons* were developed specifically for students in grades 8-10 but can be used with students through 12th grade. *Lifelines* has been widely used in Maine and is being implemented in many other states. Early versions of *Lifelines* were developed and implemented in New Jersey; the first evaluated version was implemented in 1990. A subsequent evaluation was conducted in Maine from 2003 to 2006. Maine has provided *Lifelines* teacher training since 2000. As of 2009, an estimated 33 Maine schools were implementing the curriculum. Twenty-nine schools in Maine have been funded by Federal grants to implement and evaluate the comprehensive program.⁷⁶

“As one of Justin’s Aunts, I can assure you that his death at age 14 touched more lives than anyone could ever imagine...even 20 plus years later. We need to be willing to really listen and take action to get the help our loved one needs.” ...Katharyn Zwicker

⁷⁶ Underwood M, Kalafat J, Maine Youth Suicide Prevention Program led by the Maine CDC. *Lifelines, A Suicide Prevention Program*.

Reducing Access to Lethal Means of Suicide

Studies in other countries suggest that reducing access to a particular means of suicide reduces the rate of suicide by that method.⁷⁷ Some methods that led to a reduced suicide rate are reducing the pack size of analgesic medicine; substituting nonlethal medications for lethal ones; installing barriers at sites that are popular for suicide; and reducing access to firearms, the most lethal of all means of suicide.

Studies of suicide deaths among youth and older adult males who used firearms indicate that death is most likely when handguns are in the home, and are stored unlocked and loaded.⁷⁸ Promoting safe firearms storage – keeping guns unloaded, storing guns separately from ammunition, and locking both guns and ammunition – may reduce the risk of suicide by firearm, especially in people prone to impulsive behavior.

Emergency Department (ED) Means Restriction Education is an intervention for the adult caregivers of youth (ages 6-19 years) who are seen in EDs and determined through a mental health assessment to be at risk for suicide. Studies show that the presence of a gun in the household increases suicide risk, yet parents who take their adolescent to an ED for a suicide attempt are often not warned about restricting their child's access to firearms and other lethal means. ED Means Restriction Education is designed to help parents and adult caregivers of at risk youth recognize the importance of taking immediate action to restrict access to firearms, alcohol, and prescription and over-the-counter drugs in the home. The intervention gives parents and caregivers specific, practical advice on how to dispose of or lock up firearms and substances that could be used in a suicide attempt. Examples are firearm locking devices or locked medicine cabinets, turning in firearms to local police, or moving the item to another location outside the home. By encouraging reduced access to lethal means, the intervention also aims to lessen the risk of violence directed at others, including homicide.

The intervention is designed to be delivered in a brief period consistent with the demands of busy EDs. The intervention consists of three components or messages that can be delivered by a trained health care professional, such as a physician, nurse, social worker, or mental health specialist. The components are 1) informing parents, when their child is not present, that the child is at increased suicide risk and why (e.g., "Adolescents who have made a suicide attempt are at risk for another attempt"); 2) telling parents they can reduce this risk by limiting their child's access to lethal means; and 3) educating and problem solving with parents about how to limit access to lethal means.

⁷⁷Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13.

⁷⁸Grossman, DC, Mueller BA, Riedy, C, et al. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. *Journal of the American Medical Association*, 293(6), 707-714; Conwell Y, Thompson C. (2008). Suicidal behavior in elders. *Psychiatric Clinicians North America*, 31(2), 333-356.

Follow-up Support after Suicidal Behavior

A previous suicide attempt is the single greatest risk factor for subsequent attempts and for death by suicide; the risk seems to be particularly acute immediately after discharge from an inpatient psychiatric program. In one study, 43 percent of people who died by suicide had been discharged within one month from inpatient psychiatric care, and 47 percent died before their first follow-up visit.⁷⁹

Inpatient programs that send letters or make follow-up telephone calls, or that have counselors who coordinate follow-up services, reduce the rate of subsequent attempts.⁸⁰ A random controlled trial of a program that made telephone follow-up calls one month after people were discharged from an emergency department because of a suicide attempt reduced the rate of subsequent attempts over the next year by almost 50 percent.⁸¹ An important caveat is that one month was too long: in another study, a sixth of the 600 individuals in the study attempted suicide again during the one month period before follow-up contact.

Follow-up support increases the effectiveness of crisis telephone lines. Crisis lines are used by suicidal callers, with some effectiveness. In one study, 11 percent of suicidal callers spontaneously reported the call prevented them from hurting or killing themselves. Follow-up outreach is needed particularly for suicidal callers with a history of suicide attempts, or with callers who still have a persistent intent to die at the end of the call.⁸²

Examples of Prevention Programs Using Multiple Approaches

In 1984, the **University of Illinois** adopted a policy requiring any student who threatened or attempted suicide to attend four sessions of professional assessment, or be required to withdraw from school. Students believed to be at risk of suicide following the assessment were referred to treatment, other types of support, and were followed-up for compliance. This policy combined elements of gatekeeper programs, follow-up programs, and treatment programs. This study is an example of an empirically supported program to prevent suicide in a college student population.

From 1984 to 2005, 2,000 students were referred for assessment under the policy. During this time the suicide rate at the university fell by almost 50 percent, from 6.91 to 3.87 suicides per 100,000 students. (During the same time period, suicide rates increased almost 30 percent in twelve comparable universities). No student involved in the program chose to withdraw rather than to complete the assessment. Only one student, because of

⁷⁹Hunt IM, Kapur N, Webb R, et al. (2009). Suicide in recently discharged psychiatric patients: a case-controlled study. *Psychological Medicine*, 39(3), 443-449.

⁸⁰Beautrais A, Fergusson D, Coggan C, et al. (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*, 120(1251), 1-13.

⁸¹Vaiva G, Vaiva G, Ducrocq F, et al. (2007). Effect of telephone contact on further suicide attempts in patients discharged from an emergency department: randomized controlled study. *British Medical Journal*, 332(7552), 1241-1245.

⁸²Kalafat J, Gould MS, Munfakh JL, et al. (2007). An evaluation of crisis hotlines outcomes. Part 2: Suicidal callers. *Suicide & Life-Threatening Behavior*, 37(3), 338-52.

particularly complex treatment needs, was asked to leave the university, and this student later returned and graduated with honors. Not a single student referred to the program died by suicide during his or her remaining time at the university. The entire cost of the program, for a campus with more than 35,000 students, was \$50,000 per year in training, administrative, and assessment expenses.⁸³

Another example is the ***United States Air Force Suicide Prevention Program*** (AFSPP), a population-oriented approach to reducing the risk of suicide. The program was founded upon the concept that decreasing suicides meant implementing a community approach in which prevention and assistance were a focus long before someone became suicidal. The Air Force has implemented 11 initiatives aimed at strengthening social support, promoting development of social skills, and changing policies and norms to encourage effective help-seeking behaviors. AFSPP's 11 initiatives include:

- Leadership Involvement
- Suicide Prevention in Professional Military Education
- Guidelines for Use of Mental Health Services
- Community Preventive Services
- Community Education and Training
- Investigative Interview Policy
- Critical Incident Stress Management
- Integrated Delivery System
- Limited Privilege Suicide Prevention Program
- Behavioral Health Survey
- Suicide Event Surveillance System

The U.S. Air Force first implemented the program with active-duty personnel in 1996. Reported results are based on data from the exposed cohort (1997-2002) and an unexposed cohort (1990-1996). A study examined data through 2007. Personnel exposed to the program experienced a 33 percent reduction of risk of completing suicide compared with those prior to implementation. Compared with Air Force personnel during 1990-1996, those exposed to the program in 1997-2002 also experienced:

- A 54 percent reduction of risk for severe family violence ($p < .0001$)
- A 51 percent reduction of risk for homicide ($p = .05$)
- A 30 percent reduction of risk for moderate family violence ($p < .0001$)
- An 18 percent reduction of risk for accidental death ($p = .05$)⁸⁴

⁸³ Joffe P. (2008). An empirically supported program to prevent suicide in a college student population. *Suicide and Life Threatening Behavior*, 38(1), 87-103.

⁸⁴ SAMHSA's national registry of Evidence based programs and practices (NREPP). United States Air Force Suicide Prevention Program. <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=121>

Maine Suicide Prevention Plan 2012-2017

Guidelines for suicide prevention initiatives in Maine

- Suicide affects Maine people of all ages, ethnicity, gender, and economic status, and must be addressed across the life span.
- Silence about suicide, mental illness, and substance abuse reinforces stigma and shame. Breaking silence supports people to seek help.
- In every prevention and intervention activity, the most important standard is DO NO HARM. Staff, whether volunteer or paid, are appropriately trained and use appropriate standards of practice.
- All suicide prevention activities are culturally competent and age appropriate.
- Lifespan suicide prevention activities built upon a foundation of partnerships between state agencies, regional & local organizations and citizen groups.
- Efforts are strengthened and meaningful collaborations formed, so that activities are implemented through existing networks at local, regional, and state levels.
- Expectations for change are realistic. State and local leaders are encouraged to implement activities that match available resources and infrastructure.
- Research indicates that suicide prevention activities must be sustained over time to derive the benefits; the plan recommends strong state leadership and partnerships with local government and community organizations.
- The plan builds on Maine Youth Suicide Prevention Program experience, knowledge, resources, and partnerships, especially its connections within the Maine Center for Disease Control and the Department of Health and Human Services and the long-standing connection to the Maine school community.
- Resources are maximized by integrating suicide prevention activities into state and local programs and organizations dedicated to improving the health of Maine's people. In a time of shrinking federal and state budgets, activation of local and regional organizations and partnerships will bring the flexibility and creativity needed to implement suicide prevention to vulnerable people across the state and throughout the lifespan.
- Coordinated efforts are essential to leverage additional resources from all appropriate public and private sources.

- People in groups at heightened risk for suicide are identified and prevention activities are prioritized to effect change in these groups.
- Suicide prevention programs and activities adhere to available evidence-based or promising practices where they are available for the target population and setting. Priority is given to activities with the greatest evidence of success. They include but are not limited to:
 - Integration of suicide prevention into primary health care practice and Emergency Department settings,
 - Gatekeeper-style programs with an evidence base of success with the target group,
 - Awareness training
 - *Lifelines*
 - Workplace suicide prevention protocols
 - Suicide hotlines and mobile crisis response and follow-up,
 - Follow-up activities after contact with persons contemplating suicide,
 - Reduction of access to lethal means
- A statistically significant reduction in suicide rates takes a number of years to achieve. Interim benchmarks are identified for each strategy where appropriate.

Lead Agencies, Implementing Organization and Statewide Partners

Suicide prevention is up to all of us and many diverse partners are needed.

Implementation and support of a comprehensive lifespan suicide prevention plan requires the involvement of a significant number of primary and supporting partners to ensure success. Leadership is needed at the state, regional and local levels. Implementation requires partnership between governmental and private organizations involved in planning, regulating, funding and supporting efforts that impact the way we live our lives.

The public meetings held to review the draft plan provided clear feedback that a central coordinating body has been essential to the success of suicide prevention efforts in Maine over the past 12 years. The Suicide Prevention Coordinator has been housed in the Maine Injury Prevention Program (MIPP) of the Maine Center for Disease Control and Prevention (Maine CDC) since inception of the program. The role of the Suicide Prevention Coordinator encompasses leadership, keeping the momentum going, planning and guiding suicide prevention efforts across partnering organizations, monitoring the nature and extent of the problem, providing content expertise and knowledge of national evidence-based practice models, limiting duplication of efforts and providing assistance in implementation and evaluation.

“In order for the plan to be effective, there needs to be partnerships with other agencies. You gain power by partnering.” ...From a stakeholder meeting

Public-private partnerships play an essential role of carrying out the elements of a statewide suicide prevention plan. Much of the actual work of addressing the needs of individuals at increased risk for suicide occurs at the local level through a myriad of the local partners that form an essential safety net across Maine. A list of State Agencies and Partner Organizations involved in implementing suicide prevention programming is in Appendix 4. This list is not comprehensive, but reflects a range of organizations and people who are, or have been, involved in suicide prevention efforts in Maine or who have been recommended to become involved.

Goals, Objectives and Activities to Prevent Suicide in Maine

The work of the Maine Suicide Prevention Program is founded on the shared belief that many suicides can be prevented. Most suicidal behaviors occur during a time of crisis in an individual's life; when personal coping ability is overwhelmed, the person feels hopeless, and sees few or no alternative ways to solve the crisis. Many of these crises are short-lived, and resolution of the crisis can lead to improved mood and safety. Information, support and appropriate intervention can avert many suicides and recovery from the physical and emotional pain can allow a person to move forward with their life. Suicide prevention is based on the belief that people can recover from mental illness and substance abuse and live productive lives.

Maine's Suicide Prevention Strategic Plan 2012-2017

* **NOTE:** S refers to **State Level** and reflects a need for state level oversight, leadership or programming;
C refers to **Community Level** for those activities that would take place at the local level.

Because suicide takes a life in Maine every two days...

Goal 1: Statewide leadership and coordination guides suicide prevention among Maine people. (Performance Measure: The number of individuals possessing content area expertise to implement the Maine Suicide Prevention Program Plan through the Maine Suicide Prevention Program's Advisory Council.

A coordinating and overseeing infrastructure of state and local organizations is necessary to maximize use of available human, programmatic and monetary resources, to increase knowledge of effective suicide prevention and to integrate suicide prevention into existing programs and services. The most effective coordination requires leadership and a centralized body of expertise to act as a clearinghouse of information and training and to provide support and assistance to regional and local initiatives.

Local residents know their regions and the people and regional stressors on their lives. Implementation must occur on a local level in order to reach those most in need.

"Without a centralized program, who implements the plan?"...From a public stakeholder meeting

Objective 1: Increase coordination, collaboration and leadership at the state and community levels to support suicide prevention activities.

Activity 1: Support a statewide Suicide Prevention Program Coordinator position to inform and guide the implementation of suicide prevention program activities in Maine. (S & C)

Activity 2: Form sustainable state and local partnerships to lead the advancement of suicide prevention across the lifespan in Maine. (S & C)

Activity 3: Maintain the commitment of state and partner organizations to integrate suicide prevention efforts. (S & C)

Activity 4: Develop and maintain a listing of state and local community suicide prevention stakeholders and activities to enhance coordination and communication. (S)

Activity 5: Collaborate with national, regional and other state suicide prevention programs. (S)

Objective 2: Strengthen the Maine Suicide Prevention Program Advisory Council to broaden representation from diverse stakeholders and enhance leadership capacity at the state, regional and local levels.

Activity 1: Identify and seek commitments from stakeholder groups representing constituents across the lifespan to be represented on the Advisory Council. (S)

Activity 2: Build connections to Public Health District Coordinating Councils and other regional entities in order to enhance suicide prevention initiatives regionally across the state. (S & C)

Activity 3: Enhance connection to and representation from Maine's Tribal Communities. (S)

Activity 4: Identify leadership for the Advisory Council among community members with expertise and interest in suicide prevention. (S & C)

Objective 3: Maintain capacity to provide data and informational resources to stakeholders and Maine citizens.

Activity 1: Implement a Maine Violent Death Reporting System to systematically collect suicide and violent death data. (S)

Activity 2: Ensure that suicide and self-injury questions are included on surveys administered to Maine people across the lifespan. (S)

Activity 3: Collect, analyze and disseminate death certificate, hospital discharge, emergency department and other relevant data on suicide and violence in Maine. (S)

Activity 4: Gather and distribute information on evidence based suicide prevention programs and interventions to Maine partners and stakeholders. (S)

Activity 5: Use data to develop educational materials to inform Maine citizens and stakeholders about suicide risks across the lifespan. (S)

Activity 6: Provide resource materials for the public and professionals through a state level resource center and website with links to evidence-based resources. (S)

Activity 7: Produce and disseminate an annual report on suicide and violence in Maine. (S)

Objective 4: Identify and seek support for the implementation of effective suicide prevention programming in Maine.

Activity 1: Identify funding opportunities to prevent suicide across the lifespan and disseminate information to partners. (S & C)

Activity 2: Seek funding to support state and local level implementation of evidence-informed suicide prevention programs and services. (S & C)

Activity 3: Build upon collaborations among public and private sectors when seeking funding. (S & C)

Activity 4: Provide training and assistance to enhance effective implementation of evidence-informed for suicide prevention programs and services. (S & C)

Because people need access to comprehensive health care...

Goal 2: Maine's people can access suicide prevention and intervention services in health care settings across the state.

(Performance Measure: The number of health care providers implementing evidence based suicide prevention screening tools as a standard of care.)

Research shows that people, including those at high risk for suicide, more frequently visit their primary care providers or hospital emergency departments, rather than mental health care providers, when they are thinking about suicide and during times of crises. The ongoing stigma associated with mental illness and suicide creates a barrier to people getting the help they need from a mental health provider.

Intervention – screening, assessment, treatment, and referral – through primary care and emergency department practices has the potential for identifying and assisting

the greatest number of people across the lifespan who have attempted or are contemplating suicide. To prevent suicide, people need to be able to access the care they require. Integration of physical health and behavioral health services at the practice level, and coordination of referrals and services with existing mental health resources in communities is vital to this effort.

“The goal for this particular area should be that there is no wrong door to access services.”...From a stakeholder meeting

Objective 1: Increase the number of Primary Care Practices that implement evidence-based suicide prevention interventions as a standard model of care.

Activity 1: Educate primary care practitioners on the efficacy of and methodology for integrated suicide screening, assessment, treatment and referral. (S & C)

Activity 2: Partner with the Maine Primary Care Association and other Primary Care organizations to integrate suicide prevention screening, assessment, and treatment within behavioral health care in Maine’s Federally Qualified Health Centers. (S & C)

Activity 3: Partner with the Maine Assembly on School-based Health Care to ensure that evidence-based standardized suicide screening and intervention programs are used in all School-based Health Centers. (S & C)

Activity 4: Seek additional partners to bring behavioral health integration and evidence-based suicide prevention practices into health care practices for all ages across Maine. (S & C)

Objective 2: Increase the number of health care settings that routinely screen for depression and assess for risk of suicide using evidence-based, standardized instruments

Activity 1: Partner with primary care offices and School-based Health Centers to implement evidence-based screening (eg. Patient Health Questionnaire depression screen like PHQ-9) and treatment protocols for patients with depression. (S & C)

Activity 2: Partner with the Maine Hospital Association and the Maine Crisis Network to implement uniform suicide risk screening and referral protocols in hospital emergency departments (S & C).

Activity 3: Partner with the Maine Crisis Network to implement uniform screening and referral protocols in diverse health care settings for people at risk of suicide and seen for a risk assessment. (S & C)

Activity 4: Partner with Maine’s Mental Health Crisis Providers to develop and adopt a uniform set of protocols to inform suicide risk assessment, intervention, follow-up and postvention with Maine’s people at risk for suicide. (S & C)

Activity 5: Engage relevant stakeholder agencies and review and disseminate research to develop appropriate screening and assessment instruments for use in diverse settings across Maine. (S & C)

Objective 3: Increase the number of health care settings that implement the use of standard practices to monitor and follow-up with individuals screened as at risk for suicide and referred on to outpatient support.

Activity 1: Develop and implement discharge planning guidelines for health care settings that include the use of written follow-up plans for individuals at risk for suicide. (S & C)

Activity 2: Develop materials and procedures to ensure that at risk clients, who receive a written, individualized follow-up plan from the assessing provider, receive the recommended follow-up care. (S & C)

Because preventing suicide is up to all of us...

Goal 3: Maine’s people are protected through integration of effective suicide prevention efforts within public and private organizations statewide. (Performance Measures: The number of schools that implement evidence based or promising practice suicide prevention programming. The number of schools with suicide prevention, intervention and postvention protocols.)

Effective programs and practices that can help reduce the incidence of suicide among Maine people must be implemented at the state, regional and local levels. State leadership is necessary to guide the implementation of promising and evidence-informed programs for various settings and for use with people across the lifespan. Successful suicide prevention requires partnerships with the diverse local and regional groups and organizations that come into contact with people most at risk.

Objective 1: Increase the number of public and private organizations statewide that implement effective suicide prevention programs and practices within their organizations.

Activity 1: Identify and reach out to key public and private organizations for integration of evidence-based or promising suicide prevention strategies. (S & C)

Activity 2: Promote the integration of evidence-based suicide prevention programming for organizations in Maine including, schools, colleges, correctional

centers, employers, community groups and other community-based organizations. (S & C)

Activity 3: Seek funding to support integration of promising and evidence-based suicide prevention programs and to evaluate the impact of these programs. (S)

Activity 4: Disseminate data and information on training/education opportunities and links to evidence-based resources that support integration of suicide prevention strategies into state agencies, state-contracted organizations and local programs and organizations. (S & C)

Objective 2: Increase the number of direct service organizations that are prepared to identify and intervene with individuals, across the lifespan, who are at risk for suicide.

Activity 1: Provide guidance and assistance to organizations to develop and implement suicide prevention and intervention protocols to best serve the population. (S & C)

Activity 2: Provide guidance and assistance to agencies that provide suicide screening, assessment and referral resources for at risk individuals. (S & C)

Activity 3: Promote wide awareness and use of the Statewide Maine Crisis Hotline (1-888-568-1112) and the National Suicide Prevention Lifeline (1-800-273-8255) as a means of accessing assistance and support for individuals at heightened risk of suicide. (S & C)

Activity 4: Provide guidance and assistance to ensure that all Maine correctional facilities follow the National Commission on Correctional HealthCare standards for suicide prevention. (S)

Activity 5: Provide guidance and assistance to ensure that community corrections programs use standardized suicide assessment and treatment protocols and develop working relationships with mental health crisis, substance abuse and other community referral agencies. (S & C)

Activity 6: Interface and collaborate with veteran and active military organizations to ensure that their personnel are prepared to address the increased risk of suicide present in veterans and active military personnel. (S & C)

Activity 7: Provide information and assistance to DHHS Child and Family Services and other appropriate organizations to ensure that youth in foster care, transitioning out of foster care or those in other high-risk settings are supported in maintaining safety and stability. (S)

Activity 8: Provide information, resources and best-practice interventions to organizations serving, supporting and representing GLTBQ youth and adults. (S & C)

Activity 9: Develop, modify and disseminate screening tools and response protocols for at-risk groups for integration within community programs and services. (S & C)

Activity 10: Provide information and assistance to state licensing agencies to develop regulations requiring suicide prevention standards for facilities caring for populations at risk for suicide. (S)

Objective 3: Increase the number of employers that integrate effective suicide prevention programs within their organizations.

Activity 1: Disseminate model suicide prevention and intervention protocol guidelines to Maine employers, prioritizing those who hire individuals from vulnerable populations. (S & C)

Activity 2: Provide assistance to employers that integrate suicide prevention, intervention and postvention protocols within their organizations and their Employee Assistance Programs. (S & C)

Activity 3: Provide assistance to employers for educating employees about suicide prevention and establishing intervention programs. (S & C)

Objective 4: Increase the number of schools (elementary through post-secondary) that implement evidence-based or promising suicide prevention programming.

Activity 1: Support schools to implement comprehensive, evidence-informed suicide prevention programming such as the *Lifelines* model. (S & C)

Activity 2: Promote the adoption of suicide prevention expectations into the job descriptions of all school-based clinical and behavioral health staff. (C)

Activity 3: Support schools to maintain and update Comprehensive School Health Education (CSHE) curricula K-12 to include mental health key concepts. (S & C)

Activity 4: Support schools to implement best practice and promising programs designed to improve outcomes for all students including improvements to school climate and bullying prevention. (S & C)

Activity 5: Disseminate resources that promote health during periods of significant student transitions such as moving schools, graduating high school, taking a new job, etc. (S & C)

Objective 5: Improve access to and community linkages among schools, mental health, substance abuse, correctional services and suicide prevention services statewide.

Activity 1: Promote the development and functioning of “provider referral networks” in Maine’s Public Health districts, college and school communities, tribes and other settings. (S & C)

Activity 2: Provide support to service providers, schools, employers and other programs to follow evidence-based guidance for referral and routine follow-up with people who are known to have attempted suicide or expressed suicidal ideation. (S & C)

Objective 6: Increase the number of faith-based organizations adopting policies and programs promoting suicide prevention and effective intervention/postvention.

Activity 1: Develop/disseminate appropriate suicide prevention/intervention education and resource material for clergy and faith-based community. (S & C)

Activity 2: Provide assistance to places of worship and existing coalitions of faith-based organizations to integrate suicide prevention efforts into their work. (S & C)

Objective 7: Increase the number of survivors of suicide who receive support and acceptance during their grief and who participate in suicide prevention efforts statewide.

Activity 1: Provide professional organizations with information on suicide survivor needs and support resources; include this information in all MSPP training programs. (S)

Activity 2: Convene, train and support a volunteer Suicide Survivor Speakers Bureau to help increase awareness of the impact of suicide and to spread effective suicide prevention messages. (S & C)

Activity 3: Promote access to suicide survivor support and grief support groups across the state. (S & C)

Activity 4: Provide Funeral Directors with access to resources to support newly bereaved suicide survivors. (C)

Because people need to know how to help prevent suicide...

Goal 4: Professionals working with Maine people are knowledgeable in suicide prevention, intervention and postvention. (Performance

Measures: The number of school and university personnel who attend gatekeeper training. The number of schools requesting technical assistance related to suicide prevention, intervention, postvention protocols.)

An effective way to identify and assist those who are actively suicidal or at increased risk for suicide is through the actions of a knowledgeable professional community. An adequately trained and alert professional health, public health, behavioral health, public safety, education, labor, and corrections workforce is vital in the effort to identify and intervene with those at risk for suicide. Training and education programs are a cornerstone of suicide prevention programs. Access to up-to-date education and training and best-practice curricula is essential to prepare professionals in effective suicide prevention. Knowledge saves lives.

“The greatest thing about the Maine Suicide Prevention Program is how they offer training at an affordable (or no cost) rate. It makes it that much more available for individuals and agencies to participate.” ...From a stakeholder meeting

Objective 1: Increase the number of professional organizations that develop, implement and promote effective clinical and professional practices for suicide prevention in Maine.

Activity 1: Engage relevant stakeholders, in the development, review and adaptation of evidence-based or promising suicide prevention training materials for use with Maine clinicians and professionals working with at risk populations. (S & C)

Activity 2: Provide best practice suicide prevention, intervention and postvention training and education to Maine clinicians and professionals working with people at risk of suicide. (S)

Activity 3: Modify or create and disseminate suicide prevention training modules to address the needs of governmental, professional, educational and volunteer organizations statewide. (S)

Activity 4: Integrate effective professional/clinical suicide prevention practices and training for staff members in direct service roles with populations at risk for suicide. (C)

Objective 2: Increase the proportion of clinicians and professionals in Maine who are knowledgeable about the increased risk of suicide associated with a traumatic history and who develop trauma informed practices.

Activity 1: Promote the integration and use of assessments for adverse childhood events or another standardized trauma history assessment for clients seen by health, mental health and substance abuse providers. (S & C)

Activity 2: Provide education and support for professionals working with Maine trauma survivors to develop trauma-informed practices and procedures. (S & C)

Activity 3: Promote the use of suicide prevention awareness and education materials to staff and volunteers working with victims of domestic violence and sexual assault. (S & C)

Objective 3: Increase the number of trained suicide prevention gatekeepers in multiple settings who maintain their skills.

Activity 1: Develop and implement gatekeeper training for a variety of audiences serving people of all ages statewide. (S & C)

Activity 2: Provide follow-up, consultation, continuing education and practice updates to trained gatekeepers statewide. (S)

Objective 4: Increase knowledge of the risk of suicide associated with access to lethal means and implement effective methods to reduce access to lethal means for people at increased risk for suicide.

NOTE: Lethal means include firearms, medications, drugs and other common means used for suicide.

Activity 1: Educate Maine professionals working with people at-risk for suicide to routinely ask about the presence of all types of lethal means in the home and educate their clients and their families about actions to reduce associated risks. (S)

Activity 2: Provide training and information to law enforcement officials and other first responders about the importance of removing lethal means from the environment of suicidal individuals. Provide law enforcement and first-responders model protocols and tools to assess for the presence and guide the removal of lethal means from the environment of suicidal individuals. (S)

Activity 3: Disseminate data and research describing the benefits of strengthening lethal means access procedures regulations to prevent suicide. (S & C)

Activity 4: Promote public awareness about the importance of restricting access to all types of lethal means around vulnerable individuals as an important way to prevent suicide. (S & C)

Objective 5: Increase the readiness of Maine professionals to address suicide risk through the provision of continuing education opportunities that provide advanced knowledge in suicide-related topics.

Activity 1: Provide an annual conference that increases understanding and knowledge of recent advances in the field of suicide prevention (Beyond the Basics of Suicide Conference). (S)

Activity 2: Promote and support a broad range of educational presentations for professionals working with vulnerable populations across the lifespan that address suicide prevention, intervention and postvention topics. (S & C)

Activity 3: Create and/or modify education and training offerings on suicide prevention in various formats, including electronic, to meet the needs of a diverse professional audience. (S & C)

Activity 4: Provide research data, information and training on the association between self-injury and suicide to multiple audiences in Maine. (S & C)

Because seeking help saves lives...

Goal 5: A culture of help-seeking for people in need exists in Maine (Performance Measure: The number of individuals and agencies that report increased awareness of helping resources at the local and state levels available for persons in need of treatment services.)

As long as suicide is seen as a private tragedy, associated with individual and familial shame and failure, it is difficult for suffering people and their families to seek help. Creating the opportunity for open discussion about the prevalence of suicide and its risk factors, including mental illness and depression, and changing the perception of seeking help, can begin to break down these barriers. To effectively address suicide, it must be safe to talk about suicide.

*"My 18 year old son's death by suicide on July 14, 2007 forever changed the lives of our entire family and it is impossible to describe the pain that losing Ryan has brought into our lives. He was a talented athlete, a great friend, and he loved to laugh. We never thought we could lose him to suicide. Anything we can share about suicide and suicide prevention that means other families will not experience this loss is important to us."
...Rachel Morales*

Objective 1: Increase public awareness that suicide is a preventable public health problem and help is available.

Activity 1: Develop, disseminate and promote media messages to increase the number of adults who know how to get help when they or someone they know is contemplating or has attempted suicide. (S & C)

Activity 2: Develop and maintain the Maine Suicide Prevention Program website as a dynamic resource for suicide prevention information and data to professional, lay and youth audiences and as a resource for training opportunities related to suicide prevention. (S)

Activity 3: Promote awareness of Maine Suicide Prevention Program resources for suicide prevention among key state and local stakeholders and the general public. (S & C)

Activity 4: Promote the continued use of the Maine Substance Abuse and Mental Health Services Information Resource Center as a clearinghouse and access point for suicide prevention information and resources for all Maine people. (S & C)

Objective 2: Increase the understanding of the general public in Maine that mental health problems are treatable, and that mental health and substance abuse prevention and treatment services are part of overall health care.

Activity 1: Educate individuals on how to advocate for their own and their family's mental health care needs. (S & C)

Activity 2: Identify and promote ways to decrease stigma and misperceptions surrounding mental illness, suicidal behavior, and substance abuse issues/conditions. (S & C)

Activity 3: Provide information and resources to people, organizations, communities and others to underscore the importance of seeking help in moments of distress. (S & C)

Objective 3: Improve media reporting practices about suicide to reduce stigma and increase public awareness that suicide is a preventable public health problem and help is available for those in need.

Activity 1: Educate media representatives about safe reporting practices regarding suicide. (S)

Activity 2: Monitor print and electronic media sites and provide feedback encouraging accurate and responsible depictions about suicidal behavior, mental illness and related issues. (S & C)

Activity 3: Provide education and assistance to participants of MSPP training and education programs in order to increase understanding of the key issues surrounding media contagion. (S & C)

Activity 4: Promote the development and dissemination of media and social media messages that normalize help-seeking behavior. (S & C)

Objective 4: Increase active outreach to identified populations at higher risk of suicide and attempts through traditional media, social media and other venues.

Activity 1: Partner with visible community and statewide organizations to identify champions within at-risk groups to increase help-seeking messages. Promote the message that help-seeking behavior is a sign of strength. (S & C)

Activity 2: Partner with organizations and programs serving Maine's elders to increase effective outreach efforts targeting isolated, depressed and terminally ill elders lacking adequate supports. (S & C)

Activity 3: Partner with active military, veteran organizations and programs to ensure optimal suicide prevention outreach activity to Maine's military personnel and families and veterans. (S & C)

Activity 4: Explore and pursue effective ways to access and engage groups at higher risk for suicide such as non-college bound youth ages 19-25 and middle-age men to address their increased risk for suicidal behavior. (S & C)

Activity 5: Develop and disseminate educational material guiding the appropriate use of various forms of social media for suicide prevention for parents, educators and organizations, especially those working with youth and young adults. (S & C)

Activity 6: Provide outreach to and build working relationships with Maine's Tribal Communities to work collaboratively to support suicide prevention efforts. (S & C)

Activity 7: Partner with organizations, groups and families to ensure effective outreach and proactive suicide prevention efforts among Maine's LGBTQ youth and adults. (S & C)

APPENDICES

APPENDIX 1: GLOSSARY OF TERMS

APPENDIX 2: MSPP ADVISORY COUNCIL

APPENDIX 3: RESOURCES

APPENDIX 4: PARTNER ORGANIZATIONS

APPENDIX 5: CLINICAL TREATMENT

APPENDIX 1

Glossary of Terms

Adolescent: A person between childhood and adulthood usually understood to be between ages of 10 and 24; sometimes 19-24 is referred to as young adult.

Aftercare treatment programs: Programs that provide treatment and support recovery after an initial episode that required residential or hospital treatment.

Anxiety Disorder: A common mental illness group defined by persistent feelings of uneasiness, worry and fear that cause significant difficulty in daily functioning. Anxiety disorders include agoraphobia, PTSD, Panic Attacks and Generalized Anxiety.

Baseline: The initial information collected prior to the implementation of an intervention, against which outcomes can be compared at strategic points during and at completion of an intervention.

Behavioral Health: A general concept, referring to the reciprocal relationship between human behavior, individually or socially, and the well-being of the body, mind, and spirit. The term is commonly used to describe a field of scientific study encompassing mental health and substance abuse.

Behavioral Health Integration: The intentional process of co-location of behavioral health practitioners and services into the practice flow of a primary care setting.

Best practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.

Cognitive Behavioral Treatment: Treatment method that focuses on here and now behaviors, thoughts and responses. Uses variety of techniques to teach adaptive behaviors and skills (affect identification, planned responses, desensitization, relaxation, etc.)

Co-morbidity: The co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.

Conduct disorder: A repetitive and persistent behavior pattern during which the basic rights of others or major age-appropriate norms or rules are ignored and often violated. A diagnosis of conduct disorder is likely if the behaviors continue for a period of six months or longer.

Contagion: A phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

Crisis response plan: A document that spells out the steps to be followed in the event of threatening situations to assist a person to return to baseline and keep the environment safe for that person and others.

Crisis team: A group of individuals trained and assembled for the purpose of responding to the needs of others during and after a crisis event/situation. All schools in Maine are required to have a crisis response team and plan.

Culturally competent: A set of values, behaviors, attitudes, and practices reflected in the work of a person, an organization or program that enables it to be effective across culture; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Depression: A constellation of emotional, cognitive and physical signs and symptoms, including sustained sad mood or lack of pleasure. Clinical depression is highly correlated with suicidal thoughts.

Effective: Programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in a target group more than in a comparison group.

Epidemiology: Study of statistics and trends in health and disease across communities.

Evaluation: Systematic investigation of the value and impact of intervention or program.

Evidence-based: Programs or practices that have undergone formal evaluation and proven to be effective at achieving the desired impact.

First Responder: Professional who works at the scene of an accident, crime or other traumatic event; For example, emergency medical technicians, firefighters, law enforcement officers, funeral directors, and clergy.

Gatekeeper: Term used to define the role of the individuals who are trained to know basic suicide prevention steps. Gatekeepers are trained to recognize and respond appropriately to warning signs of suicidal behavior and to assist at risk individuals in getting the help they need.

Goal: A broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health disparities: The disproportionate burden of disease, disability and death among a particular population or group when compared to the general population.

Help-seeking behavior: Actions taken by a person to obtain informal or professional support and assistance in times of need.

High Risk: An individual or a group that is statistically shown to have elevated risk when compared to the population as a whole. May also refer to the behaviors that place an individual at increased risk.

Infrastructure: An underlying base or foundation especially for an organization. Infrastructure includes staff, facilities, equipment, etc. needed for the functioning of a system or organization.

Information and Resource Center (IRC): A program of the Office of Maine Substance Abuse and Mental Health Services that functions as a clearinghouse of information and materials on substance abuse and suicide that is available to all Maine people.

Intentional injury: Injuries resulting from purposeful human action, whether directed at oneself or others that are intended to cause harm. Suicide and self-inflicted injury are examples of intentional injuries.

Intervention: A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.

Lethal means: Any instrument or object utilized to carry out a lethal, self-destructive act (i.e. firearm, poison, medication, rope, chemicals and/or other hazardous material).

LGBTQ: An abbreviation or acronym used to refer to someone who identifies as being a member of a sexual minority including lesbian, gay, bisexual, transgender or questioning.

Lifespan: The period of time between birth and death.

Maine Integrated Youth Health Survey (MIYHS): A biennial survey of middle and high school students conducted in Maine as part of a national effort by the U.S. CDC to monitor health-risk behaviors of the nation's students.

Means: The instrument or object used to carry out a self-destructive act (e.g. firearm, poison, medication). See also lethal means.

Means restriction: Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Medical Examiner: A physician officially authorized by the state to determine causes of deaths, especially those deaths suspected of not occurring under natural circumstances.

Mental health parity laws: Some states have passed legislation requiring insurance companies to provide full coverage of psychiatric services equivalent to medical services. EX: If they provide 80 percent coverage for physical illness then they would have to provide the same percent of coverage for behavior health services.

Mental illness (disorder): A diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's daily functioning.

MIPP: The Maine CDC Injury Prevention Program serves as the lead state agency for injury and suicide prevention. The MIPP provides training, data, and links to prevention resources statewide. The MIPP coordinates the MSPP and partners with key groups to address other leading causes of injury.

Mobile crisis team: Mental health clinicians trained to assess and respond to the needs of an individual experiencing behavioral health crisis. This includes performing suicide assessments/evaluations in multiple settings such as an emergency department, client's home, school, etc.

Mood disorders: Mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders.

Morbidity: The relative frequency of illness or injury, or the illness for injury rate, in a community or population.

Mortality: Relative frequency of death, or the death rate, in a community or population.

MSPP: The Maine Suicide Prevention Program is a multi-state agency program led by the Maine CDC which employs a public health approach to address suicide across the lifespan. The MSPP is based upon collaboration among state agency leaders and private sector groups and organizations. The long-term goal of the MSPP is: To reduce the incidence of fatal and non-fatal suicidal behavior among Maine citizens.

National Strategy for Suicide Prevention: A comprehensive and integrated approach to reduce the loss and suffering from suicide and suicidal behaviors across the lifespan. This document was initially issued in 2001 as a catalyst for social change and was updated and re-released in 2012.

Non-fatal suicidal behavior: A term for a suicide attempt which does not end in death.

PHQ-9: The Patient Health Questionnaire (PHQ-9) is a 9 question self-administered diagnostic instrument for screening for depressive disorders.

Partners: Entities, including organizations, groups and individuals working together toward a common goal.

Post-Traumatic Stress Disorder (PTSD): A type of anxiety disorder brought on by exposure to severe trauma that was life threatening or perceived as life threatening and which causes great difficulty in functioning normally.

Postvention: A coordinated and comprehensive set of specific interventions to be implemented after a crisis or traumatic event such as a suicide has occurred.

Prevalence: The percent of the population with a particular condition or characteristic. Calculated as the number of people in a population who have the health condition divided

by the total number of people in the population. Prevalence may be expressed as a rate per 10,000 or 100,000 people, for example, or as a percentage.

Primary Care Provider (PCP): Health professionals serving in a primary care setting, including physicians, physician assistants, nurse practitioners, and nurses who routinely provide health care services and who make referrals for specialty services for patients when indicated.

Protective Factor: The positive conditions, personal and social resources that promote resiliency, protect and buffer the individual, and reduce the potential for high-risk behaviors, including suicide.

Protocol: A set of procedures or guidelines describing actions to take in a given situation. MSPP developed protocol guidelines to help schools and agencies be prepared to address suicide prevention, intervention, and postvention.

Public Health: Regulatory and voluntary focus on effective and feasible risk management actions at the national, state and community level to reduce human exposures and risks, with priority given to reducing exposures with the biggest impacts in terms of the number affected and severity of effect.

Referral Network: Organizations or professionals that a school, agency or other organization might turn to for assistance, support, intervention or treatment for individuals needing services.

Resilience: Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse outcomes.

Risk Factor: Long standing conditions, stressful events or situations that may increase the likelihood of a suicide attempt or death and other adverse outcomes.

Screening: Administration of a tool to identify individuals in need of more in-depth evaluation or treatment.

Self-harm or Self-injury: Terms used to describe self-inflicted injury, such as cutting, self-battering, taking overdoses, or burning oneself. Sometimes referred to as non-suicidal self-injury and *generally* not assessed as suicidal in nature.

Sexual Minority: Refers to gay men, lesbian women and bisexual and transgendered persons. These groups are considered to be a minority because of several commonalities with other minority groups, including separate cultural norms, use of language and terminology, and the experience of being discriminated against because of their social minority status.

Sexual Orientation: Refers to an emotional, romantic, or sexual attraction that one feels toward men, toward women, or toward both. Sexual orientation ranges along a continuum generally described in terms of *heterosexual*—attraction to the other sex—*homosexual*—attraction to the same sex—and *bisexual*—attraction to both sexes.

Social Support: Assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services from family, friends, religious communities or other individuals and groups.

Stakeholder: Entities, including organizations, groups and individuals, who are affected by and contribute to decisions, consultations and policies. Stakeholders have an investment in a program, entity or an issue.

Stigma: Commonly defined as the use of stereotypes and labels when describing someone. Stigmatization of people with mental disorders is manifested by bias, distrust,

stereotyping, fear, embarrassment, anger, and/or avoidance. It may reduce access to resources and lead to low self-esteem, isolation, and hopelessness.

Substance Abuse: The misuse of drugs including alcohol. For persons under age 21, all drug use (except with a doctor's prescription) is termed substance abuse.

Suicide: Self-inflicted death with evidence (implicit or explicit) of the intent to die.

Suicide Attempt: Non-fatal self-injurious behavior for which there is evidence that the person intended to kill him/herself.

Suicidal Behavior: A spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and death by suicide.

Suicide Ideation: Clinical reference to thoughts about dying by one's own deliberate actions.

Suicide Survivor: Family members, significant others, friends, colleagues or acquaintances who are strongly affected by the loss of a loved one due to suicide.

Suicide Attempt Survivor: An individual who has attempted suicide and lived.

Surveillance: The ongoing, systematic collection, analysis, and interpretation of health data with timely dissemination of findings.

Warning Sign: The earliest, observable signs that indicate the risk of suicide for an individual in the near-term (within minutes, hours, or days).

Young adults: Persons aged 20-24.

Youth Risk Behavior Survey (YRBS): A biennial survey of middle and high school students conducted as part of a national effort by the U.S. CDC to monitor health-risk behaviors of the nation's students.

APPENDIX 2

MSPP Advisory Council

Mary Beiter, Social Work Team Leader
Edmund N Ervin Pediatric Center
MaineGeneral Medical Center
30 Chase Avenue
Waterville, Maine 04901
mary.beiter@mainegeneral.org
P: (207) 872-4303
F (207) 872-4294

Susan Berry, Coordinator
Health Education and Health Promotion
Department of Education
23 State House Station
Augusta, Maine 04333
susan.berry@maine.gov
P: (207) 624-6695
F: (207) 624-6691

Amy Brook, Clinical Coordinator
CHCS Crisis Service
P.O. Box 425
Bangor, Maine 04402-0425
abrook@chcs-me.org
P: (207) 947-0366 X4647

Kate Chichester, Executive Director
Co-Occurring Collaborative Serving ME
94 Auburn Street, Suite 110
Portland, Maine 04103
cchichester@ccsme.org
P: (207) 878-6170

Cara Courchesne, Coordinator
Communications and Outreach
Maine Coalition Against Sexual Assault
83 Western Avenue, Suite 2
Augusta, Maine 04330
cara@mecasa.org
P: (207) 626-0034
F: (207) 626-5503

Marissa Deku, MSPP Trainer
NAMI Maine
1 Bangor Street
Augusta, Maine 04330
mdeku@namimaine.org
P: (207) 622-5767
F: (207) 621-8430

Cheryl DiCara, Consultant
11 Brian Drive
Brunswick, Maine 04011
Cdicara62@gmail.com
P: 207-725-2885

Leticia Huttman, Recovery Manager
Office of Substance Abuse and Mental
Health Services/DHHS
11 State House Station
AMHI Campus-Marquardt Building
Augusta Maine 04333
leticia.huttman@maine.gov
P: (207) 287-4253
F: (207) 287-4268

Danny Gay
Borland Hill Road
Nobleboro, ME 04555
daniel.gay@maine.edu
P: (207) 400-4535

Kimberly Gleason, Director
Eastern Division AFSP
P.O. Box 129
Hudson, Massachusetts 01749
kgleason@afsp.org
P: (978) 568-0818

Abigail Lourie
Crisis and Counseling Services
Caldwell Street
Augusta, Maine 04101
alourie@crisisandcounseling.org
P: (207) 213-4510

Joleen Fowler, Coordinator
Suicide Prevention
Togus VA Medical Center
1 VA Center
Augusta, Maine 04330
P: (207) 623-8411 x4289
F: (207) 623-5791

Vacant
Child Welfare Policy & Practice
Office of Child & Family Services
DHHS
11 State House Station
2 Anthony Avenue
Augusta, Maine 04333
P: (207) 624-7913
F: (207) 287-6156

Geoffrey Miller, Associate Director
Prevention and Intervention
Office of Substance Abuse and Mental
Health Services/DHHS
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333
geoff.miller@maine.gov
P: (207) 287-8907
F: (207) 287-8910

Rebecca Morin, Director of Quality
Maine Primary Care Association
73 Winthrop Street
Augusta, Maine 04330
rmorin@mepca.org
P: (207) 621-0677 x207
F: (207) 621-0577

Shelia Nelson, Coordinator
Adolescent and School Health
Maine CDC/DHHS
11 State House Station
Augusta, Maine 04333
shelia.nelson@maine.gov
P: (207) 287-3856
F: (207) 287-7213

Darcy Shargo, Chief Operating Officer
Maine Primary Care Association
73 Winthrop Street
Augusta, Maine 04330
dshargo@mepca.org
P: (207) 621-0677 Ext. 216
F: (207) 621-0577

Robert Small, Director
University Counseling Services
University of Southern Maine
96 Falmouth Street
P.O. Box 9300
Portland, Maine 04104-9300
rsmall@usm.maine.edu
P: (207) 780-4050
F: (207) 780-5749

Joan Smyrski, Assistant Director
Community Programs
Division of Licensing and Regulatory
Services/DHHS
11 State House Station
Augusta, Maine 04333
joan.smyrski@maine.gov
P: (207) 287-9259
F: (207) 287-9304

Lisa Sockabasin, Director
Office of Health Equity
Maine CDC/DHHS
11 State House Station
Augusta, Maine 04333
lisa.sockabasin@maine.gov
P: (207) 287-6227
F: (207) 287-9058

Libby Stone-Sterling, Asst. Director
Vocational Rehab, Department of Labor
150 State House Station
45 Commerce Center Drive
Augusta, Maine 04333
libby.stone-sterling@maine.gov
P: (207) 623-7943
F: (207) 287-5292

Holly Stover, Acting Director
Office of Multicultural Affairs/DHHS
11 State House Station
Augusta, Maine 04333
holly.stover@maine.gov
P: (207) 624-7919
F: (207) 624-8074

Nancy Thompson
6 Pine Ridge Road
Cape Elizabeth, Maine 04107
nancyethompson1@gmail.com
P: (207) 799-6669
C: (207) 318-8095

Katharyn Zwicker
Maine Injury Prevention Program
Maine CDC/DHHS
11 State House Station
286 Water Street
Augusta, Maine 04333
katharyn.b.zwicker@maine.gov
P: (207) 287-5359
F: (207) 287-4631

Vacant
Department of Public Safety

Vacant
Department of Corrections

Note: Carrie Horne, Jan Avery, Kristine Bertini, Mary Cuskelly, Marya Faust, Destie Hohman Sprague, Susan Lieberman, Greg Marley, Virginia Marriner, Pete MacMullen, Joseph Riddick, Steven Sherrets and Linda Williams served as Advisory Council members during the time this plan was written.

APPENDIX 3

Resources

Maine Resources

Maine Crisis Hotline

1-888-568-1112
(Voice/TTY)

A 24 hour hotline to access crisis services for a range of behavioral health crisis situations including suicide assessment and intervention help. Calls are answered by trained behavioral health clinicians located in the crisis service center closest to the caller's location.

Maine Warm Line

1-866-771-9276

A peer staffed Intentional Warm Line operated 24 hours a day and offering telephone support for adults in non-crisis situations. Connect with trained peers who have experienced mental illness and recovery.

NAMI Maine Help Line

1-800-464-5767
Mon.-Fri., 8am-4:30pm

Provides confidential non-crisis help for consumers of mental health services and their family members, and offers support and assistance with information about mental illness and the support & treatment system, understanding your rights and where to get the help you need.

Maine Suicide Prevention Program

<http://www.maine.gov/suicide/>

1-800-698-3624
TTY users call
Maine Relay 711

Statewide prevention program led by the Maine CDC/DHHS in collaboration with other state agencies and private sector partners. The mission of the program is to increase statewide public awareness about suicide and suicide prevention; reduce the incidence of suicidal behavior among citizens; and improve access to appropriate prevention and intervention services. The program website offers information and resources for all concerned and links to training and national resources.

Maine Child Abuse and Neglect Hotline

1-800-452-1999
TTY users call
Maine Relay 711

24 hour hotline of Maine's Department of Human Services Child Protection Division to report suspected child abuse or neglect.

Maine Coalition Against Sexual Assault (MECASA) **1-800-871-7741**
www.mecasa.org **TTY 1-888-458-5599**

The Maine Coalition Against Sexual Assault is organized to put an end to sexual violence and to ensure that there will be ongoing support and services for victims and survivors.

Maine Office of Substance Abuse & Mental Health Services **1-800-499-0027**
Information and Resource Center (IRC) **TTY users call**
<http://osairc.informe.org/> or email osa.ircosa@maine.gov **Maine Relay 711**

The IRC houses a collection of books, videos/DVDs, and pamphlets which are searchable online. Library materials are available on loan, and pamphlets and handouts are distributed free statewide.

Northern New England Poison Center (NNEPC) **1-800-222-1222**
<http://www.nnepc.org> **TTY users call**
 Maine Relay 711

The NNEPC provides immediate treatment advice for poison emergencies, as well as information about poisons and poison prevention, 24 hours a day, seven days a week.

National Resources

National Suicide Prevention Lifeline **1-800-273-TALK (8255)**
A 24-hour hotline available to anyone in suicidal crisis or emotional distress. Home of the **Veterans Crisis Line; press “1” for veterans**. Website links to additional information and resources for those in crisis and their family and friends.

American Association of Suicidology (AAS)
<http://www.suicidology.org>
The national professional organization of the people involved in suicide prevention across the U.S. and abroad. Resource for information, training and program development support.

American Foundation for Suicide Prevention (AFSP) **1-212-363-3500**
<http://www.afsp.org>
A national not-for-profit organization dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. Its primary efforts include: funding scientific research, offering educational programs for professionals and providing programs and resources for survivors of suicide loss and people at risk.

Means Matter
<http://www.hsph.harvard.edu/means-matter/index.html>
"Means reduction" (reducing the odds that an attempter will use highly lethal means) is an important part of a comprehensive approach to suicide prevention. This site contains links to studies, frequently asked questions and resources.

National Action Alliance for Suicide Prevention

<http://actionallianceforsuicideprevention.org/>

The public-private partnership advancing the National Strategy for Suicide Prevention (NSSP) by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the NSSP, and cultivating the resources needed to sustain progress. Its vision is a nation free from the tragic experience of suicide.

National Strategy for Suicide Prevention 2012

<http://www.samhsa.gov/nssp>

This updated National Goals and Objectives for Action is a report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. It outlines the national strategy to guide suicide prevention actions. Includes 13 goals and 60 objectives across four strategic directions: wellness and empowerment; prevention services; treatment and support services; and surveillance, research, and evaluation.

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://samhsa.gov/prevention/suicide.aspx>

A resource listing providing individuals, families, professionals, and organizations with information and resources to seek help, provide assistance, and/or implement suicide prevention programs in their communities. Lists multiple links to additional suicide prevention resources.

Suicide Prevention Resource Center (SPRC)

1-877-438-7772

www.sprc.org

This website, home to the national SPRC initiated by the 2001 Surgeon General's National Suicide Prevention Strategy, contains over 490 web pages and 250 library resources on suicide prevention ranging from mental health news to strategic tools for developing suicide prevention programs. The site includes individual state suicide prevention pages, news and events, online library, training, and links to other web sites.

The Centre for Suicide Prevention of Calgary, Canada

<http://www.siec.ca>

An education center which provides information and resources for suicide prevention. The center provides library and information services, fact sheets and other resources.

Web-based Injury Statistics Query and Reporting System (WISQARS)

www.cdc.gov/ncipc/wisqars/

Available online from the U.S. CDC, WISQARS is an interactive database system that provides customized reports of injury data at the national and state level. An important and easily mastered tool for gathering data about suicide, homicide and injury mortality on the state and national levels.

APPENDIX 4 PARTNERS

Maine State Agencies involved in Implementing Suicide Prevention Programming

State Agencies

Department of Health and Human Services:

 Maine Center for Disease Control and Prevention:

 Maine CDC Injury Prevention Program

 Division of Local Public Health

 Rural Health and Primary Care

 Office of Health Equity

 Maine State Public Health Nurses

 Adolescent and School Health

 Public Health District Offices

 Office of Substance Abuse and Mental Health Services

 Prevention Intervention Treatment Recovery Support Services

 Data and Quality Management

 Information and Resource Center

 Office of Child and Family Services

 Office of Aging and Disability Services

Department of Defense, Veterans & Emergency Management

Department of Education (DOE)

 Coordinated School Health

Department of Labor (DOL)

 Unemployment Services

 Vocational Rehabilitation Services

Department of Corrections (DOC)

Department of Professional and Financial Regulation (DPFR)

Department of Public Safety (DPS)

 State Police

 Emergency Medical Services (EMS)

Maine Attorney General

 Office of the Chief Medical Examiner

Partner Organizations for Implementing Suicide Prevention Programming Regionally and Locally

American Academy of Pediatrics, Maine Chapter
American Association of Retired Persons Maine
American Foundation for Suicide Prevention
American Psychiatric Association, Maine Chapter
American Psychological Association, Maine Chapter
American Red Cross
Area Agencies on Aging
Association of Family Practice Physicians
Association of Osteopathic Physicians
Boy Scouts and Girl Scouts
Boys to Men
Catholic Archdiocese of Maine
Colleges and universities
Community Health and Counseling Services
Consumer Affairs Council
Co-Occurring Collaborative Serving Maine
County Governments
County Correctional System
Domestic Violence Service Providers
Drug Free Communities
Emergency Medical Services Providers
Employers
 Wellness Committees
 Employee Assistance Programs
 Human Resource Departments
Employment/Career Centers/Unemployment supports
Episcopal Diocese of Maine
Equality Maine
Family Planning Association of Maine
Federally Qualified Health Centers
Food banks and food pantries
Fraternal Organizations and other Civic Groups
Funeral Directors
Gaining Empowerment Achieves Results (Gear)
Gay Lesbian and Straight Education Network (GLSEN)
GLTB Support and Advocacy Organizations and programs
Health Insurance Carriers
Health Service Providers
Hearty Girls, Healthy Women
Healthy Maine Partnerships
Home Health personnel
Home Visiting Programs
Homeless services providers for youth and adults

Hospice Programs
Law Enforcement
Legislators
Mail Carriers
Maine Trauma Network
Maine Association of Family Physicians
Maine Association of Social Workers
Maine Association of Substance Abuse Programs
Maine Association of Prevention Programs
Maine Association of Mental Health Providers
Maine Employers Mutual Insurance Companies/Workers Compensation
Maine Citizen's Against Handgun Violence
Maine Chiefs of Police Association
Maine College Health Association
Maine Coalition Against Sexual Assault
Maine Coalition to End Domestic Violence
Maine Council of Churches
Maine Criminal Justice Academy
Maine Crisis Network and Crisis service providers
Maine Domestic Violence Review Panel
Maine Emergency Management
Maine Emergency Medical Services
Maine Funeral Directors Association
Maine Health Care Access Foundation
Maine Health Care Association
Maine Higher Education Council
Maine Homicide, Suicide, Aggravated Assault Review Panel
Maine Hospital Association
Maine Indian Tribal-State Commission
Maine Medical Association
Maine National Guard
Maine Nurse Practitioner Association
Maine Osteopathic Association
Maine Practice Improvement Network
Maine Press Association
Maine Primary Care Association
Maine Psychiatric Association
Maine Public Health District Coordinating Councils
Maine Quality Counts
Maine Sheriffs Association
Maine State Police
Maine Veterans' Administration Suicide Prevention Program
Maine Youth Action Network (MYAN)
Meals on Wheels Programs
Media, social, print, television and radio
Medical Care Development

Medical Examiner's Office
Mental Health Association of Maine
Mental Health Treatment and Support Providers
Municipal and Town Government
National Alliance on Mental Illness of Maine
National Association of Social Workers, Maine Chapter
Natural Helping Networks
New England School of Broadcasting
Northern New England Poison Control
Parent/Family Organizations
Pathways to Excellence
Peer Support Programs
Penobscot Suicide Prevention Coalition
Physicians for Social Responsibility
Public Safety Dispatchers
Religious Organizations Statewide, Regional and Local
Rod and Gun Clubs
Salvation Army
School systems
Sexual Violence Service Providers
Sexual Assault Nurse Examiner Program
Sportsman's Alliance of Maine
Substance Abuse Prevention Coalitions (Regional and Local)
Substance Abuse Providers
Suicide Survivor Speaker's Bureau
Suicide survivors
The Center for Grieving Children
The Unity Project
Traumatic Brain Injury Programs and support services
Tribal health leaders and Tribal representatives
University of Maine Center on Aging
Veterans Administration
Victim Advocates
Volunteer Organizations
Wabanaki Mental Health Center
Youth groups/organizations

APPENDIX 5

Clinical Treatment of Suicidal Behavior

In randomized controlled trials, **cognitive behavioral therapy (CBT)** interventions have been shown to be effective in reducing repeated suicide attempts.^{85 86} Of particular interest is **dialectical behavioral therapy (DBT)**, an intensive and long-term intervention featuring a combination of behavioral, cognitive, and supportive elements developed to treat patients with borderline personality disorder. DBT has been extensively documented and found to reduce suicide attempts among patients with recent suicidal and self-harm behaviors and borderline personality disorder.⁸⁷⁸⁸

A review of psychological and psychosocial interventions after attempted suicide found that psychodynamic interpersonal therapy may also be effective in reducing suicidal ideation, habitual self-harming behavior, and suicide attempts among patients with borderline personality disorder.^{89 90}

Common interventions among empirically supported psychological treatments for suicidal patients include: clear treatment framework; defined strategy for managing suicide crises; close attention to affect; active, participatory therapist style; and use of exploratory and change-oriented interventions.⁹¹ The National Registry of Evidence-based Programs and Practices lists several specific programs with significance to suicide prevention and intervention across the lifespan, including Cognitive Behavioral Therapy for Late-Life Depression; Dialectical Behavior Therapy; Multi-Systemic Therapy with Psychiatric Supports; and Trauma Focused Coping.

Cognitive Behavioral Therapy (CBT) for Late-Life Depression is an active, directive, time-limited, and structured problem-solving approach program that follows the conceptual model and treatment program developed by Aaron Beck and his

⁸⁵ Stanley B, Brown G, Brent DA, Wells K, Poling K, Curry J, Kennard BD, Wagner A, Cwik MF, Klomek AB, Goldstein T, Vitiello B, Barnett S, Daniel S, Hughes J. Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *J Am Acad Child Adolesc Psychiatry*. 2009 Oct; 48(10):1005-13.

⁸⁶ Tarrier N, Taylor K, Gooding P. Cognitive-behavioral interventions to reduce suicide behavior: a systematic review and meta-analysis. *Behav Modif*. 2008 Jan; 32(1):77-108.

⁸⁷ Koerner K, Linehan MM. Research on dialectical behavior therapy for patients with borderline personality disorder. *Psychiatry Clin North Am*. 2000 Mar; 23(1):151-67.

⁸⁸ Robins CJ, Chapman AL. Dialectical behavior therapy: current status, recent developments, and future directions. *Journal Personality Disorder*. 2004 Feb; 18(1):73-89.

⁸⁹ Guthrie E, Kapur N, Mackway-Jones K, Chew-Graham C, Moorey J, Mendel E, Francis FM, Sanderson S, Turpin C, Boddy G. Predictors of outcome following brief psychodynamic-interpersonal therapy for deliberate self-poisoning. *Australia New Zealand Journal Psychiatry*. 2003 Oct; 37(5):532-6.

⁹⁰ Falk Leichsenring, D.Sc.; Eric Leibing, D.Sc. The Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders: A Meta-Analysis. *American Journal Psychiatry* 2003; 160:1223-1232. 10.1176/appi.ajp.160.7.1223.

⁹¹ Weinberg I, Ronningstam E, Goldblatt M, Schechter M, Wheelis J, Maltzberger JT. Strategies in the Treatment of Suicidality: Identification of Common and Treatment-Specific Interventions in Empirically Supported Treatment Manuals. *J Clin Psychiatry* 2010 June 71:6: 699-705.

colleagues. CBT for Late-Life Depression includes specific modifications for elderly depressed individuals who are being treated as outpatients. The intervention includes strategies to facilitate learning with this population, such as repeated presentation of information using different modalities, slower rates of presentation, and greater use of practice along with greater use of structure and modeling behavior. Patients are taught to identify, monitor, and ultimately challenge negative thoughts about themselves or their situations and develop more adaptive and flexible thoughts. Where appropriate, emphasis is also placed on teaching patients to monitor and increase pleasant events in their daily lives using behavioral treatment procedures. The intervention consists of up to 20 50- to 60-minute sessions following a structured manual.

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatically emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric) is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity. Youth receiving MST-Psychiatric typically are between the ages of 9 and 17. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations while allowing youth to spend more time in school and in home-based placements. Like standard MST, on which it is based, MST-Psychiatric has its foundation in social-ecological and social learning systems theories. It includes specific clinical and training components for staff designed to address (1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.

MST-Psychiatric teams intervene primarily at the family level, empowering parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. The intervention assists parents and caregivers in engaging their children in pro-social activities while disengaging them from deviant peers. In addition, it addresses individual and systemic barriers to effective parenting. The intervention is delivered in the family's natural environment (e.g., home, school,

community) daily when needed and for approximately 6 months. A MST-Psychiatric team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings.

Trauma Focused Coping (TFC), sometimes called Multimodality Trauma Treatment, is a school-based group intervention for children and adolescents in grades 4-12 who have been exposed to a traumatic stressor (e.g., disaster, violence, murder, suicide, fire, accident). The intervention targets posttraumatic stress disorder (PTSD) symptoms and other trauma-related symptoms, including depression, anxiety, anger, and external locus of control.

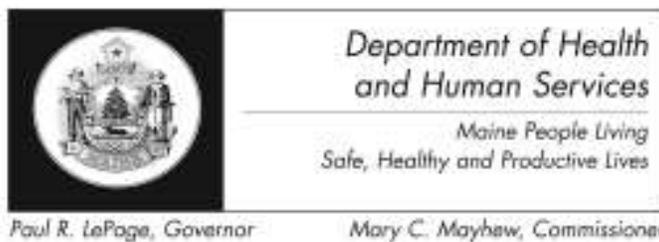
TFC uses a skills-oriented, peer- and counselor-mediated, cognitive behavioral approach. The intervention is delivered in 14 weekly, 50-minute sessions, providing youth with gradual exposure to stimuli that remind them of their trauma. The sessions move from psycho-education, anxiety management skill building, and cognitive coping training to activities involving trauma narratives and cognitive restructuring. Implementation of TFC requires a master's-level clinician and should include a co-facilitating school counselor when administered in a school setting.⁹²

Psychosocial Interventions

There is evidence that outpatient psychosocial and psychoeducational programs reduce risk factors for suicide. A 2009 study considered the impact of a 20 week outpatient program on people who had a history of repeated suicide attempts.⁹³ Unlike programs focusing on people with a single diagnosis, participants in this program had a variety of difficulties: depression, bipolar disorder, eating disorders, substance abuse, anxiety, and various cognitive and impulsivity problems. Small groups met weekly with trained facilitators, including peer facilitators when possible. The program consisted of four modules of skill development: 1) emotional literacy, 2) problem solving, 3) crisis management, and 4) interpersonal relationships. At the conclusion of the training, participants reported a significant reduction in depression symptoms and feelings of hopelessness, and an increase in life satisfaction, problem solving skills, and the ability to describe one's feelings.

⁹² SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). www.nrepp.samhsa.gov.

⁹³ Bergman, Y, Links PS. (2009). Reducing potential risk factors for suicide-related behavior with a group intervention for clients with recurrent suicide-related behavior. *Annals of Clinical Psychiatry*, 21(1), 17-25.



The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 and the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to DHHS' ADA Compliance/EEO Coordinators, 11 State House Station – 221 State Street, Augusta, Maine 04333, 207-287-4289 (V), 207-287-3488 (V), TTY users call Maine relay 711. Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

Footnote

The reorganization of Maine's DHHS in 2005 combined several formally discrete offices under one Department. This has facilitated access to information by and between the offices within our Department, without the need for formal Memorandums of Understanding. These offices now include: Office of MaineCare Services (Medicaid), ME Center for Disease Control and Prevention, Office of Continuous Quality Improvement, Office Children's and Family Services, Office of Adults with Disabilities, and our own integrated Office of Substance Abuse and Mental Health Services. Additionally, we have formal MOUs and/or regularly scheduled monthly meetings with: Department of Education, Department of Corrections, Department of Labor, and Maine State Housing Authority.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. Behavioral Health Planning/Advisory Council and Input on the mental Health/Substance Abuse Block Grant Application

Footnote:

The planning mechanism used in Maine to implement substance abuse services is the Office of Substance Abuse and Mental Health Services (SAMHS). DHHS has been well positioned to recognize the co-occurring nature of substance abuse and mental health conditions and now is well positioned to better coordinate the service delivery structure as one integrated office. SAMHS is structurally organized around five pillars: Prevention and Intervention, Treatment and Recovery, and Data Quality Management and Resource Development.

The State's Mental Health Authority advisory body is known as the Quality Improvement Council. The council consists of providers, consumer's family members, and state staff from SAMHS, OCFS, OMS, Departments of Education, and Labor. The council has monthly meetings and subgroups focusing on council directed issues which also meet regularly. The Council composition largely consists of persons with lived experiences. The council has been instrumental with planning and development of utilizing peers in the Maine Behavioral Health System. The council also has been effective in assisting state contract staff with onsite provider reviews.

August 5, 2015

I am the chair of Maine's QIC (Quality Improvement Council) which is the state's mental health planning council. The council has reviewed the application and implementation report and recommends that they be transmitted as attachments by the state. The council actively participated in the MHBG application/report. The council did not feel that they actively participated in the state plan. The council will look at ways to be proactive in the state plan and work on communication between the state and the council. The council could have the state plan on the standing agendas to ensure the council knows what is happening with the state plan. The council looked at the impact of peer supports, APS, BHH, service delivery, juvenile justice system, MaineCare advisory council and many other issues.

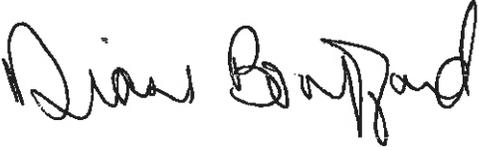
The council is actively trying to integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns and activities into its work. The council has a TA from SAMSHA scheduled for August 24, 2015 to get input into fully integrating into a behavioral health council. The council has started to have substance abuse issues on the standing agenda and bring in guest speakers in that area to educate the council on issues, concerns and activities going on in the substance abuse system

The council membership comes from all parts of the state. We still would like to have representatives from the military, the northern part of our state, deaf population and more parents of young children. The council has input from lived experiences and gathers input from families, consumers and youth that representatives work with. The council gives input to the state on gaps and needs in the service system and also gives input in what works in the system. The council questions the state on these gaps and needs and tries to work together to find a solution to the issue. The council has educated themselves and state members by having special speakers present on different services and initiatives. This helps the council advocate more with the information learned and gathered. The council stays

up to date on legislative bills that might affect individuals with SED/SMI. Some individuals also worked with SAMSHA on the definitions of SED/SMI.

The council will continue to work on integrating into a behavioral health council. If you need any more information or have any questions please feel free to call me at 207-612-8996.

Warmly,

A handwritten signature in black ink that reads "Diane Bouffard". The signature is written in a cursive, flowing style.

Diane Bouffard

QIC Chair

Maine Statewide Quality Improvement Council
AGENDA
SAMHS, 41 Anthony Avenue, Augusta, ME
April 3, 2015
9:00-2:00

1st hour Adult and Children Committee Meetings (9:00-10:00)

BREAK (10:00-10:15)

Full Council Meeting starts at 10:15

Welcome, Announcements, Adjustments to the Agenda (10:15-10:30)(15 mins)

Establish Quorum

Any changes to the agenda?

Guest Speakers (10:30-12) (90 mins)

Matthew Wells, LCSW, SAMHS Recovery Manager

Break for Lunch 12-12:30 (30 Minutes)

Departmental, Committee and Workgroup Updates: 12:30-1:30 (60 Minutes)

- Children's and Adult Committees report out only if they need to make a motion to the full Council
- OCFS, DOE, SAMHS, DVR, DOC, MaineCare update
- Orientation manual update
- Legislative update
- MH/SA topics or issues to discuss
- Mental Health Block Grant
- Behavioral Health Council(How to do this)(use TA Guide)
- Fill out TA request

Regular Business: 1:30-1:45 (15 Minutes)

- Approve Minutes
- Treasurer's Report

Final Items: 1:45-2:00 (15 Minutes)

Maine Statewide Quality Improvement Council

AGENDA

SAMHS, 41 Anthony Avenue, Augusta, ME

April 3, 2015

9:00-2:00

Any remaining business

Set the next agenda

- Adjourn

Maine Statewide Quality Improvement Council
AGENDA
SAMHS, 41 Anthony Avenue, Augusta, ME
June 5, 2015
9:00-2:00

1st hour Adult and Children Committee Meetings (9:00-10:00)

BREAK (10:00-10:15)

Full Council Meeting starts at 10:15

Welcome, Announcements, Adjustments to the Agenda (10:15-10:30)(15 mins)

Establish Quorum

Any changes to the agenda?

Guest Speakers (10:30-12) (90 mins)

David Dostie MBA,MSB, Finance Manager DHHS

Mental Health Block Grant presentation

Break for Lunch 12-12:30 (30 Minutes)

Departmental, Committee and Workgroup Updates: 12:30-1:30 (60 Minutes)

- Children's and Adult Committees report out only if they need to make a motion to the full Council
- OCFS, DOE, SAMHS, DVR, DOC, MaineCare update
- Orientation manual update
- Legislative update
- MH/SA topics or issues to discuss
- Behavioral Health Council(How to do this)(use TA Guide)
- Update on TA request

Regular Business: 1:30-1:45 (15 Minutes)

- Approve Minutes
- Treasurer's Report

Maine Statewide Quality Improvement Council
AGENDA
SAMHS, 41 Anthony Avenue, Augusta, ME
June 5, 2015
9:00-2:00

Final Items: 1:45-2:00 (15 Minutes)

Any remaining business

Set the next agenda

- Adjourn

Maine Statewide Quality Improvement Council
AGENDA
SAMHS, 41 Anthony Avenue, Augusta, ME
June 5, 2015
9:00-2:00

1st hour Adult and Children Committee Meetings (9:00-10:00)

BREAK (10:00-10:15)

Full Council Meeting starts at 10:15

Welcome, Announcements, Adjustments to the Agenda (10:15-10:30)(15 mins)

Establish Quorum

Any changes to the agenda?

Guest Speakers (10:30-12) (90 mins)

David Dostie MBA,MSB, Finance Manager DHHS

Mental Health Block Grant presentation

Break for Lunch 12-12:30 (30 Minutes)

Departmental, Committee and Workgroup Updates: 12:30-1:30 (60 Minutes)

- Children's and Adult Committees report out only if they need to make a motion to the full Council
- OCFS, DOE, SAMHS, DVR, DOC, MaineCare update
- Orientation manual update
- Legislative update
- MH/SA topics or issues to discuss
- Behavioral Health Council(How to do this)(use TA Guide)
- Update on TA request

Regular Business: 1:30-1:45 (15 Minutes)

- Approve Minutes
- Treasurer's Report

Maine Statewide Quality Improvement Council
AGENDA
SAMHS, 41 Anthony Avenue, Augusta, ME
June 5, 2015
9:00-2:00

Final Items: 1:45-2:00 (15 Minutes)

Any remaining business

Set the next agenda

- Adjourn

Maine Statewide Quality Improvement Council
AGENDA
SAMHS, 41 Anthony Avenue, Augusta, ME
July 10, 2015
9:00-2:00

1st hour Adult and Children Committee Meetings (9:00-10:00)

BREAK (10:00-10:15)

Full Council Meeting starts at 10:15

Welcome, Announcements, Adjustments to the Agenda (10:15-10:30)(15 mins)

Establish Quorum

Any changes to the agenda?

Block Grant Work (10:30-12) (90 mins)

Will be working together on the block grant

Break for Lunch 12-12:30 (30 Minutes)

Departmental, Committee and Workgroup Updates: 12:30-1:30 (60 Minutes)

- Children's and Adult Committees report out only if they need to make a motion to the full Council
- OCFS, DOE, SAMHS, DVR, DOC, MaineCare update
- Orientation manual update
- Legislative update
- MH/SA topics or issues to discuss
- Behavioral Health Council(How to do this)(use TA Guide)
- Update on TA request

Regular Business: 1:30-1:45 (15 Minutes)

- Approve Minutes
- Treasurer's Report

Final Items: 1:45-2:00 (15 Minutes)

Maine Statewide Quality Improvement Council

AGENDA

SAMHS, 41 Anthony Avenue, Augusta, ME

July 10, 2015

9:00-2:00

Any remaining business

Set the next agenda

- Adjourn

Statewide Quality Improvement Council

February 6, 2015

Draft

Attendance: Diane Bouffard, Virginia Jewell, Mary Hansen, Vickie McCarty, Eddie Greyfox Burgess (left 12:10), Karen Frasier (left 10:55), Karen Evans, Marcia Hard, Matthew Leavitt, Richard Ladd, Sr., Margaret Carr (gone from 9:45-12).

Excused: Liz Bradshaw, Peg Armstrong, Jennifer Olivier-Gut, Brie Masselli,

Guests: Stephan Corral, Stacy Chandler

Meeting called to order: 10:17 a.m.

Quorum established.

Additions to agenda.

Introductions made

Stacy Chandler (SA) presented PowerPoint (Gave as handout). Discussion about methadone vs. other forms of treatment. Statistics statewide as well as national outcomes presented.

Stephan Corral (SA) presented PowerPoint (gave as handout). Great discussion about the survey for students statewide for schools who choose to participate.

SAMHS: Cindy McPherson-Looked over e-mail about getting TA from SAMHSA. Need to apply (missed leadership training). We are trying-we have SA on agenda, special speakers, educating self on what's going on. Need to get SA actively involved in QIC. (Ask Sheldon who we should ask to join). Diane to fill out survey and don't ask for any specific individual.

WEB-BGAST- Vickie and Eddie have access, Diane to set up her account.

-Sole source application for MeGeneral in Portland for \$91,000 over 2 yrs. For early intervention for 1st psychotic episode.

HTI/IRP- Youth MOVEME was awarded the Healthy Transition Initiative for youth peer support.

Block Grant submission is due in September instead of April. Accepting public comment before finalization.

Reorganized who handles/oversees PATH program, joined it with housing (BRAP & Shelter Plus Care).

Sheldon: Commissioner requested RFP time frames, but it keeps getting bumped. Many entities involved. OCFS and SAMHS will write it and send to Quality Improvement-goes back and forth for months. Then goes to Contract Management who won't sign off, then has to go full circle again. There is no National Standard for what is attempting to be done. It makes people nervous, looking at Promising Practices.

Crisis RFP-aspiring to be out in April. Rate study being done by Barnes and Associates.

Section 65- 10% rate reduction, what services will be touched. Fact sheet is published and given to legislature. (Sheldon to send to Diane).

Next Wednesday-Emergency Supplemental Spending Bill to ask for \$1.1 million of additional need for consent decree. Heard before the HHS or Appropriation committee.

Wall between assessor and service provider. Closest we have is in DD with Guild Services.

Administration Procedure Act-service is to be implemented within 90 days after voted in.

Section 13-keep on radar. Need clarification on TCM, ICM, and Id services. For homeless TCM is for referral only.

Recovery Manager, Matthew Wells to start 2/17/15.

Transportation Liaison-legislature looking at restoring bus passes.

Consent Decree-\$5.7 million for consent decree in Feb/Mar?

It started in 1989 from people dying of heat exhaustion. Class of 4000, now entire system?*****

CI to be funded by Medicare, Feds had a problem with this.

Ombudsman model similar to DD or OADS. Less widget counting, move to direct service providing.

Fiscal year 16-17- \$5.7 million not to include BRAP. \$1.3 million for BRAP.

Looking at cutting methadone, pushing suboxatone (SP)****. Steering into primary care. Even with 1 on 1 therapy, national outcomes show that 30% will recover for a year. Looking at the BRAIN initiative.

Big marijuana vs. Big tobacco

Voc. Rehab: Trying to fill vacancies.

MeCare: No updates

DOE: Some bills in legislature. There is a new virtual school opening in fall.

Minutes: No minutes

Treasure's Report: Haven't gotten checks, so no up to date report.

Orientation Manual: Is there a way to get a check cut to cover costs? Yes, Diane to scan her receipt and Cindy will submit to get check.

Next Month: Would like to invite APS/McCare and if not transportation.

Tamara has applied to become a member to the QIC. She has been interviewed. Tamara was asked to step from the room. There was a discussion about applicant. Motion made to accept Tamara as a member, MSVP. Welcome Tamara!

Meeting adjourned 1:58 pm.

Maine QIC

March 6, 2015

Attendance: Jennifer Oliver Gutsell, Richard Ladd, Sr., Matt Leavitt, Marcia Hard, Brie Masselli, Virginia Jewell, Diane Bouffard, Peg Armstrong, Liz Bradshaw-Livingston, Vicki McCarty, Mary , Tamara Manzer, Karen Evans, Eddie Burgess Greyfox, Karen Frazier, Margaret Carr (gone 9:50-12).

Excused: Sherry Langway, Cindy

State: Theresa Burrows, Sheldon Wheeler (10:35)

Guests: Roger Levine (Member Liaison), Kelly Bickmore (Program Director), Kelly Parnell (Clinical Manager)

Meeting called to order: 10:15 a.m.

SAMHS: (Sheldon)- continue to work on 1915 I-SPA application to feds. Hopefully, April or May. But quickest turnaround is 18 months.

APS: Kelly Bickmore- went over structure and handed out 2014 annual report. APS is in a corporate structure under Universal American. APS is fairly independent (19 states involved under UA). Office located in S. Portland with about 30 on staff, 14 clinicians. Currently have capacity to hire staff for statewide input.

In Maine APS has a contract with MeCare services. APS meets with OCFS, SAMHS. Help identify gaps, too expansive services, attend groups, provide trainings to consumers, families and provider.

Helps providers with documentation.

Kelly Parnell- Handout

Roger Levine: Not a consumer, a family member. And a clinician.

-If possibility of denial, goes to APS physician (clinician doesn't deny). Clinician reviews provider requests. If there is a denial-parent needs to talk with their provider. Every request is reviewed case by case. Never Black and White (except with diagnosis). Using MeCare policy. Member and provider presents together (that's the assumption), not happening on the ground. Only documentation APS has to go on is documentation from provider.

APS often used as a scapegoat. Members can call APS to find out what was written by provider. There is a grievance process. 20,000 cases to review. Very small percentage of denial. APS wants to be open and transparent.

Want to debunk myths: “increase in denials because contract is soon to expire”-Not true. No funding difference. In fact denials cost more because more people have to be involved and doctor has to review.

Full denials/partial denials-all considered a denial. (complete denials is for eligibility).

1st level denial- reviews by internal Dr.

2nd level-Letter goes to member. Letter goes electronically to provider as well as a fax.

Member and provider can appeal by providing additional information. Has to be a different doctor reviewing-checks and balances.

3rd level-Member can appeal denial-service is reinstated until hearing (Stay Put Law). Legal hearing and evidence presented by both sides. Decision made and is signed off by higher ups.

When request is sent, response is within a day now. Very quick turnaround than in past. Providers seem to be talking with APS more and notes are put in member files which helps with continuation of services and less paperwork for both sides.

IOP-individual need instead of program structure.

Issues with school approvals between IEP vs. ITP. There seems to be a disconnect with school based services. In 2013 a web based portal, Care Connection, was put into place to help with communication. If a service is to be funded, it needs to be written into the IEP, which can be documented through this portal. Schools are leary to do this because if a service is denied through APS, schools are stuck with the expense. Its an evolutionary process. For example: day treatment is not in ME Special ED regulations, but needs to be for APS.

Myth: APS changes DOE and MeCare policies-They don't. APS has to follow MeCare language. BHP has to be supervised by clinical supervisor in order to be billed to MeCare. APS has to be ready for audits and aware of Medicare fraud cases. There are trainings for providers on web or can be done in person. Conferences takingmplace at the Civic Center 5/14.

January 2016, SIS (Supports Intensity Scale) affecting section 21 will be implemented. Still uncertasin how APS fits in.

Myth: APS has an inside track-They are surprised as anyone!

They receive information in July to be implemented in January, phased in.

No children's subcommittee report out.

Adult's subcommittee would like Matthew Wells to come in April.

MeCare: Liz Bradshaw-?-Proposed rule change section 45-hospital services, readmittance into hospitals within 48 hours, now its 14 days not reimbursed. Why? MeCare redesign task force.

-What about misdiagnosis, complications? Who pays then? Public hearing 3/30 @ 2pm 19 Union St. rm. 110-policy writer-Ann O'Brien. Can submit comments online. (Liz to send link to Diane)

Liz can't discuss Governor's budget-Information is online. (Diane to send out link). Liz can take comments back, but cannot and will not respond.

Voc. Rehab: Division of Voc. Rehab

15% of budget for youth.

Reducing waitlists-still having trouble with engagement services. Director Hopkins is working on this.

Have to get to work within 90 days.

Visually impaired-not only for employment but for DSL services. Merged with IRIS. Opening an emergence center hopefully by fall 2008. Coalition working on issues as work should be one. "employment first".

Coalition supports 1915I waiver, effort to eliminate subminimum wage (Bill is out in draft form). Cross system issue from- schools, OADS, OCFS, VR, SAMHS.

DOE: Lots of legislative bills. Rule about early intervention for dyslexia. Bill for opting out of all standardized testing.

Orientation Manual: Binders and folders are here. Ginny to finish draft and get to Cindy.

MH/SA topic: survey feedback-

Educate youth before administering-how, why, confidentiality, who as well as involve youth in process.

Treasurer's Report: February slightly higher because that is January and February combined. Binders are not on here yet. Motion to accept TR, MSVP.

Minutes: February minutes handed out, changes made. Motion made to accept minutes with changes. MSVP. Ginny will not be here in April-Matt agreed to do minutes.

Try to get Matthew Wells for upcoming meeting as special guest.

Meeting adjourned:

Statewide Quality Improvement Council

May 1, 2015

Attendance: Diane Bouffard, Margaret Carr (gone 9:45-), Virginia Jewell, Marcia Hard, Karen Evans, Liz Bradshaw, Cindy McPherson, Eddie Greyfox Burgess, Mary Hanson,

Excused: Brie Masselli, Matt Leavitt, Richard Ladd, Sr., Jennifer, Vickie McCarthy, Peg Armstrong, Karen Frazier

New member: Matthew Wells (SAMHS)

Meeting called to order: 10:20

Introductions made.

Handouts given and discussed.

Family Independence-McCare, FS (SNAP), TANF, Child Support Enforcement, Disability Determination. Overseer: General Assistance

16 offices about 1,000 employees.

“Heat & Eat” program. SNAP and LIHEAP are related. Changes have taken place since the 2014 Agricultural Act (Farm Bill).

SNAP and ABAWDS (an abled-bodied adult without dependents)-discussion

There are lots of significant changes-going from case load to task based. Work is equalized across state.

Call Q implemented in July 2014. As of mid-April all sites up and running. 80,000 calls/month. The need was underestimated, had to double and triple staff. Numbers are pulled and reviewed daily. Revisions are being made. Looked at call center structure. Hopefully by July 2015, automatic system for some services.

There’s 22,000 walk-ins/month. 2 individuals on staff to help assist veterans.

Children’s and Adult’s subcommittees-No motions.

McCare:-Liz Bradshaw- BHH opt-in letters will be mailed out mid-May. It goes out periodically. Comment about being aware of the pressure it puts on individuals.

Program manager (Kitty) gone. Cybil is doing some of Kitty’s roles during transition.

Ginger Roberts-Scott wanted to let us know there is a transition plan-CMS came up with new community based support guidelines. (Liz to send out).

A video from “Speaking out for us” about person centered plan.

OCFS- New department flow chart handed out. Also, delay in RFP for peer services. Extension for 6-9 months. No gap in services.

DOE- Bill looking at extending notice for parents about IEP from 7 to 14 days. There’s still an opt-out option for parents to lessen this notice.

Discussion on virtual schools funding, charter schools, and online standards for winter school.

DOC-No one yet to sit on committee, may have to settle for occasional updates.

SAMHS-Matt Wells has been appointed by commissioner to attend QIC as a replacement for Sheldon.

LD 1209-Bill to remove intentional peer support from slate and put out to RFP went to hearing last Friday. Work session on Monday @1. Does State have rights to training? “proprietary rights”.

ACT team \$42 million pulled out.

Intentional peer support discussion on MeCare billable, medical model discussed.

Governor’s Budget: consent decree increase, BRAP increase \$1.3 million state dollars.

Riverview- 8-12 acuity specialists (higher than MHRT 3), Dave Dosty MH BG (internal financial) Cindy to ask?

MeCare under section 17- \$19,000 adults, discussion on children’s vs. adults.

Minutes: Table minutes. March is not finished. Matt is not here to do April. Not enough to vote.

Treasurer’s Report: Not enough for vote. Discussion on using monies for trainings for the QIC.

Membership: Jen has 2 more applications, and 2 more coming in. Due to her schedule, she wants to resign from this position. Please let Diane know if you are interested.

Updates: T.A. form has been submitted by Diane. She was e-mailed back, still waiting on conformation of request.

APS statewide conference 5/24-ethics CEU class-Eddie to forward.

Statewide Veterans Conference 5/16 hosted by UMO. Jerry DuWett does a yearly UMF veterans conference.

Adjourned 1:47 pm.

Children's subcommittee

Richard Ladd, Sr, Marcia Hard, Matt Leavitt, Brie Masselli, Sherry Langway, Rachel Posner, Diane Bouffard, Virginia Jewell, Peg Armstrong.

Guests: Alice Preble

Rachel Posner handed out organizational chart and went over it.

What happens to unspent respite funds? State funds do not carry from one year to another. Can redelegate to meet unmet need. Funding has been reduced. Increased number of days a family could have per month. Excess monies went to State general funds. Funding group respite discussion at State level, but not sure of what it was all about. It would have to put into an RFP, which is for 1 year and possible can be up to 3 additional years. Working on developing an RFP for respite. NAMI has until end of fiscal year 16. Looking at how to collect information from the public/stakeholders. Discussion on different formats and whys?

WFYWC discussion and the importance of conference. And thoughts on how to raise money. How much was cost?

NAMI and MAFO planning conferences in November.

QIC

6/5/15

Attendance: Richard Ladd, Sr, Marcia Hard(left 1:30), Matt Leavitt, Brie Masselli, Sherry Langway, Rachel Posner, Diane Bouffard, Virginia Jewell, Peg Armstrong, Jennifer Oliver-Gutgsell (10-1:15), Cindy McPherson, Karen Frazier, Karen Evans, Vicki McCarty, Matthew Wells, Liz Bradshaw (12:30-

Guests: Alice Preble, Kimberly Sprague, Chet Barnes

Excused: Margaret Carr, Tamara, Eddie Greyfox-Burgess, Mary Hanson

Meeting called to order: 10:18 a.m.

Agendas handed out. Introductions made. Quorum established.

Chet Barnes-SAMHS-Rental Service Manager.

3 subsidy rental programs along with PATH. (Hand-out given)

BRAP-looking at changing name. Bridging Recovery Assistance Program

Created as a transition program, but there were problems. (Section 8 not enough funding, don't qualify (criminal checks). Moving away from transition and just becoming a housing program. If person is in transition housing they are still considered homeless under federal regulations which are increasing state homelessness. If a youth qualifies for section 17, should qualify for BRAP if meet other qualifications/priorities (priorities changing).

Discussion on homelessness in rural communities and how can it be documented and addressed.

Discussion on **PATH** program. Trying to understand data, identify individuals and reach the needs of that individual. Instead of "you need to do this" it's "what do you need, how can we help".

Shelter Plus Care- Federally funded program. Focusing to help those that have been homeless the longest. Second priority-"long-term stayers" homeless 180 days in last year. Third- Actual homeless-in shelters or not. Sub-categories- victims of domestic violence, youth in transition, and veterans

\$1.2 million additional funds have been approved for BRAP.

Couch surfing-HUD says couch surfing not considered homeless, but if there's need there may be help.

After Chet left had a great discussion on what we, as a QIC, really do and how can we best influence change.

For July 10 committee meeting discuss Block Grant.

In August agenda talk about continuum of care.

TA request was sent in. And all TA has to be done by Sept. A representative (Bruce Emery) will be in area end of August. Since September's meeting would fall on Labor Day weekend, could meeting be moved to end of August?

Adult sub-committee: Discussion about special speakers and reimbursement. A motion made to purchase 4 gas cards in the amount of \$35.00 each to be used for potential applicants and/or special speakers not otherwise compensated.

Children's sub-committee: No motion

OCFS-Rachel Posner: OCFS working with DRM (DRC) to rewrite responsibilities of rights and recipients. Very difficult because there are 2 sets of regulations to follow. Entered into an agreement with DRM to have 2 child/youth advocates.

TCM-have had 3 provider meetings, new push to be out there more with providers to rebuild relationships. Quality Assurance will be starting to look at TCM soon. Continuing with work with MeCare on section 28. Working on revising section 97. Work continues with behavioral health unit. A bunch of stuff going on with transition. Putting early information on transitioning from OCFS into OADS.

DOE-Peg Armstrong: Leg. Session 189 education related bills. Creating a teacher effectiveness had been postponed another year. Smarter balance assessment. Adopted common core. Proficiency based education.

Membership: Jennifer-There are 4 applicants. 2 have had interviews, 2 still trying to interview. Kimberly Sprague introduced herself, and we had a chance to ask questions. Kimberly left room for vote. Discuss and vote.

Discussion about Alex. A letter will be written concerning the need for him to commit to the attendance policy.

SAMHS: Matt and Cindy- Lots of leg bills had impact on SAHMS this session. Been approved for Consent Decree monies. Discussion and clarification about Consent Decree. As a SAMHS organization look at gambling, alcohol, hours of operation, alcohol displays, advertising, etc. Medication management-no answer.

DVR: Karen Frazier- Budget and legislature taking a lot of time and energy. Employment first discussion. Unified workforce for employment in Maine for ALL people. Coming federally and locally.

DOC: Diane has been in contact with DOC and we will have a representative here in July. We will have all federally mandated slots filled.

MeCare: Liz Bradshaw- someone will come in to discuss ICD-10 which takes place 10/01. Dr. does a DSM diagnosis, and then billing does an ICD-10 code for billing. CMS only recognizes ICD format.

Hand-outs of sample letters concerning behavioral health homes. Can give feedback, but it's pretty much a done deal for this round. Mailed in month of May. Changes can be done for next round.

Minutes: Reviewed May's Minutes and made changes. Motion to accept with changes MSVP.
Reviewed March's minutes and made changes. Motion to accept with changes MSVP.

Treasurer's report: TR reviewed. Motion made to accept

Meeting adjourned:

Next meeting Friday, July 10, 2015

Maine QIC Membership Roster (For Member Use)
June 2015 (REV)

NAME AND CONTACT INFORMATION	QIC POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION(S)	REGULAR CONTACT BY:
BOUFFARD, DIANE PO Box 442 Norridgewock 04957 612-8996 (C)	Chair	Children's provider	October 2010	Children	Som	dbouffard@crisisandcounseling.org or maineqicchair@gmail.com	<i>GEAR Parent Network</i>	Email Phone
MCCARTY, VICKIE 82 Willow St Apt3 Augusta 04330 687-6033 (C)	Vice chair Adult Chair	Consumer	2007	Adult	Kenn	vmccarty@maineconsumers.org	<i>Consumer Council System of Maine PAIMI (DRC)</i>	Email
LADD, RICHARD SR. 118 Ladd RD Barnard Twp 04414 965-0044 (H)	Treasurer, Historian	Family Member	1997	Children	Pisca	rwlsr50@gmail.com		Email Phone Mail
JEWELL, VIRGINIA 279 Brown's Corner RD Canaan 04924 858-5998 (C)	Secretary, Children's Chair	Parent	2007	Children	Som	ginnysnaturalcorner@yahoo.com		Phone email

Maine QIC Membership Roster (For Member Use)
June 2015 (REV)

NAME	QIC POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION(S)	REGULAR CONTACT BY:
Carr, Margaret 47 Turtle Cove Rd Raymond 04071 458-3563 (C)		Family Member	2004	Children	Kenn	Mdcarr47@aol.com	<i>NAMI Maine</i>	Email Phone text
LEAVITT, MATTHEW 185 LANCASTER ST PORTLAND 04102 740-4688		Youth Provider	June 2014	Children	Cumb	mleavitt@youthmovemaine.org	<i>Youth M.O.V.E Maine THRIVE</i>	Email
Fraser, Karen 150 State House Station Augusta 04330 623-7961(W)		Vocational Rehabilitation	Nov 2014	Adult	Kenn	Karen.d.fraser@maine.gov	<i>State of Maine, Dept. of Labor</i>	Email
MANZER, TAMARA 185 LANCASTER ST PORTLAND 04101 740-5473 (W)		Youth	Feb 2015	Adult	Cumb	tmanzer@youthmovemaine.org	<i>Youth M.O.V.E. Maine Thrive</i>	Email
O'NEILL, COLIN 25 TYSON DRIVE STATE HOUSE STATION 111 AUGUSTA 04333 287-2711		Criminal Justice-Juvenile	June 2015	Children	Kenn	Colin.O'Neill@maine.gov	<i>State of Maine , Dept. of Corrections</i>	Email
EVANS, KAREN 145 Spring ST, Apt. N Portland 04101 772-7140 (H)		Consumer	1996	Adult	Cumb	Kazgir1927@gmail.com	<i>PAIMI, DRC CCSM APS Healthcare</i>	Email Mail
HARD, MARCIA		Consumer	Dec	Children	Andro	marciahard@		Email

Maine QIC Membership Roster (For Member Use)
June 2015 (REV)

87 Scribner Blvd #2 Lewiston 04240 740-7930 (C)			2011			yahoo.com		
NAME	QIC POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION(S)	REGULAR CONTACT BY:
OLIVER, JENNIFER 2063 State Route 129 South Bristol 04568 644-8269 (H) 462-2722 (C)	Member-ship Chair	Family Member	March 2011	Children	Lincoln	livlulu_07@yahoo.com	<i>Mobius, Inc.</i>	Email
Hansen, Mary 76 Eastern Ave Augusta 04330 626-0003 x117 (W) 270-2420(C)		Adult Provider	October 2014	Adult	Kenn	mhansen@bsmaine.com	<i>Graham Behavioral Health Services</i>	Email
LANGWAY, SHERRY OCFS SHS #11 Augusta 04333 624-7910		Children's Mental Health (NV)	March 2011	Children	Kenn	Sherry.langway@maine.gov	<i>DHHS/Office of Child & Family Services (OCFS) Behavioral Health Services for children</i>	Email
MASSELLI, BRIE 723 Riverside St Apt 412 Portland 04103 805-1056 (H) 240-9607 (C)		Consumer	June 2014	Children	Cumb	bmasselli@youthmovenational.org	<i>Youth Move National Thrive Youth M.O.V.E Maine</i>	Email
MCPHERSON, CINDY DHHS/SAMHS 41 Anthony Ave		Adult Mental Health (NV)	April 2011	Adult	Kenn	Cynthia.McPherson@maine.gov	<i>DHHS/Office of Substance Abuse and Mental Health Services (SAMHS)</i>	Email

Maine QIC Membership Roster (For Member Use)
June 2015 (REV)

Augusta, ME 04333 592-2279								
NAME	QIC POSITION	MEMBER CATEGORY	MEMBER SINCE	QIC COMM.	COUNTY	EMAIL	AFFILIATION(S)	REGULAR CONTACT BY:
BRADSHAW, ELIZABETH 11 SHS, 242 STATE ST Augusta 04333 624-4054 (W)		Medicaid	2012	Adult	Kenn	Elizabeth.s.brads@maine.gov	<i>DHHS Office of MaineCare Services, Policy</i>	Email
BARROWS, TERESA 2 ANTHONY AVE AUGUSTA 04330 624-7915 (W)		OCFS	2014	Children	Kenn	Teresa.barrows@maine.gov	<i>DHHS/Office of Child and Family Services(OCFS)</i>	Email phone
ARMSTRONG, PEG Maine Department Of Education Special Services 23 State House Station Augusta 04333 624-6654 (W)		Education	Sept 2013	Children	Kenn	Peg.armstrong@maine.gov	<i>Maine Department of Education Special Services</i>	Email
WHEELER, SHELDON Director of Substance Abuse & Mental Health Services (SAMHS) 41 Anthony Ave Augusta, 04333 287-2595		Housing/ Adult Mental Health (NV)	2008	Adult	Kenn	sheldon.wheeler@maine.gov	<i>DHHS/Office of Substance Abuse and Mental Health Services(SAMHS)</i>	Email

Maine QIC Membership Roster (For Member Use)

BURGESS, EDWARD GREYFOX PO BOX 72 BUCKFIELD 04240 520-9967		Adult	Aug 2014	Adult	Oxford	Edwardburgesjr@yahoo.com	<i>Student</i>	Email Phone
SPRAGUE, KIMBERLY 76 PLEASANT ST BRUNSWICK 04011 721-00214(W) 522-9816(C)		Children's Provider	June 2015	children	Cumb	ksprague@merrymeetingbha.com	<i>Merry Meeting Behavioral Health Services</i>	Email Phone
WELLS, MATTHEW RECOVERY MANAGER(SAMHS) 41 ANTHONY AVE AUGUSTA 04333 287-4274		Recovery (SAMHS)	June 2015	Adult	Kenn	Matthew.wells@maine.gov	<i>DHHS/Office of Substance Abuse and Mental Health Services</i>	Email
PREBLE, ALICE MOVING FORWARD PROJECT DIRECTOR – OCFS 2 ANTHONY AVE AUGUSTA 04333 626-8666 (W) 446-4690 (C)		OCFS /Moving Forward Project – Director	June 2015	Children	Kenn	Alice.preble@maine.gov	<i>Moving Forward Project Director -located at both DHHS/Office of Child and Family Service (OCSFS) and Substance Abuse and Mental Health Services (SAMHS)</i>	Email

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Margaret Carr	Parents of children with SED		Augusta , ME 04330	
Vickie Mc Carty	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Council System of Maine	Augusta , ME 04330	
Karen Evans	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Council System of Maine		
Virigina Jewel	Parents of children with SED			
Diane Bouffard	Parents of children with SED	GEAR Parent Network	32 Winthrop Street Augusta, ME 04330	
Richard Ladd Sr.	Parents of children with SED			
Jennifer Oliver	Parents of children with SED			
Marcia Hard	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		87 Scibner Blvd #2 Lewiston , ME 04240 PH: 207-740-7930	
Cynthia McPherson	State Employees	Office of Substance Abuse and Mental Health Services	32 Blossom Lane Augusta, ME 04333-0011 PH: 207-592-2279 FAX: 207-287-2156	cynthia.mcperson@maine.gov
Sherry Langway	State Employees	Office of Child and Family Services	2 Anthony Ave, SHS 11 Augusta , ME 04333-0011 PH: 207-624-7910 FAX: 207-287-6156	sherry.langway@maine.gov
Peg Armstrong	State Employees	Department of Education	23 State House Station Augusta, ME 04333-0023 PH: 207-624-6600 FAX: 207-624-6700	peg.armstrong@maine.gov
Sheldon Wheeler	State Employees	Office of Mental Health and Substance Abuse Services -Housing	41 Anthony Ave , 11 State House Station Augusta, ME 04333-0011	

Mary Hansen	Parents of children with SED	Graham Behavioral Health Services	76 Eastern Ave Augusta , ME 04330 PH: 207-626-0003
Brie Masselli	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	MPF/THRIVE Fam Cmte/MADSEC/DHHS/CBHS/MDOE/KMCC/GovTaskF/CMIS AdvBd	185 Lancaster Street Portland , ME 04102 PH: 207-740-4688
Karen Frasier	State Employees	Dept of Labor Vocational Rehabilitation	150 State House Station Augusta , ME 04330 PH: 207-624-7961
Tamara Manzar	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Youth Move Thrive	185 Lancaster Street Portland, ME 04101 PH: 207-740-5473
Colin O'Neil	State Employees	Dept of Corrections	25 Tyson Drive , # 111 State House Station Augusta, ME 04333 PH: 207-287-2711
Elizabeth Bradshaw	State Employees	DHHS Office of Maine Care Services	242 State Street , #11 State House Station Augusta , ME 04333 PH: 207-624-4054
Teresa Barrows	State Employees	DHHS Office of Children and Family Services	2 Anthony Ave , #11 State House Station Augusta , ME 04333 PH: 207-624-7915
Edward Grayfox Burgess	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 72 Buckfield , ME 04240 PH: 207-520-9967
Kimberly Sprague	Providers	Merry Meeting Behavioral Health Services	76 Pleasant Street Brunswick , ME 04011 PH: 207-721-0021
Mathew Wells	State Employees	DHHS Office of Substance Abuse and Mental Health Services	# 11 State House Station , 41 Anthony Ave Augusta , ME 04333 PH: 207-287-4274
Alice Preble	Others (Not State employees or providers)	DHHS Moving Forward Project	#11 State House Station , 2 Anthony AVE Augusta , ME 04333 PH: 207-626-8666
Mathew Leavitt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Youth Move Thrive	185 Lancaster Street Portland , ME 04102 PH: 207-458-3663

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	24	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED*	6	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	14	58.33%
State Employees	9	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	10	41.67%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="2"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="2"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="2"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The State's Mental Health Authority advisory body is known as the Quality Improvement Council. The council consists of providers, consumer's family members, and state staff from SAMHS, OCFS, OMS, Departments of Education, and Labor. The council has monthly meetings and subgroups focusing on council directed issues which also meet regularly. The Council composition largely consists of persons with lived experiences. The council has been instrumental with planning and development of utilizing peers in the Maine Behavioral Health System. The council also has been effective in assisting state contract staff with onsite provider reviews.

Footnotes:

JUL 7 2015

Mr. Sheldon Wheeler
Department of Health and Human Services
41 Anthony Ave
Augusta, ME 04333-00111

Dear Mr. Wheeler:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Page – 2 Mr. Wheeler

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

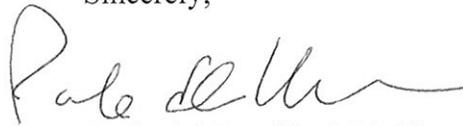
Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

Page – 3 Mr. Wheeler

Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a large initial "P" and a long horizontal stroke at the end.

Paolo del Vecchio, M.S.W.

Director

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

cc: Cynthia McPherson
Sherry Langway
Diane Bouffard

Enclosures:

2016 MHBG Prospective Allotments

MHBG Project Officer Directory